VA GENDER-SPECIFIC HEALTH CARE SERVICES FOR WOMEN VETERANS AND RELATED ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VA GENDER-SPECIFIC HEALTH CARE SERVICES FOR WOMEN VETERANS AND RELATED ISSUES

WEDNESDAY, MARCH 9, 1994

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:30 a.m., in room 334, Cannon House Office Building, the Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Kennedy, Long, Quinn, and Hamburg.

Also President: Representative Schroeder.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The hearing will come to order.

We appreciate everyone being with us bright and early this morning.

Since 1987, when I became chairman, this subcommittee has regularly conducted hearings on issues of particular importance and concern to women veterans. VA's provision of gender-specific health care to women veterans, in particular, has been a continuing concern.

Women now comprise about 12 percent of our active duty Armed Forces and are the fastest growing segment of the veterans population. The number of women veterans will continue to grow as military recruiters increasingly rely on women to so-called "man" the armed services, and the roles and responsibilities of women in the Armed Forces expand and change in important ways in the future, as well.

This year, for example, women are expected to account for a full 20 percent of the Army's enlistees. Women are now coming aboard the carrier *Eisenhower*, the first U.S. warship aboard which women will serve, and last month 1st Lt. Jeanie Flynn became the first woman to train in and pilot an F–15E Strike Eagle, the world's most sophisticated jet fighter plane.

As the roles and responsibilities of women who serve in the Armed Forces change, so will their need for VA health care. Growing numbers of women veterans will come to the VA for health care services, and more women veterans will turn to the VA for their service-connected conditions.

This subcommittee has repeatedly urged VA to improve health care services for women veterans; to recognize and respond to the legitimate needs of this growing veterans population. In some cases our advice has been heeded, but in other cases it has not. There is both good news and bad news.

First, one full-time women veterans coordinator has been appointed for each Veterans Health Administration region, but too many facility women veterans coordinators only have 5 hours per week to perform their important collateral duties.

VA has completed or funded 131 projects at a reported cost of more than $672 million to improve privacy, but many facilities lack adequate public restroom facilities for women veterans as outpatients, and women inpatients must continue to share bathrooms with male hospital patients.

As a result of staff initiative and local management support, important improvements in VA health care for women veterans have been made at some facilities, but because of inadequate oversight and a lack of management support and leadership, little or no real improvement has been made in women veterans health care at other VA facilities.

VA canteens now offer more gender-specific items for women veterans and are more willing to special order items, but at some VA facilities women inpatients are still forced to wear men's pajamas.

Finally, as a result of past hearings, Congress and the Department have taken action to improve VA health care for women. Improvements at many facilities have been reported, but progress throughout the VA has been slow. Much more can and must be done to further improve the VA health care system for women veterans systemically throughout VA.

The current Administration, I believe, has taken positive steps to better meet the gender-specific health care needs of women veterans. As I noted last June, Deputy Secretary Gober has candidly acknowledged the historic inadequacy of the VA health care services for women veterans.

More recently, Joan Furey, who testified before this subcommittee on many occasions, has been appointed to serve as Director of the VA's Office for Women Veterans. This clearly shows a sensitivity of Secretary Brown and this Administration for improving VA responsibilities to women veterans.

But as recently as last June, the Office of Inspector General told this subcommittee that many fundamental problems still hampered VA delivery of gender-specific services to women veterans. Today we want to know what the VA has done since then to improve delivery of gender-specific care to women veterans, what has been accomplished and what yet remains to be done.

We look forward to the testimony the subcommittee will receive today and to further progress in women's health care in the VA.

I want to bring up an important matter. Late yesterday the subcommittee learned of a troubling development, a development which this subcommittee intends to address. In their folders, the members of this subcommittee will find two versions of the testimony submitted by Dr. Joanne Sulewski. The doctor, who is employed by the Buffalo, NY, VA Medical Center, was invited by the chair to testify this morning and to present her personal views at

the suggestion of our colleague from New York, Congressman Jack Quinn.

The subcommittee understands that the personal views of the doctor which the subcommittee requested are presented in one of these statements, and the other statement submitted by the VA on behalf of the doctor are the doctor's views as changed by the bureaucracy.

Frankly, these changes made by the bureaucracy are puzzling. In her original statement, the doctor has given us nothing more than her personal views on women's health care, the very opinions that this panel requested and the very opinions that this panel needs to make informed policy decisions. She has not advocated the violent overthrow of the republic or grave bodily harm to any public servant. The views represent her purely personal views and professional judgment and opinions, and she is fully entitled to these views.

If the subcommittee had invited the doctor to testify on behalf of the President or the Department of Veterans Affairs, the massaging of her testimony to represent the views of others could certainly be more readily understood. Changing her personal views cannot be understood.

For some very puzzling reason, an overzealous bureaucrat has made a very bad error in judgment. The subcommittee is not aware of any past effort to orchestrate the personal opinions of witnesses appearing before this panel and will not tolerate any similar effort in the future.

The chair believes that colleagues on both sides of the aisle in this committee share that view. If necessary, each and every witness invited to present his or her personal views before this panel can be asked under oath if their testimony is their own. Obviously we hope this will not be necessary.

This subcommittee relies on and must continue to have direct access to the views of those who have relevant knowledge and experience. The subcommittee and the Congress depend upon the honesty and truthfulness of those who testify before us. We expect nothing less; we will accept nothing other than that, as well.

Finally, if any witness before this subcommittee believes that he or she is treated unfairly as a result of presenting their personal views before this panel, this subcommittee wants to know, and we want those individual witnesses to contact me personally.

The subcommittee will not be sidetracked this morning by this development. On behalf of the women who served in our Armed Forces past, present and future, we intend to focus our attention on the subject of today's hearing: women's health care in the VA hospital system.

We will now start with our first panel and ask them to come forward as their names are called out. The members of our first panel are Kay Dennis, Toni Lawrie, Jean Reed, Carolyn Rennert, Dr. Joanne Sulewski, Dr. Valerie Ulstad and Barbara Zicafoose.

Before introducing other members of the panel, I am very pleased to welcome and recognize the gentlemen from California, Mr. Hamburg, at this time to introduce two of the members of the panel, and we will now yield to him.

OPENING STATEMENT OF HON. DAN HAMBURG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. HAMBURG. Thank you very much, Mr. Chairman, and I think it is very important and timely that you are holding this hearing on women's health care in the VA system.

I am also pleased, as you mentioned, to introduce to your subcommittee two constituents from the First Congressional District of California who have come all the way from California to testify before the subcommittee today.

Kay Dennis served as the American Legion representative on the Martinez VA Medical Center Women's Veterans' Committee from 1987 to 1991 and was appointed by the Governor of California to serve on the State Commission for Women Veterans in 1988.

Carolyn Rennert is a 100 percent service-connected disabled veteran and Vice Chairperson of Operation VA, which is a Solano County, California, group formed to advocate for the timely construction of a replacement VA medical center at Travis Air Force Base in Fairfield, which is Solano County in the First Congressional District.

I say the timely construction with a little bit of hesitance because if we were really talking about timely construction of that replacement hospital, it would be there today. It is ironic that a couple of months ago when the House was discussing emergency earthquake relief for Southern California, I certainly felt for the people who have suffered from the Northridge earthquake, but I also noted that we are still suffering the effects of earthquake in Northern California, and one of the results of that earthquake was the closing of the Martinez Hospital, and we are definitely suffering the effects of that in terms of veterans' health care in Northern California.

And as Chairman Evans has noted, there are 400,000 veterans in the Northern California catchment area who do not have good access to a VA medical center since the closure of Martinez, and that represents more veterans than 29 States' veterans in this country. So this is a very acute situation, and I am very glad that two of my constituents could come back today.

Just one more plug for Operation VA. This group has mobilized the community in Solano County in Northern California. Chairman Evans, you were kind enough to come out to my district and to the Fairfield area on January 10th of this year. You heard Kay Dennis and Carolyn Rennert speak about the devastating impact of the closure of Martinez Hospital, and you have joined the fight with great enthusiasm to move this construction project along for the benefit of nearly half a million veterans in Northern California.

So finally, I just want to thank Ms. Rennert and Ms. Dennis for coming all the way from the West Coast to testify on these women's health issues this morning, and I am sure that their testimony will be of great value to this subcommittee.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you very much.

I want to tell Kay and Carolyn that we are following up on this issue, and that Dan has been like a pit bull dealing with the VA officials and members of this committee since the hearing and be-

fore. We want to keep the pressure on VA to move up the construction to open up that facility just as quickly as we can. We appreciate your testifying before us again because of the importance this facility has on the veterans' population generally, but specifically as it affects women veterans. We appreciate your being here again today.

It's a pleasure to now introduce the other members of the panel. Toni is the Women Veterans' Coordinator at the Bay Pines VA Medical Center in Florida.

Jean is a retired Air Force veteran and serves as a member of the Governor's Advisory Committee on Women Veterans in the State of Ohio.

Dr. Sulewski is the Chief of Gynecologic Section, Department of Surgery, at the Buffalo VA Medical Center.

Dr. Ulstad is from the VA Medical Center in Minneapolis, MN, and works with the Women Veterans' Comprehensive Health Care Center.

Barbara is an adult nurse practitioner, female veteran co-coordinator and Women's Health Clinic Coordinator at the VA Medical Center in Salem, VA.

We are pleased to welcome each of you this morning, and thank you for your participation in today's hearing. All of your written statements will be made part of the record, and you may summarize from your formal remarks.

We also appreciate the interest of Congressman Quinn from New York in today's hearing, and we thank him. We understand he is in route at this point. We will now begin with this panel and, Kay, start with you.

STATEMENTS OF KAY DENNIS, NAPA, CA; TONI LAWRIE, VA MEDICAL CENTER, BAY PINES, FLORIDA; MARY JEAN REED, GOVERNOR'S ADVISORY COMMITTEE ON WOMEN VETERANS, STATE OF OHIO; CAROLYN RENNERT, VACAVILLE, CA; DR. JOANNE SULEWSKI, CHIEF, GYNECOLOGIC SECTION, DEPARTMENT OF SURGERY, VA MEDICAL CENTER, BUFFALO, NY; DR. VALERIE ULSTAD, CINIC DIRECTOR, WOMEN VETERANS COMPREHENSIVE HEALTH CARE CENTER, VA MEDICAL CENTER, MINNEAPOLIS, MN; AND BARBARA ZICAFOOSE, VA MEDICAL CENTER, SALEM, VA

STATEMENT OF KAY DENNIS

Ms. DENNIS. Thank you, Congressman Evans, and thank you, Congressman Hamburg, for inviting me back here, and thanks to my American Legion friends in Northern California, I am here.

The closing of the Martinez VA Medical Center in Northern California with its new and outstanding Women's Clinic has been a real tragedy. Traditionally women veterans have been greatly underserved in a VA medical system that has been, and in many cases still is, designed and run solely for male veterans, even though women represent the fastest growing group of veterans.

Approximately 140,000 women veterans live in California, the highest number of any State, with 64,000 residing in Northern California.

In 1985, the Women's Clinic was established in the Martinez VA Medical Center. A primary care clinic for women veterans, and the first of its kind in California, it served as a model for other primary care women's clinics. VA hospitals from all over the western United States sent representatives to study its programs. It was the only VA hospital to have a permanent gynecologist on staff, and he retired when the hospital was closed in 1991.

I was a member of the California State Commission on Women Veterans which existed from 1988 until the funding was canceled in 1991 due to State budget deficits. We held hearings up and down California on the availability of services to women veterans, such as home loans, vocational counseling, and particularly medical care.

We had a questionnaire that was distributed to thousands of women veterans through every possible source, 2,130 of which were completed, returned, and tallied. I know; my husband and I tallied them.

We all were appalled again and again to find that a significant number of women veterans at the time of discharge were not aware of their rights as veterans with two exceptions. They all knew they were entitled to educational benefits and a GI home loan.

With the establishment of the Martinez VA Medical Center Women's Clinic, women veterans were finally receiving care for problems uniquely theirs. For example, when a man enters a VA medical center or hospital, he is usually offered a routine prostate examination regardless of why he is there. Women, however, could not find any routine gynecological care, such as pelvic and breast examinations, mammograms, pap smears, and bone density scans, even though this care should be just as routine for women.

I need to explain here that my interest in and dedication to the cause of medical care for women veterans is the result of losing two very dear friends to uterine cancer. They were members of the California State Veterans Home in Yountville, and both women had been bleeding for 2 or 3 months. The only gynecologist available for consultation through the VA system was one from Stanford Hospital, who was available through the Palo Alto VA Hospital one afternoon a week.

These two women tried repeatedly for over 2 months to get an appointment, but they were always told he was not coming in that week or his calendar was full. They tried to get permission to see gynecologists in Napa with the VA paying the bill because neither woman could afford it. They were told it would have to be at their own expense.

Finally, someone reminded one of the veterans that she was a retired Army major who could go to Letterman Hospital at the Presidio in San Francisco. They immediately performed a hysterectomy and then told her that they wished they had seen her a month or two earlier. They could not get it all.

Both women left the veterans' home and moved to Loma Linda in Southern California, where one died of a cerebral hemorrhage and the other died screaming every time the morphine wore off.

Since the Martinez Medical Center closed, I keep wondering just how many women veterans in Northern California are ignoring bla-

tant signs of trouble because they must travel such great distances to get surgical consultation and care.

About a month ago I talked to a World War II friend in Yreka, just 57 miles south of the Oregon border, who had to have surgery after Martinez closed and was forced to travel 382 miles one way from Yreka to Palo Alto for all pre-surgical and post-surgical consultations and for the surgery. She was lucky. She had a family member who could take her.

How many are there who are bleeding or feel a lump in their breast and have absolutely no one to help them? One is too many; ten is horrifying.

We cannot wait until 1999 or the year 2000 or one year from never to get a replacement for the Martinez VA Medical Center. We, female veterans and male veterans, need it yesterday.

Thank you.

[The prepared statement of Ms. Dennis appears on p. 69.]

Mr. Evans. Thank you, Kay.

Carolyn, Please proceed whenever you are ready.

STATEMENT OF CAROLYN RENNERT

Ms. RENNERT. Chairman Evans, Congressman Hamburg, members of the committee, my name is Carolyn Rennert. I am 100 percent service-connected disabled veteran. I am a graduate of the University of Maryland with a Bachelor of Science degree in nursing. I am a lifetime member of Disabled American Veterans, a member of the National Association for Uniformed Services in Fairfield, CA, and Third Vice President of the United Veterans Memorial Association in Vacaville, CA. I am also the Vice Chairwoman of Operation VA.

I am a chronic field veteran who was medi-vaced home during Vietnam and have been dealing with the VA health care system ever since. Chronic illnesses limit, disable, and blind. They age, robbing the ill of any semblance of normal life. Chronic illnesses are incurable and will not go away.

Healthy people do not understand what life is like for someone like myself. People look at the ill differently and do not seem to realize that we are functioning, worthwhile human beings, even if we are no longer able to work.

The VA has labeled me disabled. I have had to adjust my life, and in the process I have learned to hold all my feelings and pains inside because most people do not know how to react to those who are ill.

In addition to dealing with my disability on a daily basis, the frustrations that I or any other woman veteran encounter when seeking medical treatment in the VA system is appalling. Women veterans are not treated with respect.

At the present time there is a 6 to 9-month wait for an appointment with the one part-time gynecologist that sees the more than 64,000 women veterans in Northern California. If a woman veteran cannot wait the 6 months, she is seen by one of the general medicine doctors who are usually not versed in women's health care issues and appear displeased with treating a woman due to this reason.

Mr. Chairman, it saddens me deeply to report to you that women's health care has not improved or been addressed by the outpatient clinic in Sacramento, CA, the clinic that is nearest to my home, a 50 mile trip one way.

Routinely women veterans are not offered breast exams or mammograms or any other procedure inherent to women's health care. If I seek treatment for a condition outside of general medicine, I am referred to a facility 175 miles away in Palo Alto, CA.

This referral starts a lengthy process to provide me with the care mandated by Congress for my service-connected condition.

My most recent hospitalization in November was at the VA in San Francisco. I was the only woman veteran in the hospital, and privacy was at a premium. I had to share the same communal bathroom as the men. When it was time for me to use the facilities, there was pandemonium clearing out the bathroom shower so that I could use it.

Items available for women and men were almost nonexistent. No toothbrush, no soap, no wash basin, no emesis basin. In fact, when I asked for a water glass, I was given a sterile urine cup.

As far as I could ascertain, there were no gender-specific items available.

In addition to the lack of facilities for women veterans, the disrespect and neglect of women is exemplified by this story from a fellow woman veteran. At the age of 19, she was raped by a man whom she told me was her commanding officer. After the attack, she made her way back to her barracks to informed the charge of quarters. She was met with disbelief.

She went to the hospital and again was treated poorly. She was given a cursory pelvic exam without another woman present, and she was not given the opportunity to speak with a rape crisis counselor, but she was given an Article 15 and discharged with a general discharge from the service.

Needless to say, the man was not reprimanded, discharged, or demoted. This woman veteran now described the last 25 years of her life as a loss because she has lost every emotion.

In the last year she has applied for a service-connected disability for post-traumatic stress disorder. She has been denied.

How many other women have had to suffer such an injustice? When is the Government and the VA going to take their heads out of the sand, look at the needs of the woman veteran, and stop treating us as nonpersons, which the dictionary defines as a person regarded by the Government as not existing.

The most pressing need for women veterans is a coordinated professional program that would identify women veterans in every state and determine their needs and advise them of the veterans benefits to which they are entitled. However, it is surely apparent that despite the VA's somewhat aggressive actions to insure equal access for women for all treatment and medical programs and to address their unique needs, the problem of informing women veterans of their benefits still seem to resist the VA's best outreach efforts.

A survey of 1,545 women veterans in California revealed that only 14 percent of them ever contacted the woman's coordinator

now stationed in all California VA hospitals. The survey confirms that outreach and education should be the VA's highest priority.

Women veterans have historically made a significant contribution to the United States and the State of California. It is incumbent upon our Nation to insure that these women are located and advised of their entitlements and that they receive equal access to veterans benefits.

The issues that affect women veterans not only affect them, but all other veterans. The outpatient clinics in Northern California are so overburdened and backlogged that there is usually a 4 to 6-hour wait, even if you have a scheduled appointment.

We veterans wait in long lines for the simplest procedures, if we can get them at all. Is it any wonder that only 9 percent of the veteran population in the United States even attempts to use the VA medical system?

Every chronically ill veteran realistically knows that further hospitalizations will be necessary. In such a person's life, there is always turmoil and frustration when one knows that once again medical help must be sought.

Now in Northern California with the added burden of not knowing where we will go for that medical care, the anger and frustration already felt is heightened. The hospital in San Francisco is old and sorely in need of renovation. The 200-bed facility serves over 500,000 veterans.

In 1991, within 120 days, the VA closed down the Medical Center in Martinez, CA. At the time of closure, there were 250 patients that had to be either discharged or transferred to the already critically overcrowded VA in San Francisco.

As I previously stated, I am Vice Chairwoman of Operation VA, a group which was formed in the spring of 1993 to help insure that the funding for the replacement hospital at Travis Air Force Base is appropriated. The ensuing battle for the appropriation of funds has been a long, hard fight. We veterans have waited 3 years for a replacement facility.

The completion date for the hospital is scheduled for December of 1998. This time line is unacceptable to every veteran living in Northern California.

In the California State legislature, Senator Feinstein and State Senator Thompson, Congressmen Hamburg and Fazio, veterans' organizations around the country, to name a few, endorse Operation VA. There are some of us who might not see this hospital become a reality, but the veterans of Northern California will continue to rally and fight for this critically needed hospital.

I feel it is my duty to report to you that there have been documented cases of veterans dying in Northern California because they had no VA facility to get comprehensive medical care.

Mr. Chairman, thank you for the opportunity to come to Washington and report to you the unsatisfactory condition of women's health care in the VA system. All around this room today you are seeing the many women veterans who are willing to give their all in their service to our great country.

We implore you to take our stories to other members of our government and to make them aware of the atrocities that we have incurred and still continue to live with on a day-to-day basis.

[The prepared statement of Ms. Rennert appears on p. 90.]

Mr. EVANS. Thank you, Carolyn, very much.

Before recognizing the next witness on the panel, the chair will recognize the members of the subcommittee and then introduce Congresswoman Schroeder for her remarks.

The gentleman from Massachusetts.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY, II

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

First of all, I want to very much welcome all of our witnesses. I know that some of you, and, Dr. Sulewski, we very much appreciate your testimony, in particular, and I want to thank all of you for having the courage to come forward and talk about in many cases personal issues and the difficulties that you have faced.

We appreciate the difficulties that you encounter when talking about some of these questions, and I think that under the leadership of Chairman Evans, there are a few of us on this committee that have tried very hard to make certain that the VA becomes more sensitive to the needs of women veterans.

As we enter a period of time in the country's history where we are expanding the role of women in terms of active military service, it stands to reason that very soon afterwards the veterans system is going to have to become much more sensitive to the needs of women veterans.

We have not done so in the past. I very much commend all of you for coming forward, and, Mr. Chairman, I appreciate your efforts and look forward to continuing our efforts together to make certain that this issue is dealt with by the committee and by the Veterans' Department.

I have a full statement that I would like to submit for the record, but, again, I would like to thank you for this hearing and look forward to hearing directly from our witnesses.

Mr. EVANS. Without objection, your statement is entered into the record.

The gentleman from New York.

OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman.

I want to join my colleagues here in welcoming the members of the panel for their comments this morning, and I apologize for being a few minutes late.

In particular I think I am, and we are, fortunate to have Dr. Sulewski with us this morning, and I want to welcome her from Buffalo, NY, and also Ms. Helen Jacob from Buffalo, NY.

As we continue this morning—and I know the Chairman referred to this in his opening statement—I think if we are going to do our jobs as members of this subcommittee of the Veterans' Affairs Committee and as members of Congress, we need to have a very, very accurate picture of the current situation out there.

The only way that we can get that accurate picture is to hear testimony from people in the field, and the testimony we receive today, like always, is very important for us to do our job and to help our veterans, whether they are in Buffalo, NY, and Rochester or all across the country.

So I want to join in welcoming the panel here this morning and look forward to the testimony so we can help, and so we can do our jobs to help you do your jobs.

Thank you, Mr. Chairman.

Mr. EVANS. I want to thank you for urging us to invite her. At your request, we did, and we appreciate that very much. It will be very helpful to us in our deliberations.

We are very happy to welcome our colleague from Colorado, Congresswoman Pat Schroeder. She has been a tireless and forceful advocate for women veterans and their health care needs, and we thank you for joining us, Congresswoman, and we would recognize you. Your entire statement, of course, will be entered into the record.

STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mrs. SCHROEDER. Mr. Chairman, I want to thank you and members of this subcommittee. This has been a tireless subcommittee in trying to deal with the problems of the VA and women's health, and this very distinguished panel shows how hard you worked to point out how important this is.

I thank you for putting my statement in the record. I guess the thing I wanted to point out, what I was most shocked about, was that as we see more and more veterans becoming women, we also see less than half of the usage of the VA by women than by men; that women have gotten the message that the VA does not care about them, and as we see more people who are in the services becoming women, I think this is a serious issue for the VA.

It is also shocking to me because many of our veterans were nurses who cared for active duty service members, and then to see the VA so careless in how they treat them is very shocking.

But I guess the thing that shocked me the most (and you are going to hear more about this from the Inspector General, so it is kind of silly for me to go into it, but I heard from your testimony the same thing) was the issue of cleanliness. My goodness, we just take cleanliness for granted, but as I was looking at the Inspector General's report, I was absolutely shocked by the lack of cleanliness that they found, and it looks like one of the ways we will find out for the first time that the VA is taking women seriously is if we ever get "potty parity."

But your point about how women are being told over and over and over again that there are not women's restrooms, or they have to share women's restrooms, or the rooms are not marked, or they do not tell men that they are using unisex restrooms, or they do not have shower curtains, or they do not have any items for women, any gender-specific items at all, or they throw women in pajamas that do not fit them, and on and on. All of those things just send an absolutely incredible message, and they seem so very simple.

We know the other issues, such as if you want something as basic as a mammogram, you can be told to drive 150 miles. And I know how hard you have worked on trying to get these coordinators, and yet we still find there are places where a coordinator is working less than 5 hours a week. And I am sure you are going

to hear this morning that many centers are not going to be able to send their coordinators to a training mission because it costs too much. So it tells you their priority.

And yet you do not see them using any other innovative way of getting that training. Could they do a teleconference? Could they do anything? There might be some cheaper way, and you just kind of see them shrugging it off, saying we cannot go because it costs too much, and so, therefore, that is the end of that.

I guess I just take deep breaths and salute your courage in continuing to push ahead. I think I could go on and on. You have heard me before. It does not make any sense to speak to the choir. I guess our challenge is what in the world do we do. How do we finally get the VA to focus on this issue and to take women seriously?

So thank you for being here, and thank you for having all of these wonderful witnesses here, and anything we can do in the Congressional Caucus on Women's Issues to help, let us know because we are frustrated beyond belief that this issue keeps going on and on and on, and we do not seem to be able to make an imprint on the VA.

Thank you.

Mr. EVANS. Thank you, Pat. We appreciate your testimony and continuing leadership on these issues.

Mrs. SCHROEDER. Thank you.

Mr. EVANS. We will resume with the panel with Toni.

STATEMENT OF TONI LAWRIE

Ms. LAWRIE. Mr.Chairman, members of the panel, thank you for this opportunity to report on VA actions to improve health care to women.

While I represent only one hospital program, the program is based in Florida which is second in the Nation, only to California, in the number of women veterans in the State. We have 85,400 by the 1990 census estimate.

In 1983, then Florida Medical District 12 designated women counselors in all of its health care facilities. That was 2 full years before VA recommended women veterans' counselors to be appointed.

There are estimated to be 17,000 women veterans in the Bay Pines service area, with 7,000 of those women alone in Pinellas County, the county that houses the Bay Pines facility.

I have worked at Bay Pines since 1981 in various positions in nursing service and watched the program for women grow from no organized program to one of some positive celebrity in the VA system.

A visit from the VA Advisory Committee on Women Veterans to Bay Pines in October of 1987 was probably a catalyst for raising our consciousness about the unmet needs of women veterans. I feel the VA's commitment to enhancing service for women is sincere and evidenced by support of the women's programs in an era of down-sizing, through the appointment of women veterans' coordinators regionally and locally full time, and with some facilities appointing full-time coordinators from within existing resources.

The VA need of the recognition for sexual trauma counseling, along with comprehensive health care services, including contraception, screening and prevention, health maintenance and restoration, and psycho-social interventions combined with the publication of VA women veterans' health care guidelines are compelling indications of intent.

However, major barriers continue to block access to VA health care for the majority of our 27.2 million living veterans. They were uninjured, not yet victims of an impending chronic disease, and healthy when they left active duty military service.

The barriers are the confusing array of rules for eligibility and entitlement on release from active duty. All of 1.2 million women veterans volunteered for military active duty. Almost half of them volunteered for service during a time of war and left the military when the threat diminished. None were drafted.

This patriotism long went unrecognized and unrewarded for World War I and II veterans, for women who served in Korea and Vietnam, and more recently for veterans of Panama and Granada.

If they came to VA, we were woefully and largely unready to serve them. In this age of health care reform, VA has the opportunity to put its might and money into a mutually beneficial pact with women veterans. The many women who currently seek services through our VA are pleased with the care provided, but frustrated by a lack of access to comprehensive outpatient care needed to restore or maintain health.

Changes must continue to evolve in the culture of the VA care to women in issues of sensitivity and privacy. Counseling of women for trauma and the sequela of sexual abuse is now generally delivered in the mental health clinic setting. For many women, this means that because they were raped or otherwise sexually abused in the military, their first encounter with the VA health care system will probably be associated with a mental health visit, which might prejudice future care.

Similarly, admitting women to locked, male dominated psychiatric wards for treatment of the aftermath of sexual trauma is inappropriate. Some VAs, however, have no alternative at present.

Changes needed in structural privacy are relatively easy to recognize. Our daily practices are more subtle and truly require the paradigm shift so often invoked in VA.

I was reminded one day when I was discussing a young, 33 year old woman's dissatisfaction with her treatment in our ER. She asked me, "Would you feel comfortable in a six-bed observation room with men in four of the beds listening to your symptoms of abdominal pain?"

I began with the standard reassurance that I would, reconsidered and shifted my paradigm. We now have physically separate facilities for acutely ill men and women in our evaluation area.

Overall, Mr. Chairman, I feel that the VA on a national level and Congress with the passage of Public Law 102–585 is responding with alacrity to identify needs and issues of women veterans. Funding for women veterans' comprehensive health centers, sexual trauma counselors in the vet. centers, full-time women's coordinators, training sensitivity, training for health care professionals in the VA regarding women issues, authorization to provide gender-related

services not available at VA facilities are not steps, but leaps in the right direction.

A follow-up study to the 1985 survey on female veterans by Harris, et al., is still needed to determine general policy and planning issues in the area of care to women, to the growing population of women veterans, and more specifically, to address issues as they relate to the elderly and minority women.

VA also needs to identify several centers of excellence, VA or non-VA, in the care of women in each region and arrange for staff likely to be asked to examine women to be updated on relevant assessment skills. Provider staff in some VAMCs and outpatient clinics might not have had occasion to perform breast or vaginal examinations during their entire VA career.

I believe from my experience and my association with other women veterans and women veterans' coordinators that strong support for these programs is growing at the local levels in VA, and we will be able to change the culture and environment of the VA to accommodate all veterans who seek our services if we can be freed of the many bureaucratic regulations that bind and confound us.

We only need the opportunity to reach consensus, and that is the plan as we transition to primary care and continue to focus on improving care to women.

Thank you for this opportunity to make my statement.

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

Mr. EVANS. Thank you, Toni.

We have been joined by Congresswoman Jill Long and the chair is pleased to recognize her for an opening statement or other remarks.

Ms. LONG. Thank you, Mr. Chairman. I do not have an opening statement, but I do want to commend you for holding this hearing. This is obviously a very important issue to the women veterans of this country.

Mr. EVANS. Thank you.

Mary Jean Reed is our next witness.

STATEMENT OF MARY JEAN REED

Ms. REED. Good morning, Chairman Evans and members of the House Veterans' Affairs Subcommittee on Oversight and Investigation.

I am Mary Jean Reed, Lieutenant Colonel, Retired, U.S. Air Force. I am here today representing the Governor's Advisory Committee, Women Veterans in Ohio, of which I am a member, and I would like to thank you, Congressman Evans, for coming to the State of Ohio and holding the hearings on Chillicothe Medical Center.

In January I attended a public hearing at the VA hospital in Chillicothe, Ohio, where Congressman Evans and Congressman Strickland were present. Many questions from the audience were raised regarding various issues and concerns with respect to the care and treatment received by veterans at VA facilities. However, not much to my surprise but, rather, disappointment, I was the only person who raised questions concerning specifically the treatment of women veterans at those same facilities.

At that time Congressman Evans informed me of this hearing, and I am proud to have been invited to testify before the subcommittee.

The Governor's Advisory Committee for Women Veterans is an unfunded committee and was established in January 1993. It is comprised of women veterans and active duty service women, including National Guard and Reserves, who have served in the military from World II through the present. This committee, established by Governor George V. Voinovich, was asked to provide the governor with recommendations on the issues, needs and concerns of Ohio women veterans.

To best fulfill the governor's request, we had to first develop some goals and set an agenda. The committee decided that it must do the following:

First, identify and assess the special needs of women veterans, to provide information which would meet the needs of women veterans, including benefits and entitlements, education, training for unemployment through federal referral programs. We would research and assess the need of women veterans to identify services currently offered and to determine which services are lacking.

We recommend and plan events honoring women veterans who have served and those currently serving in the military. These events would be utilized for development and enhancing a positive image of women veterans and to coordinate and monitor efforts to accomplish all of the above goals and objectives.

Point of contact with various organizations needed to be established to acquire information and avoid duplicate effort.

Once these goals were developed, the committee then needed to formulate a continuing means by which to accomplish them. The committee formed four subcommittees with each focusing on the specific areas. The subcommittee for identifying Ohio women veterans was created because, in order to address these issues, those who would be affected by other initiatives needed to make us aware of their concerns.

Currently there are an estimated 40,000 women veterans in Ohio. Unless these women already considered themselves to be veterans, which unfortunately it has been reported that they do not and they utilize the services of the VA centers, Ohio's Bureau of Employment Services, or register with the veterans county service offices, we do not have a way to identify them.

A hearing and survey subcommittee focused in on coordinating statewide hearings with the intention of drawing women veterans to testify before the committee and present their experiences, special interests, and needs or ideas that the committee could study and consider when making recommendations.

The subcommittee also carefully crafted a survey which included several different categories in an effort to gather as much information and encompass as many areas as possible which would assist in accomplishing our goals.

The awareness and publication subcommittee is responsible for sending press releases to the media, conducting editorial boards for writing articles for various publications, and consequently preparing testimony for congressional hearings.

Our subcommittee on women's veterans' health care has the responsibility to identify problem situations which women veterans have encountered at VA clinics and hospitals. This subcommittee also works towards keeping abreast of what type of care and benefits are offered at the VA facilities.

I appreciate your patients with the overview of what our committee entails. The relevance is the close correlation among each of the goals, as well as the task of the subcommittee.

To date our committee has distributed over 4,000 surveys and has received close to a 25 percent return, something we are very proud of. These surveys are not short. They had 65 questions covering seven pages and touched the bases of education, income, marital status, health care, and dates spent in the service. Eventually this information will be entered into a database.

For many of the surveys we are accumulating. most of the questions which ask for some sort of written response were filled in. These answers, which have been very consistent, clearly address the issues that there is a problem with health care facilities with respect to the treatment of women.

Although there were general comments which could be applied to any veteran, here are some of the few relating to women veterans. One woman explained that while in the hospital for a shoulder reconstruction, I had to share a bathroom with a male Vietnam veteran.

It is felt that in many cases we served our country as well as, if not better, than most men, and we have equal rights to all available benefits. I have a major fear that because I am a woman, it is a waste of Government money for me to receive disability and dependent benefits.

Another woman veteran traveled approximately 70 miles to deal with facilities not equipped for women, employees unwilling to accept women, and, in my opinion, below average medical care. In 99 percent of my experience, I was made to feel like an animal.

From a woman veteran who cannot receive a treatment within her local area, I must travel to the nearest VA hospital for treatment not handled in the local VA clinic, which is only set up for mainly male veterans. They do not realize they are veterans, and most clinics are set up for men only.

And a female veteran, a Vietnam veteran's response regarding the experience with the VA medical facilities, she could only write, "Believe me, there is too much to say for this little space. My stay in the hospital for 4 days was a complete nightmare."

The VA medical center needs to be set up better and more understanding for the care of women.

The Toledo outpatient clinic sent a separate survey and received similar reactions to the problems that women veterans had at their clinic. Female veterans' service-connected disabilities were not treated on the same level as men.

The women also responded to questions asked about the gynecological care there. In one instance, a woman went to Ann Arbor, no GYN doctor, just a general practice doctor; could not answer various questions on women's concerns.

Another woman could not receive care because I did not have a regular appointment. I had a hysterectomy, so it probably is not as necessary.

In another case, the woman veteran received no follow-up from a mammogram.

Last summer our committee conducted several hearings throughout the State. From the testimony received, several witnesses explained the following.

I was the only female. I had to undress in a room with a door that would not close while men were lined up and down the hallway.

I encourage women to have privacy in hospitals. Close the doors.

The final bottom line can be summarized with the way the women are treated is terrible, and I assure you all of this goes on. It is plainly evident that these are areas and issues which need to be brought to your attention, and you have the power to make a positive impact.

This is the type of information our committee is searching for so that we can help these women and alleviate some of the horror stories and unequal treatment. Although our committee is in its infant stage, we are dedicated to working on our initiatives.

It is also apparent that Ohio is not the only State which is trying to accommodate its women veterans through the equality of male veterans. As you see, I have attached various newspaper articles from all different parts of the United States which also have stirred some interest.

It is our hope that after having been invited to testify before this committee, you continue to study the type of care which is provided to the women veterans, consider the comments received by women veterans, and address these issues boldly.

Thank you once again, and I would be pleased to answer any questions you may have.

[The prepared statement of Ms. Reed appears on p. 74.]

Mr. EVANS. Thank you, Mary Jean. We appreciate your testimony today and for speaking up in Chillicothe. It has been a very big help to us.

Dr. Sulewski, you are next. Personal views only, please.

STATEMENT OF DR. JOANNE SULEWSKI

Dr. SULEWSKI. Mr. Chairman, members of the committee, I am proud to be part of the VA. It offers an alternative for health care to women veterans in need.

At the Buffalo VA, it provides services that are equal to or better than those of the private sector. For example, counseling services, whether for sexual trauma or smoking cessation, and diagnostic studies, like densitometry which determines the extent of osteoporosis and susceptibility to bone fracture are virtually inaccessible to patients in the private sector because for the most part they are not reimbursable by third party payers.

And virtually any medication is available at the VA at a cost of $2.

I see the VA is leading the change in health care for women. For example, if you review current textbooks used in medical school, there is little mention about sexual trauma and its often long-term

effects, mentally, physically, and functionally, on the survivor. The VA held a national conference this past year on sexual trauma to educate health care providers on how to better diagnose and treat survivors. It also provides trained counselors at each VA to help the survivors.

The VA's approach to sexual trauma can only be a positive influence for other institutions and medical schools.

Another example of the leadership of the VA. Starting July 1, 1994, the VA will train physicians through its new Women's Health Fellowship Program to provide an integrated rather than a fragmented, organ-by-organ approach to women's health care. The quality of the fellowship is unparalleled in that it emphasizes research in women's health issues. I know of only two other programs in women's health care offered by two medical schools, but neither program approaches the quality of the VA fellowship.

The Buffalo VA hopes to be one of those five centers selected to offer a woman's health fellowship.

Already the VA's initiatives in women's health care have significantly influenced medical education at the State University of Buffalo. On May 1, 1994, the University Physicians Service will launch a women's health care program for treating women patients, and there is serious consideration being given to providing a women's health care training program for physicians at the university.

The VA also reaches out to the community. The Buffalo VA in an educational program with the School of Nursing at Daemen College in Buffalo this year has undergone a project, "In search of homeless women veterans." We have provided services to approximately ten homeless women veterans in the last 7 years. If there are homeless women veterans in Buffalo and in Erie County, New York, we intend to find them and to offer services to them.

During this month of March, Women's History Month, the Buffalo VA is a major supporter and participant in a series of week-long events entitled "In Celebration of Women and Their Dreams." Twenty-five thousand women have been invited to attend this event sponsored by more than 120 women's organizations. The women will learn about the health care program for women veterans at the VA.

There are some areas in which the VA can improve services to women veterans. Some examples are by changing eligibility requirements; by providing greater access to dental care, since osteoporosis is believed to contribute to dental loss.

When staff reductions are mandated, we cannot see or treat as many veterans who need health care. When research funds are decreased, opportunities for needed research in women's health care and the health care of all veterans and nonveterans are lost.

In my opinion, the cooperative research studies of the VA do for the health care of our Nation what the GI bill did for our society and economy when more than 20 million Americans received an education.

The VA and I as a physician can only deliver services to women veterans as provided for by Congress. The leadership of the VA, Dr. Susan Mather and those who work with her, Barbara Brandau, Andrea Love, and more recently Joan Furey, put together the format through which women veterans can be served through the VA.

I continue to be impressed and gratified by how much is being done for women's health care at the VA. Thank you very much for giving me this opportunity to thank you, and thank you, Ms. Long, Mr. Kennedy, Mr. Quinn, and Mr. Hamburg for your kind comments.

[The prepared statement of Dr. Sulewski appears on p. 95.]

Mr. EVANS. Thank you, doctor. We appreciate your testimony.

Dr. Ulstad.

STATEMENT OF DR. VALERIE ULSTAD

Dr. ULSTAD. Good morning, and thank you, Mr. Chairman and members of the committee.

I would like to discuss my experience with women's health care specifically at the Minneapolis VA Medical Center. I am a physician who trained in the University of Minnesota system, receiving part of my residency and fellowship training at the Minneapolis VA Medical Center. I am Board certified specialist in general medicine and a subspecialist in cardiology.

My particular interest in cardiovascular disease in women brought me to involvement in women's health care in general, and my current perspective on women's health care in VA comes from my experience in the Minneapolis VA Medical Center's Women Veterans Comprehensive Health Center.

I was privileged to join the Women Veterans Comprehensive Health Care Center staff at the Minneapolis VA in August of 1993 when the clinic was initially developing. The comprehensive center at the Minneapolis VA grew out of a history of serving women veterans beginning with the delivery of gynecologic services in 1974 through, at that time, a contractual arrangement with the University of Minnesota.

That GYN clinic offered regular pap and pelvic exams and gynecologic consultation to women veterans. The Minneapolis VA Medical Center then became the first VA to have on-site mammography in 1985, when under the leadership of Dr. Neil Wasserman, one of our radiologists, the Breast Cancer Detection Clinic was started. In this clinic regular screening of women veterans by clinical breast exam and mammography was done annually.

Going on in 1988 then, Dr. Kristin Nichol, our Chief of General Internal Medicine, and Linda Daninger, one of our nurses, developed the Women's Preventative Medicine Clinic. This clinic offered cancer screening, cardiovascular risk factor screening, counseling on smoking cessation, and immunizations.

The Women's Preventive Clinic worked with the Breast Cancer Detection Clinic and the gynecology clinic to begin to coordinate care of women veterans. These clinics were made part of the new Women Veterans Comprehensive Center which opened this August.

Dr. Kris Ensrud, a leading investigator in the field of osteoporosis and the most recent Director of the Preventative Women's Clinic, provided the leadership for the center's formation and is now serving as its Medical Director.

We have been open and seeing patients for 6 months and have seen 1,086 women veterans. I want to tell you a little bit about who we serve. Our patients range from age 20 to 90. Of the women veterans over 40 years of age, we see the following distribution of the

major killers and disablers of women: 28 percent of them have known heart disease; 26 percent carry a current or past diagnosis of cancer; and 20 percent have osteoporosis.

Cardiovascular disease is the number one killer of women. Actually women think it is breast cancer. It is cardiovascular disease. Breast cancer is certainly important, but cardiovascular prevention is a key part of our mission as well. The subset of women veterans over the age of 40 in our clinic have a high prevalence of risk factors for cardiovascular disease. Sixty-one percent are overweight; 42 percent have high blood pressure; 36 percent have a high cholesterol; 14 percent have diabetes; and 28 percent are still smoking.

The most important part of the mission of WVCHC is to provide comprehensive primary and preventative health care services to women veterans in order to enable them to maintain their highest level of health.

The two internists, myself and Dr. Ensrud, and a physician assistant, Patricia Olson, are the health care providers. While our three providers participate in the delivery of primary care to women veterans, our PA is the backbone of the preventative part of our clinic. In her preventative clinic, she sees women veterans yearly. The annual visit consists of an assessment of the individual's health issues, cancer, and cardiovascular risk factor screening, and an assessment of mental health needs. A physical exam is performed, a clinical breast exam, and then personal instruction in self-breast exam are performed. The visit also includes pap and pelvic examination.

When indicated according to established guidelines, mammography is performed immediately, that day, after the preventive visit.

The two internists provide care for women with active medical problems and provide consultative care. Gynecologic consultation services continue to be provided through a contractual arrangement with the University of Minnesota. However, this summer we hope to hire our own full-time gynecologist. The gynecologists who provide gynecologic consultation perform necessary gynecologic surgery at the medical center.

Support from our dietician, social worker, medical administration clerk, administrative secretary, clinical psychologist, women veterans coordinator, research assistant, and nurses are critical for the delivery of comprehensive health care.

The Comprehensive Center is dedicated to fostering improvement in women's health care through efforts in research, education, and quality assurance. Our current research efforts are directed primarily at describing our very diverse population.

The eight Comprehensive Centers are currently cooperating to develop uniform research methodology to allow for studies that are generalizable to the women veteran population at large. In our center, both internists are involved in national clinical trials on important areas of women's health care, including the Study of Osteoporotic Fractures, the Fracture Intervention Trial, and the Women's Health Initiative.

In our institution other investigators are encouraged to cooperate with us. Dr. Maureen Murdoch in our General Medicine Section,

for example, is studying domestic violence in the women veterans population.

Educational efforts are ongoing at many levels. We hope we will have medical students and medical residents regularly participating in the women's health program.

On another level, each staff member in our Comprehensive Center serves to educate her peers in women's health. This includes active education in the medical, nursing, social work, and mental health areas. Quality indicators are in place for pap smears, pelvic exams, and mammography. Monitoring these results is routinely evaluated, and quality assurance programs will be expanded.

Minneapolis VA is committed to notifying all eligible women veterans in the Minneapolis service area through outreach efforts. This has proven to be challenging because there is no one master list of women veterans. Our women veterans coordinator, Nancy O'Brien, has been very creative in finding potential women veterans for our center. She has coordinated multiple meetings at local conferences to get the word out.

We have relied on county veterans service officers to help spread the world outside of the Twin Cities metro area. We regularly see women veterans who have not been getting health care at all, as you have heard from other individuals this morning. The burgeoning untreated medical and emotional problems has been alarming. For example, 32 women veterans received counseling for sexual trauma in fiscal year 1993 at our center.

We believe in serving the physical and emotional needs of women veterans in a gender-sensitive setting. In our center, women have a place to come for any physical or mental health concerns. They embrace this concept and enjoy the opportunity to interact with known and trusted health care providers. I have frequently heard, "Finally, a place for us."

We are currently surveying our patients to determine their satisfaction with our center and to figure out how to better serve our population.

In finishing up, I want to tell you about the specific benefits of the multi-disciplinary comprehensive concept. This provides the ability to coordinate patient appointments to avoid multiple visits. This gives us the ability to discharge patients from busy subspecialty clinics and gives us the ability to streamline medication prescriptions to enhance understanding of the medications and to get rid of unnecessary medications.

More centralized care for women veterans allows us to decrease fragmentation of care and provides an excellent way to coordinate our services with mental health services.

It has been very rewarding to have patients report they are feeling safe enough finally to allow complete disclosure of their health care needs.

As health care providers, we continue to be impressed by the prevalence of serious mental health concerns in our population. We are currently gathering data to better understand this problem and to enhance our services.

Minneapolis VA Comprehensive Center acknowledges our role as a vanguard program and realizes that we must serve as a model for other VAs in their effort to establish women's programs. A vari-

ety of individuals from other VA facilities have done mini-residencies with us. Dr. Ensrud and I have participated in a variety of satellite conferences to offer our experiences.

We also serve, I believe, as a model of comprehensive health care delivery in our own VA. I believe the multi-disciplinary Women Veterans Comprehensive Center offers an opportunity to demonstrate that comprehensive, preventative, and primary care is a matter of health care delivery that may be a better way to serve all veterans.

Thank you.

[The prepared statement of Dr. Ulstad appears on p. 101.]

Mr. EVANS. Thank you, doctor.

Barbara.

STATEMENT OF BARBARA ZICAFOOSE

Ms. ZICAFOOSE. Chairman Evans and members of the subcommittee, I am Barbara Zicafoose, and I am pleased to be here today to present information on our female veterans health care programs available at the Salem VA Medical Center.

I am a nurse practitioner who has been at the Salem VA for 22 years and presently am employed in the surgical-medical unit and ambulatory care. In addition, I am the female veteran co-coordinator; and the Women's Health Clinic coordinator for the medical center.

Our Women's Health Clinic began as a concept in the fall of 1991, when staff in Salem recognized the need for women's health care based upon the following: an increase in the number of women seeking care at our facility; medical emphasis on providing care for all veterans; and the Veterans Health Administration's emphasis on equity of access, service, and benefits to the growing number of women veterans.

An interdisciplinary task force developed plans for the clinic which opened in June of 1992. One unique aspect of Salem's Women's Health Clinic is that it was established predominantly within existing resources. Physical space, equipment, and consumer focused needs were major resource issues.

One private patient room in a newly established same-day surgical-medical unit was designated twice a week as a Women's Health Clinic. Staffing requirements for the clinic include one nurse practitioner, one registered nurse, one clerk, and one-tenth physician. For the remaining 3 days per week, the above resources are shared with primary care and the same-day surgery-medical unit.

The clinic was designed to provide a specialized and comprehensive interdisciplinary program to assess, treat, and/or refer female veterans with such illnesses as cancer, hypertension, diabetes, and osteoporosis.

Health education includes information regarding life style changes, sexually transmitted diseases, menopause, breast self-exam, nutrition, smoking cessation and exercise.

The Women's Health Clinic is utilized for training and education of medical residents, staff and students. Residents and nurse practitioner students rotate through the clinic gaining experience in

providing gender-specific care within the primary care delivery model.

Salem has a Women Veterans Advisory Committee which meets monthly. One major focus of this committee and the clinic staff has been comprehensive communication strategies focused on increasing knowledge of available services to all our female veterans. We have sponsored programs focusing on services available, how to access our system, expectations from care provided, individuals to contact for questions, tours of the clinic, and the development of a promotional Women's Health Clinic brochure.

In March of 1994, State officers of the DAV will tour our Women's Health Clinic. They will evaluate our program and share their findings with their respective posts.

Not only have we communicated our services at the local and State level, but we have shared our program with other VAMCs across the Nation. In September of 1992, I participated in a panel on how to establish a women's health clinic at the national Female Veterans Coordinators Conference. As a result of this program, through written or verbal confirmation, 40 VA facilities have acknowledged use of Salem's program model for development, implementation and/or modification of their women's health clinic programs.

The canteen service at Salem carries a complete line of products used by female veterans. In addition, the Medical Center recognized the need for hair care for our women veterans, and beautician services are now available to inpatients on a weekly basis.

Salem has a forensic psychologist who specializes in sexual or physical abuse counseling. She is available to our Women's Health Clinic by consultation or on an emergency basis.

In addition, a support group which focuses on physical and mental abuse issues is held weekly and directed by a psychiatrist and clinical nurse specialist.

Our facility treats a significant number of female psychiatric patients. Appropriate placement, including safety and self-esteem issues, are of primary concern. Funding has been appropriated to develop an eight-bed unit for psychiatric female patients, with renovation slated to begin in late 1994.

An outgrowth of our Women's Health Clinic has been the development of a primary care team for women. The clinic opened in January 1994, is managed by a nurse practitioner with physician liaison, and provides comprehensive managed care for acute and chronic medical problems. Like the Women's Health Clinic, the primary care team for women veterans was initiated within existing resources.

The Women's Health Care Clinic in Salem, using an interdisciplinary approach, is an attempt by the staff to provide comprehensive, managed care while conceivably reducing health care costs and decreasing complications from potentially preventable diseases. Ongoing screening, counseling, and education are provided for a large number of individuals in an accessible, coordinated, and sensitive manner.

With members of the interdisciplinary team working together as partners in prevention and health maintenance, we can provide our female veterans with a potentially healthier future.

Thank you, again, for allowing me to be here today.

[The prepared statement of Ms. Zicafoose appears on p. 107.]

Mr. EVANS. Thank you, Barbara.

I want to thank this entire panel. Your testimony has spared the continuum from the problems to some of the solutions. It has been very useful and interesting to hear about some of the good things going on, as well as the problems.

We have been engaged in this body in a great debate over whether there is a crisis in national health care, and we are not going to get into that debate this morning, but I do believe there is a crisis in women's health care within the VA, and I think that is really undebatable and indisputable.

That is particularly true in Northern California at this point with the lack of a medical center and the Sacramento facility apparently not providing the kinds of services that women veterans require.

From this crisis in Northern California, we have an opportunity as this new hospital is constructed at Travis to make sure that women are dealt into the equation and this facility is prepared and designed accordingly.

Are women involved in that process, trying to make sure that in the interim there are some services available? Have you been consulted by the VA as this hospital develops and is designed?

Ms. RENNERT. As I understand it, Mr. Chairman, what is happening is the women's coordinators from Martinez Hospital and from the surrounding Bay Area clinics and hospitals are going to be involved in that, and hopefully some of the women veterans are going to have input on what we need into this new hospital because we are sorely lacking in all resources when it comes to women's medical care.

So I am hoping that they will bring us in on the planning of the women's health care clinics in this new hospital.

Mr. EVANS. Kay, do you have any comment on this?

Ms. DENNIS. Yes. I talked with the women's coordinator at the Martinez clinic now, and she said she has half a day once a week. It takes all of that time to set up appointments for tests on her patients and to get them notified and get them down. She has no time for anything else, and she is losing her mind because she cannot do the job she needs to do.

Mr. EVANS. She needs to be a full-time coordinator or she is full time?

Ms. DENNIS. No, she is given one-half day a week to work on the clinic. Otherwise she works elsewhere.

Mr. EVANS. What do we need to do at the Sacramento outpatient clinic in the interim to make it a better facility for women veterans?

Ms. RENNERT. We certainly need to get a more aggressive program going, and I think the only way we can do that is to start getting some women veterans in there that are really concerned about these issues. Right now we are slipping through the cracks. We do not have anybody to listen to us right now about what is going on, and all that we can do is we just keep telling them, and we are not listened to so far.

So hopefully with us coming back here and speaking before this subcommittee, they will start to take notice that we are interested, and we are going to make waves until they start to listen to us and help us out.

Mr. EVANS. Is there a lack of leadership at the local level?

Ms. RENNERT. It is very much a lack of leadership at the local level in the VA clinic.

Mr. EVANS. All members of the panel believe that local leadership has been very important in developing the women's programs where they exist, including Martinez back in 1985.

Some of the programs, Minneapolis is an example, benefit because they have had local leadership. Their work is compounded by the fact that they are receiving resources from the VA. That obviously does not exist in all of our facilities. So where do we start?

If we had to make a few recommendations to the VA, would it be starting to encourage that kind of local leadership? Because I think in all of these programs that exist in these localities, they were started by the local directors and the staff dedicating the resources and talents to these kinds of problems.

What would be your recommendations to get the VA to stress that?

Dr. ULSTAD. This is a difficult time because I think there is an awareness that the VA is down-sizing in some situations, and it takes new people. This takes new expertise. This takes a new kind of coordination.

One of the ways leadership has been so critical in our VA is that to develop a comprehensive program, you need to have all sorts of service lines talking to each other and reporting to each other that do not do so in the traditional VA system, and our leadership by Dr. Petzel, and Dr. Nichol and Dr. Ensrud has been critical in weaving together service lines—nursing, social work, dietetics, medicine in ways that we can work together and put together a really good product, I think.

It takes some encouragement, but this is something that I think the VA wants to do. That is the message we get, but I take it from some of my colleagues here that that is not the message they are getting from their local leadership. We have very much had that message, that we wanted to contribute that expertise in our program, and that is why we have gotten the support.

Mr. EVANS. Anybody else? Barbara?

Ms. DENNIS. Congressman Evans, when the women's clinic in Martinez was originally established, it was wonderful. They had a complete program, one of the finest in the country, and then when they closed the hospital, the clinic was stopped, then they built a new clinic, and now it is a total frustration. I was the only non-staff member on their women veterans committee. I met once a month with them, and they were doing all kinds of things, including the PX, pajamas, including all of the things that we talked about but it is dead now.

Ms. RENNERT. I think what we are seeing in Northern California is the fact that there are so many women veterans in a concentrated area, 64,000, and it is climbing every day that the few people that are allotted these few hours a week are finding the problem so overwhelming that it is just overpowering. We need to

get more people in there, and, again, it all relates back to the money issue.

VA does not have the money to pay these women's coordinators, and we just do not get the service. So it all just kind of relates back to the old adage of, you know, more money for these programs.

I do have to say that the women's coordinator in the Martinez clinic now does listen, but she is overwhelmingly loaded with the problem, and we just need more people to help.

Mr. EVANS. Anybody else? Barbara.

Ms. ZICAFOOSE. I think along with administrative support from the Chief of Staff all the way down, it is critical that we look at innovative and alternative ways of providing this care. For example, one of the other speakers told us about her PA that does the primary preventive health in her facility. Our nurse practitioners run our clinics. They are must more cost effective. The patients are very pleased with the care that we provide, and all you need is an alternative back-up physician liaison.

Mr. EVANS. Let me yield to the gentleman from New York for questions.

Mr. QUINN. Thank you, Mr. Chairman.

I thank you all for your testimony. I have your written statements. I was a few minutes late, but one of the things you mentioned, Mr. Chairman, that concerns me, is that it does all relate to money in the end. We have received a budget up here on the Hill recently for Veterans Affairs, and almost every member on the full committee has some problems with that budget.

We will work our way through that over these next couple of months and weeks. We are all advocates. Certainly all of you are, as are others who have testified, national commanders and others, in recent weeks. I am concerned that as we finalize the budget, working with the administration, you, and some of the others who have testified, that women's health needs are met to the same extent as the other concerns in the budget, Mr. Chairman.

One of the good things this morning is that, not only do we have the coasts covered, Northern California, and Buffalo, NY, but we also have the success stories and the good news along with the bad news.

The Chairman asked what can we do when we ask the VA to give direction to that local kind of leadership that does become so critical. I am a former school teacher of eight grade English. I taught for 10 years, and I know that sometimes the best ideas are not always expensive. Sometimes on a morning like this where seven of you have talked to us, we find out what you are doing out in California and what has worked in Buffalo and what we are working on in different areas of the country. These ideas need to be shared not only in this room, but maybe, Mr. Chairman, as we ask the VA to give direction to assist with the local leadership, we should also ask the Secretary to make an effort to let everybody know what is going on that is working.

Let us not only say we need more money, which we certainly do, but we know that is not always possible. We are hearing ideas this morning from people who have taken the time to come to Washington, DC, and they think it is important enough to try to solve the problems. I would like to suggest that under your leadership in this

subcommittee, and in our reporting back to the full committee, we ask the Secretary to assist with that local leadership. We need to do what we can with the money, but at the same time we need to share the good news with all the other people that need our help.

I am not trying to downplay the importance of the finances because you are right. We are going to deal with that in these next few months here on the Hill. But it is not all bad news, and I think we ought to try to share as best we can the success stories, and see what we can do to help.

So I do not have a question for the panel. It is more of a comment after hearing what you have said this morning. I want you to know that we are listening. We are under the able chairmanship of Mr. Evans who does, in my opinion, not to embarrass him, a super job in getting these issues in the forefront.

I will be pleased to help in any way that I can, and thanks for your testimony.

Mr. EVANS. I thank the gentleman for his comments.

The gentleman from California.

Mr. HAMBURG. Thank you, Mr. Chairman, and again I want to thank you for holding these hearings and especially thank the two women from the First Congressional District who came all the way from California to deliver this testimony.

As I listened to the panel, I have really mixed emotions. It is great to hear the success stories from Minneapolis and Buffalo and Salem, and hear all of the good things that are happening out there, all of the efficiencies that can be realized, the importance of getting women on the local level involved with the kind of health care they need, and I am glad that Congresswomen Long and Schroeder were here for part of this hearing and were able to listen to you because having women on these panels listening to women talk about women's issues is very important, and I know that that input is there.

So I was really glad to hear some of the innovations, some of the good things the VA is doing, and I do not doubt that those are true, but, on the other hand, I feel very, very frustrated about a situation in Northern California, and it really does not make me feel any better to hear Kay Dennis talk about the health clinic that existed in Martinez and the very fine job it was doing, and now we are down to a half-time coordinator who is not able to keep up with her workload, let alone be a leader in this planning effort that needs to go on now as we try to move forward with construction of the new VA medical center.

So I have really mixed emotions on my part. I am glad to hear the good stuff that is happening, but it really fuels my frustration about what we are up against in Northern California.

I do not know if I really have any specific questions, but as I was listening to you, Carolyn, I guess I was just sort of underlining in your testimony some of the things you said. I have talked to you about this, Chairman Evans, and like you, I sometimes vote against the flashy new weapons systems that the Pentagon wants, but I never vote against health care benefits for our veterans.

You know we have asked these people to make a commitment for our country and to put their bodies on the line and put their lives on the line, and then to deny them the health care when they need

it most in their lives is just unconscionable, and it reflects very badly on the Congress, reflects very badly on our entire Government.

So I feel very strongly about that, and in Carolyn's testimony when you mentioned making an appointment with one gynecologist to serve 64,000 women veterans and you also talked about these round trips and the woman who had a 380 mile trip to go from Yreka to Palo Alto to get a procedure, you know, this is unconscionable. I mean this is treating people like they do not matter, and if we are going to treat our veterans like that, I think really it is a shame on all of us.

Well, you know, I could go on, Mr. Chairman, but I think that these witnesses did a great job of talking about what the problems are and what some of the solutions are, and I really appreciate your work to try to be a solution for Northern California.

The first thing you need to do, however, is to move forward with the construction of that hospital. It really has been too long in the planning. This thing continues to kind of drag out. We are now talking about a December 1998 completion date. By the time that date rolls around, a lot of people will die or at least will suffer unjustly because that hospital is not available to them.

You stated this is an extremely large veteran area, maybe the largest in the country that is not served by an acute care hospital, and with your help and the help of Chairman Montgomery and other members of Congress who understand the injustice here, we are going to move forward, and we are going to push the VA and the Air Force to move forward as quickly as possible and get this facility built for the women and for all of the veterans of Northern California.

Thank you.

Mr. EVANS. I thank the gentleman, and I thank this entire panel, and we will be emphasizing to the VA that they should try to motivate their local directors to dedicate resources, and I think it is going to come when women, as you all have, demand that it happens.

We appreciate your testimony and this is how we get work done in Washington, DC, by hearing from people such as yourselves. We appreciate very much your honesty and personal opinions and your advice. It has been very helpful to us.

Thank you all for coming.

The members of our next panel represent the General Accounting Office and the VA's Office of Inspector General. Representing the GAO is Dave Baine, Director of Federal Health Care Delivery Issues, and he is accompanied by Jim Linz and Jackie Clinton.

Steve Trodden is the VA's Inspector General. He is accompanied today by Dr. Alastair Connell and Marion Slachta. Dave, we will begin with you once you get situated.

STATEMENTS OF DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, GENERAL ACCOUNTING OFFICE ACCOMPANIED BY JAMES R.L LINZ, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, AND JACQUELYN T.L. CLINTON, SENIOR EVALUATOR; STEPHEN A. TRODDEN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY DR. ALASTAIR M. CONNELL, ASSISTANT INSPECTOR GENERAL, AND MARION SLACHTA, PROGRAM ANALYST

STATEMENT OF DAVID P. BAINE

Mr. BAINE. Thank you, Mr. Chairman, and good morning.

We appreciate the opportunity to be here today—this time to discuss the Department of Veterans Affairs' longstanding problems in meeting the health care needs of women veterans and the implications those problems have for VA's role in a reformed national health care system.

As you know, we first identified problems in VA's provision of health care services to women veterans in 1982 and identified continuing problems in a 1992 follow-up report.

Our comments this morning will be based on some limited follow-up efforts we conducted at the VA Central Office to determine the extent to which VA followed through on the promises it made in response to our 1992 report.

Since we issued that report and since the Congress enacted the Veterans Health Care Act of 1992, VA Central Office has repeatedly stressed the need for its facilities to improve services for women veterans.

VA's greatest success has come in improving privacy for those veterans. It has completed or funded 131 projects in this area at a cost of some $670 million. Another 205 projects, estimated to cost about $800 million, are planned.

VA Central Office has also taken several other actions to enhance service to women veterans. These are detailed on pages 3 and 4 of my prepared statement.

Clearly, these actions should result in improvements in services provided to women veterans but a continuing problem limits the effectiveness of those efforts, and that is the failure to monitor medical centers to ensure that corrective actions are taken.

It is this problem more than any other that threatens the success of VA health reform plans and the quality of care likely to be provided under those plans.

Let me take a moment to discuss the issue of cancer screening examinations. These examinations are critically important for two reasons. Women veterans experience an unusually high incidence of cancer. Second, treatment is more likely to succeed if cancer is detected early.

Despite the strong evidence that cancer screening should be an important part of women veterans health care, VA made little progress in improving the thoroughness of physical examinations during the 10 years between 1982 and 1992.

In 1992, we made a very specific recommendation—that VA should require each medical center as part of the quality assurance program to develop and implement an action plan for improving

compliance with the requirement that each woman inpatient receive a complete physical examination, including a pelvic and breast examination and a pap test at appropriate intervals.

We also recommended that VA Central Office approve each of the action plans.

VA followed through on its promise to require the medical centers to submit revised plans for the care of women veterans, but it did not analyze and provide feedback to medical centers on those plans. We found no evidence of VA centralized review of some 130 of the 155 plans we obtained from VA. Our independent review of those plans showed that only 34 of them addressed all three of the minimum requirements cited in the recommendation that we had made in 1992. Only 99 included quality indicators to monitor compliance with the examination requirements.

Frequently the plans merely restated the requirements contained in the Central Office directive, without outlining an action plan for improving compliance with the requirements. VA did not notify the medical centers of deficiencies in their plans.

In September 1993, VA developed womens' health care guidelines to provide additional guidance to the medical centers. These guidelines encouraged medical centers to establish women's clinics and women's primary health care teams.

These teams, if established, could improve the thoroughness of the cancer screening examinations.

On a related issue, in 1992 we noted that some of the VA medical centers we had visited had developed innovative efforts to improve compliance, as you have heard from the previous panel.

VA initially planned to disseminate information about these practices through an information letter to its medical centers, but later decided it would be more appropriate to disseminate such information through a quarterly newsletter on women's health programs.

This type of periodic newsletter would, in our opinion, be a good forum for disseminating such information. Neither of the first two issues, however, of the quarterly newsletter contained any information on the best practices being used around the system.

Finally, in 1992, we recommended that VA as part of its quality assurance activities monitor centers' compliance with the September 1991 circular on mammography services. VA, however, did not follow through on this recommendation. We identified no VA Central Office efforts to monitor medical centers' compliance with quality control or quality assurance aspects of mammography services.

Before closing, I would like to discuss some of the implications of health reform for the women veterans program. Under VA's health reform proposals, the most critical deficiency in VA women's programs—the failure to provide appropriate cancer screening examinations—may be largely overcome as VA goes to a primary care model. Each woman veteran would have a primary care physician and be entitled to a comprehensive set of health care services.

Under such an arrangement, a doctor-patient relationship should develop in which physicians will no longer be reluctant to perform these much needed examinations.

While VA's planned move to primary care is linked to the President's health reform proposal, VA does not need to wait for health reform to implement a primary care model.

Also under health reform, VA will likely rely even more than it does now on individual facilities to insure the quality of care of both male and female veterans. Consequently, the long-standing problems in getting many VA medical centers to implement corrective actions to improve women veterans health care services may continue.

In summary, Mr. Chairman, VA Central Office continues to stress the importance of improving services for women veterans. Real improvements, however, depend more on the commitment of medical center directors than on directives from the Central Office.

The absence of complete comprehensive action plans to improve services to women raises serious questions about the potential for VA health care plans to attract women veterans if health reform becomes a reality.

We would be very happy to take your questions.

[The prepared statement of Mr. Baine appears on p. 115.]

Mr. EVANS. Thank you, Dave.

Steve.

STATEMENT OF STEPHEN A. TRODDEN

Mr. TRODDEN. Good morning, Mr. Chairman.

I am pleased and proud to be a part of your continuing focus on women's health care issues in the Department of Veterans Affairs.

My comments today are largely shaped by a recent inspection by my Office of Healthcare Inspections. Dr. Connell to my left issued that report, and Ms. Marion Slachta to his left is the author and inspector who conducted the work on which that report was based.

The findings of this study were published in our March 4, 1994, report, and the inspection itself was a follow-up to a previous piece of work that we did and presented to this committee on June 23, 1993.

Our follow-up confirms some improvements in staffing in both the Central Office and the field. A national training program for women veterans coordinators has been planned, although funding will allow attendance by only a minority of coordinators.

In our last report we stressed different VAMCs might have different approaches to women veterans' care, of which the development of a women's clinic might be one. We recommended the development of guidelines on how to establish and operate a women's health care clinic.

In fact, individual VAMCs, for example, Salem whom you just heard from, had already developed such guidelines, and we considered their work to be very good in that area.

However, declining to promulgate guidelines generally, a VA working group recommended that because of limited resources the use of primary care would be the most generally applicable approach to meeting the needs of women veterans. The group did recognize the establishment of women's clinics as an option.

In our current inspection, we focused on how effectively medical centers were meeting the needs of women veterans by visiting and evaluating aspects of women's health services in a stratified sample

of VA medical centers around the country. We went to 15 different facilities at ten medical centers, and we visited them between November of 1993 and February of 1994. Thirteen of these facilities were inpatient and two were satellite ambulatory facilities associated with the medical centers.

We reviewed the current activities of women veterans coordinators and inspected issues related to privacy and cleanliness.

We found that progress has been made in the assignment of women's coordinators. Some coordinators, however, did not seem to be fully briefed on the responsibilities of their functions, and some still do not have an adequate allotment of time to be fully effective.

On the other hand, evidence of attention to women's issues certainly existed. For example, the Brooklyn Medical Center had appointed a full-time coordinator on their own hook, so to speak, without the provision of additional funds from Central Office.

Coordinators still need to have greater visibility, and there is a continuing need for training of those coordinators.

Full-time women coordinators have been appointed in all four VA regions, and VA has appointed a special assistant for women veteran programs. The Office of the Assistant Secretary for Policy and Planning has created a full-time staff position responsible for women's issues throughout the department.

Women veterans advisory committees were functioning in all but one of the medical centers we visited. Conditions, however, for women vary widely. There are impediments to adequate privacy that include structural conditions. No medical center that we visited was comprised exclusively of private or semi-private rooms. All have some four-bed rooms or larger.

We found no examples, however, where women veterans were not housed either in individual rooms or in female only rooms. Sometimes, women veterans had to share bathrooms with males. Correcting these deficiencies does require the investment of large sums of money.

Other impediments to privacy, however, are correctable with little expense. For example, more convenient bathrooms would be one example. Notices on bathroom doors would be another, requiring veterans to knock before entry.

Standards of cleanliness varied widely. The majority of the 15 facilities we looked at were very clean, outstanding being Brooklyn, Salem, Grand Junction, and Portland.

In a minority of hospitals, however, bathrooms were dirty.

Generally hospital shops carried a better supply of female personal items than we had found last year, but deficiencies still exist. The success in the provision of better facilities at the majority of places provides some optimism. Formidable challenges, however, remain.

To bring VA hospitals to the standards of accommodations common in the private sector will involve major reconstruction, with attending expense. Short of this, however, much can be done to improve the conditions for women veterans by continued devotion to the task and sensitivity to the issues involved.

We recommended that the Acting Under Secretary for Health, first of all, reward the places, congratulate the places which have made substantial improvement; continue to insist on high stand-

ards of cleanliness in all of the medical centers; and require all the directors to insure maximum privacy for veterans, including women, within the limits of the intrinsic constraints posed by their facilities.

We have now received the response from VHA, and it is included in the report which we have provided to the committee.

Thank you, Mr. Chairman. We stand open to your questions.

[The prepared statement of Mr. Trodden appears on p. 132.]

Mr. EVANS. Thank you, Steve.

Let me ask you both, since local facility leadership obviously plays such an important role in the provision of women veterans' health care, are facility directors being held accountable by the VA at the top levels to follow through?

Mr. TRODDEN. In my opinion, no, sir, Mr. Chairman. I think this is a fundamental issue that VA has faced since the time I have been IG, and I think it will face increasingly more so in the days to come, as VA integrates with national health care reform.

This continuing issue of centralized versus decentralized, I think, is at the root of this thing. It looks to me like VA headquarters generally does the right thing in terms of issuing directives, but as Mr. Baine says, in my opinion it is woefully short in following up on whether or not those directives are being complied with.

There seems to be a reluctance to hold people properly accountable for compliance with the policy directives that come from Washington.

Mr. EVANS. Dave, any comment?

Mr. BAINE. I agree with Steve on that point wholeheartedly. I think that on almost every issue we deal with for this subcommittee and others, what we find is a willingness on the part of the VA Central Office to issue directives to address the overall problems. There is less of a willingness—and often it is attributed to the lack of resources to do this—but there is a reluctance to go and find out for themselves from a programmatic standpoint what is going on out in the system of medical centers.

That has been a source of continuing frustration, I know, for Steve; it has been a source of frustration for us; and I am sure it has been a source of frustration for you folks. What happens is you have witnesses to come here to deal with any particular issue, and the discussion is all over the lot. There are some very good activities occurring and there seem to be some very big problem areas.

This is the kind of thing that program managers in VA ought to know about and be able to come up and sit down and tell your committee about.

Mr. TRODDEN. If I could be really blunt, Mr. Chairman, I am going to submit that the response to our report exemplifies exactly what I am talking about. I had a response from central management which, in effect, says we have issued the directives. Your report is not particularly helpful. We have got all of the people out there in the world. We just had a tour of 15 facilities in the country, and we came back with a discussion on the problems, and the response is we have got enough people to cover the situation, and besides, you have not properly defined what odor is.

I think that is an incredibly shortsighted response.

Mr. EVANS. What could you recommend to us that we do?

Mr. TRODDEN. I do not know that what we are dealing with here, Mr. Chairman, and I know I said this to you before, and it is sort of frustrating, but I do not know that what we are talking about is legislative in nature. I think it is managerial in nature, and I think that what we have to have is a balance.

I agree wholly that the good things come from the bottom. So there is not the idea that Washington is going to mandate all kinds of good ideas. On the other hand, if we were smart enough to recognize what good ideas are and promulgate a policy that people should comply with, then we need to reward the ones that do, and we need to take opposition action with regard to those that do not.

There has historically, in my opinion, been a reluctance to do that in the VA.

Mr. EVANS. Would the creation of a women veterans program directorship at the VA actually be helpful in that regard?

Mr. TRODDEN. I think it should be helpful, yes, sir, but again, it will only be helpful if that person has the authority and responsibility to follow through on the pronouncements that she makes.

Mr. EVANS. Would that authority and the ability to follow through be heightened if the person directly reported to the Secretary as envisioned by Congresswoman Waters' legislation, to establish a women's bureau?

Mr. TRODDEN. Frankly, Mr. Chairman, I have not had much time to reflect on the positioning of that, but generally speaking, yes, the higher in the organization the person is placed, the more clout that they would have.

On the other hand, I have got to tell you that there is nobody better placed than the Chief Medical Director to oversee VAMC directors, and that particularly in and of itself does not seem to happen. It is a psychological managerial philosophy or something. I do not know whether it is people inside the profession reluctant to crack the whip on others inside the profession or exactly what the phenomenon is.

Mr. EVANS. Is it a cultural problem?

Mr. TRODDEN. I think it is a cultural problem, yes, sir.

Mr. EVANS. Let me visit this issue that Congresswoman Schroeder thought was so bad, and I agree with here, the issue of cleanliness within the system. You found a minority, but was it 15 different facilities?

Mr. TRODDEN. Fifteen facilities, and I will look to Ms. Slachta to tell you what she found with regard to some of those facilities.

Mr. EVANS. Can we name those facilities?

Mr. TRODDEN. We would be quite willing to name them, yes, sir.

Mr. EVANS. All right.

Mr. TRODDEN. Marion.

Ms. SLACHTA. All 15 facilities?

Mr. EVANS. Could you tell us what level of uncleanliness that we are dealing with here?

Ms. SLACHTA. At Perry Point, Maryland, the Jefferson Barracks Division of St. Louis, MO, and Columbia, MO, those three stations in which I found the bathrooms, the inpatient restrooms for the women or actually for all the veterans, in my opinion, were just not acceptable, and it was also the opinion of the women veterans that I interviewed there.

Mr. EVANS. So was recurring. It did not just happen to be the day that you happened to visit?

Ms. SLACHTA. No, sir. It was a recurring thing. One woman veteran related to me that she had been using the VA for over 10 years, and the first thing that she does when she checks in, she goes into the restroom and uses the liquid soap and washes out the sink, the toilet, the tub, and then the wall behind the commode because it was just unacceptable.

Mr. EVANS. How have the facility directors responded to these concerns?

Ms. SLACHTA. All of them have said that they were very concerned about the cleanliness issue and that they would check into it, but in reality, all of the directors had at least 2 weeks' notice, if not more, that I was going to show up.

You know, when you do these inspections, the first hospital that you go to, I get the lay of the land of how I am going to do the inspection, and by the time I get to the end of the line, they already know what I am looking at.

I realize that Perry Point was the second hospital, but by the time I got to Jefferson Barracks, Columbia, and the rest of them, they should have known that I was going to look at every and all bathroom facilities that were there.

Mr. EVANS. You have named three. There are 12 more, aren't there?

Ms. SLACHTA. Yes. Those were acceptable.

Mr. EVANS. They were acceptable?

Ms. SLACHTA. Yes, on the cleanliness issues, they were acceptable. Other stations may have had problems in the fact that they could not accommodate privacy in that women might have had to share bathroom facilities with males. In one particular instance, they had a woman's sleeping area on a PTSD ward. She was housed at one end of the corridor, and the men were all housed at the other end. However, her restroom facilities and shower were down by the men's sleeping areas and showering areas. If the station had taken a look at the surroundings, just ten feet from her room were shower facilities and restroom facilities that were no longer used by the patients and had been turned into staff restroom facilities. All they had to do was change signs on the doors from the women's restrooms to the staff restrooms, and it would have been more convenient for the women.

Mr. EVANS. Okay. Many of you said that the VA does not have to wait for national health care reform to implement primary care, which would be of great benefit, if I understand you, to women veterans to move to that mode. I know in my own instance that the clinic built in Bettendorf, IA, across the river from my district, emphasizes primary care.

Do you see that trend continuing in VA with the establishment of outpatient clinics? And what else should the VA do to go to that mode of treatment?

Mr. BAINE. I do not think there is any question, Mr. Chairman, that the transition to a primary care system is absolutely essential. VA, you know, for years and years has been based on an inpatient model in which services are not provided until somebody shows up as an inpatient. That has got to change.

The rest of medicine has gone to an outpatient model years and years ago, as discussed on several occasions in testimony about VA's outpatient services. But I do not think there is any question but what VA is going to have to go to a primary care model not just for women veterans, but for all of its veterans. And the sooner it gets there, the better the likelihood is, in my opinion, that it will be a leader in the health reform environment.

Jim, do you want to comment?

Mr. LINZ. Part of the problem with the emphasis now on providing cancer screening examinations basically through inpatient care is many patients do not have an inpatient episode for many, many years, and so they may miss out on needed cancer screening examinations.

But if you switch more toward a primary care model, if you have comprehensive eligibility reform, you may reach a lot more women a lot sooner.

Mr. EVANS. Let me recognize Minority Counsel for any questions she may have.

Ms. DONAHUE. No questions, Mr. Chairman.

Mr. EVANS. Well, we thank you for your testimony, and we look forward to working with you on these issues.

Mr. BAINE. Thank you, Mr. Chairman.

Mr. EVANS. The next witness is Dr. Susan Mather, the Assistant Chief Medical Director for Environmental Medicine and Public Health, Department of Veterans Affairs. Dr. Mather, after you are situated if you could introduce your associates, we would appreciate it, and you can then proceed when you are ready.

STATEMENT OF DR. SUSAN H. MATHER, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY JOAN A. FUREY, DIRECTOR, WOMEN VETERANS PROGRAM OFFICE; LINDA WILSON, DEPUTY REGIONAL MANAGER, READJUSTMENT COUNSELING SERVICE; LYNN SMITH, REGIONAL WOMEN'S VETERANS COORDINATOR, SOUTHERN REGION; AND MARY LOU KEENER, GENERAL COUNSEL

STATEMENT OF DR. SUSAN MATHERS

Dr. MATHER. Mr. Chairman, thank you for this opportunity to report on how the Department of Veterans Affairs is addressing health care needs of women veterans.

I will summarize my report and ask that it be submitted in full for the record.

I am accompanied today by Ms. Joan Furey, who is the Women Veterans Program Officer Director in the Office of Policy and Planning; Ms. Linda Wilson, who is the Deputy Regional Manager for the Readjustment Counseling Service, Mid-Atlantic Region; Ms. Lynn Smith, who is the Regional Women Veterans Coordinator for the Southern Region; and Ms. Mary Lou Keener, who as you know is the General Counsel.

VA is responding to the health concerns of women veterans by expanding existing services and instituting new programs. In fiscal

year 1993, VA health care facilities provided care to nearly 293,000 women, an increase of 18,500 or 7 percent over 1992.

Of that number, there were 16,157 women hospitalized, representing an 8-percent increase.

While we still need intensive outreach concerning women veterans' benefits, particular for women of earlier eras, the word that VA is here for them is certainly getting out to the newest of America's women veterans. Among Persian Gulf veterans, where women accounted for approximately 7 percent of the forces in country, 8.9 percent of the outpatients and 7.6 percent of Persian Gulf inpatients seen in VA facilities are women. The proportion is even higher among Persian Gulf era veterans, where 14 percent of both the outpatients and the inpatients are women.

Secretary Brown has committed VA to assuring equal access to health care for women veterans and making needed improvements in women veterans' health care services.

I would like briefly to highlight the VA's expanded services for women veterans. Special trauma counseling has been made more widely available through augmented staff in 69 vet. centers around the country and through the establishment of women veterans' stress treatment teams for VA medical centers.

The inpatient program at Palo Alto's Menlo Park Division for women with PTSD has been expanded to include sexual, as well as war zone, trauma.

A national training program on women veterans' health began with an emphasis on training and the diagnosis and treatment of sexual trauma and is now expanding into training for women veteran coordinators in quality assurance and primary care for women.

Eight women veterans' comprehensive centers have been established, two in each region. Twenty-two full-time women veteran coordinators have been funded at VAMCs with the heaviest workloads, and regional women veteran coordinators have been funded and are now in place in all four regions and, incidentally, will be a great help in monitoring the implementation of the GAO's recommendations.

The Women Veterans' Health Program National Steering Committee was established in 1992, and strategic plans have been developed to implement a variety of educational and informational methodologies relating to women veterans' health. Three issues of a national newsletter and a brochure concerning women veterans' health programs, including sexual trauma counseling services, were published and distributed during 1993 and 1994.

In fiscal year 1993, VA investigators conducted a total of 273 research projects related to women's health. Of these, 113 were supported by special research funding, and 160 were funded by non-VA sources, for a total of over $5 million in research.

In fiscal year 1994, John Feussner and associates began a research project entitled Breast Cancer Among Women Veterans, a Pilot Feasibility Study. This study will serve as a pilot for subsequent efforts to evaluate current primary and secondary prevention practice and rehabilitation therapy for breast cancer among women veterans.

In fiscal year 1994, five VA medical centers plan to form a consortium to pool their intellectual, financial, and other resources to implement the health services studies on women's health. Each center will implement collaborative projects, as well as be a part of the consortium.

In fiscal year 1994, the VA Environmental Epidemiologist Service began a 3-year study of reproductive health outcomes among women Vietnam veterans. This study is one of three research projects being conducted by the department, mandated by Public Law 92–272. A mortality study of women Vietnam veterans has been completed, and a study of psychological outcomes is underway.

VA has continued to stress preventive medicine. In fiscal year 1992, 20,247 women veterans received pap smears through VA, and 24,652 pap smears were done in 1993.

Policy on mammography was established in 1991. In 1992, 15,964 women veterans received mammograms through the VA. In 1993, this number rose to 20,963.

The number of publications issued in 1993 related to women veterans' health testified to the high degree of activity in the program. Among the most important were one clearly establishing a policy that women will be provided reproductive health care and the issuance of women veterans' health care guidelines, which address the need for improved services to women veterans in the areas of medical care, improved environment, the culture, which I think we have heard something of today, and outreach.

Secretary Brown's commitment to improving the services for women veterans was recently underscored when he announced the appointment of Joan Furey as Director of the newly formed Women Veterans Program Office in the department's Office of Policy and Planning.

Mr. Chairman, although VA has always opened its doors to the Nation's women veterans, the enactment of Public Law 102–585 and the special funding provided by the Congress in 1992 for improving women veterans' health programs provided a tremendous stimulus for improving VA services to women veterans. Increasing numbers of women veterans are coming to the VA for services, and thousands of dedicated VA staff are prepared to provide health and counseling services to them.

During this coming year, we plan to further expand services to women veterans and intend to make the program improvements with special emphasis on improving quality of care.

I am delighted to be able to bring you this update on what VA is doing to provide medical care for women veterans and to increase knowledge everywhere that women are veterans, too.

Thank you.

Mr. EVANS. Thank you, doctor.

I think it is important to share the good news and the progress that has been occurring within the VA, and we appreciate that, and in particular, Joan's appointment to this position, I think, is a very important step forward.

I would like her to take a few moments to explain the position, the responsibilities, the authority, the staff, and the resources that she has been provided to do this new job.

Ms. FUREY. Thank you, Mr. Chairman.

I am really pleased to be able to have the opportunity to talk about the Women Veterans Program Office. We are in our beginning stages. I have been here in Washington about a month, and at the current time the program office is situated in the Office of Policy and Planning, and I report directly to the Assistant Secretary and have been working closely with the people in that office, the analysts, on beginning to design an agenda to address the women veterans' health care issues.

Some of the areas that we are particularly focusing on is going to be in outreach and education to the women veteran community, in general. I have been in touch with Mr. Riggin in the veteran service organization area, and we will be sending out an open letter. We will be working on developing a survey of women veterans to find out their perception of their needs and assessments.

I will be making trips. I have a number of speaking engagements and will be doing site visits and meet with women veterans in the local communities to, again, find out what their experience is regarding accessing services both within VHA and VBA.

In working with Dr. Mather's shop, we are updating the brochure on benefits for women veterans, and to assure that it is both current and also to be sure that the availability is widespread and distributed across both VA facilities and the various other agencies or organizations that might come in contact with women veteran.

In the time that I have been here, I attended the recent homeless summit that the VA had. I met with a number of people there who are dealing with the issue of homeless women.

I have met with people in the Department of Labor and talked with them about veterans' employment, et cetera, and I think one of the things that we are identifying is that even within our community facilities, women are not readily asked whether or not they are veterans. We seem to do that automatically with men, but we do not do that with women, and therefore, they never get to the point of being informed of what is available and what their eligibility is.

The Department of Labor has a very nice brochure that they have done on Hire a Veteran, She's a Good Investment, and I have copies of that, and we will get access to that and hopefully get that distributed throughout the system so that we can start our own outreach into our local communities.

So that is just some preliminary ideas of what we will be doing. I will have a program assistant. At this point we are in the process of developing that description. We have not hired anybody yet, but do have access to all the resources of the Office of Policy and Planning in developing and implementing this strategic plan.

I have met with both the Secretary and the Deputy Secretary, feel very confident of their commitment to women's health issues, and also having direct access to them should that become necessary.

Mr. EVANS. The program assistant will be full time?

Ms. FUREY. Yes.

Mr. EVANS. Well, this is a good step forward, and you are an excellent choice, I believe, for this position, as well. We wish you the

best of luck and hope to hear good words from you in the future about how effectively you are able to work within the VA.

Doctor, according to the GAO, VA has not effectively monitored facilities to insure that services for women veterans are improved. How do you respond to that general criticism?

Dr. MATHER. Well, I have to accept responsibility for that criticism. That responsibility is in my shop, and in trying to be define how to use the resources that are available, it seemed more important at the point in time, when I had a half of an FTE, to spend the energy and the resources that we did have trying to expand programs, to getting the word out rather than notifying the hospitals of the problems with their plans.

However, I think the planning process is important. My staff has been expanded now. I have a full-time person. We have marvelous support from the field in the four regional coordinators, and it is the plan of the program office centrally to turn those plans over to the regional coordinators and allow them to work directly with the facilities, and I think this will result in improvement in the plans.

Mr. EVANS. With the provision of these four regional women coordinators, do you think that is sufficient to start monitoring and require——

Dr. MATHER. Well, I think it is a great start. A lot of things you have to do in a step-wise fashion, and I think it is a giant step to go from half of an FTE in a program office to go to five FTEs distributed around the system.

The centralization-decentralization tension that always exists, I think, is best dealt with by this set-up.

Mr. EVANS. If four is not enough, will you come back and tell us?

Dr. MATHER. I will.

Mr. EVANS. I am concerned that it may not be. It is a good step forward, again, but I think we will probably need more resources dedicated in that area.

Dr. MATHER. Right. I think we will have a better feel for that now that the last regional coordinator has been appointed within the last quarter. I think we will get a better feel for adequacy of the four.

Mr. EVANS. Do you view the problem that women veterans are facing generally with the VA to be a cultural problem within the institution as a whole, and in particular, in local facilities, as well?

Dr. MATHER. I think it varies from hospital to hospital. You know the expression: if you have seen one VA hospital, you have seen one VA hospital. I think we have heard today there are places where it is excellent, where the culture is good, where the support is good. All of the facilities are in place.

There are others where perhaps there are problems with culture, and we are addressing that in the guidelines and trying to bring stations around.

Mr. EVANS. Will the VA disseminate so-called best practices to facilities, and if so, when would they do that?

Dr. MATHER. At this point, you are referring to practice guidelines?

Mr. EVANS. Yes.

Dr. MATHER. Practice guidelines are a rather serious and complex thing to develop. At this point in time, we have not specifically

planned practice guidelines. However, we are working on clinical indicators for specific services, and maybe Lynn Smith, who is taking the lead among the regional coordinators on the clinical indicators and quality assurance activity would like to make a comment on that.

Ms. SMITH. We are developing a reference manual for the coordinators to use, and one of the chapters or the sections is going to be QA, and I think that is real important, and there will be indicators on what we think quality is.

National indicators such as data that is new to be provided to Congress, how many pap smears we do, mammograms, but more than that, we want to do it at the facility level as part of that follow-up and those kind of issues and give them models to use, and we want to help them with that, and that is a really big step we are going to be doing.

The four regional coordinators are working together to make this a national program instead of just a regional program. So we will be doing this nationally, and we can measure apples and apples and not measure apples and oranges, which is what we have been trying to do.

Mr. EVANS. Ms. Smith, you are one of the four regional directors who are going to make the local directors accountable.

Ms. SMITH. I am one of the regional coordinators, and I report directly to the Regional Director. Was that your question?

Mr. EVANS. Are there any plans for improving women veterans' health care submitted by facilities that were judged to be inadequate?

Dr. MATHER. I think that is our next step, and one of the things that we will be doing is distributing copies of the plans that were submitted to each of the regional coordinators so that they can evaluate where they are now.

There has been some movement in those areas, and I think we will reevaluate that.

Mr. EVANS. According to earlier testimony the reason that some facilities were better prepared and prepositioned to deal with women veterans was because of local initiatives, usually a local director and local staff making the dedicated effort to provide those kinds of services. It is important to make sure that every facility realizes they should be doing that, and that the highest level of the Department of Veterans Affairs is trying to make sure that they understand the importance of that.

Are you saying essentially that at this point in time you are going to have them submit reports to the regional directors, and then you will be making judgments based on those reports as to whether they are adequate or not?

Dr. MATHER. Right, and I think also the regional coordinators are able to get out into the field and visit some of the hospitals and work with them. Continuous quality improvement is sort of a watchword for VA quality assurance activities, and I think that is what we are trying to do, to move the stations along where they are into a better place.

For the most part the women's programs have been somewhat modest, I think. In the past they have been unwilling to call attention to their triumphs, and there have been triumphs out there. We

are trying to encourage the regional coordinators to let us know about these things. For the most part, people have just gone ahead and done their job and have not advertized their successes. I would like to change that.

Mr. EVANS. One witness testifying today indicates that the budget that has been proposed for the Department of Veterans Affairs in the research area will effectively lock out studies that might be needed for women veterans' health care services because it basically calls for no new studies.

Do you find that to be an accurate reading of the budget as far as research is concerned?

Dr. MATHER. I am not clear on that. My hope is that women will get a fair share, based on the quality of the research performed, but I have not had a clear reading on that.

Mr. EVANS. I hope that is something we can monitor, and perhaps the women veterans' program director can take specific interest in it.

Let me yield to Minority Counsel.

Ms. DONOHUE. Doctor, you say that the VA Advisory Committee on Women Veterans has consistently recommended funding of full-time women veterans' coordinator positions. Does this recommendation include full-time positions for each of the 171 VA medical centers?

Dr. MATHER. Well, I think they were more general than to say each of the 171 hospitals, but they certainly have recommended where there is adequate workload that the position be full time. We have begun to move in that direction by funding 22 at the busiest hospitals.

And we have an evaluation program in place for that group to see if this is the best use of resources. I think one has to ask "If you had 172 FTEs, what would be the best use of that to actually better improve women's health care in the facilities?" Perhaps in some of the very small facilities a full-time coordinator would not be the best use, but I think that is still an open question.

Ms. DONOHUE. Do you know if funding for these positions was requested by the VA in the fiscal year 1995 budget?

Dr. MATHER. The 22 positions will continue as a part of the recurring phase, and I think at this point we will want to see how those positions work out, what the improvement in care is in those facilities before we request additional funding.

Ms. DONOHUE. There are currently 22 full-time coordinators.

Dr. MATHER. Yes.

Ms. DONOHUE. Under VA policy, those assigned on a part-time basis may not devote more than 5 hours per week?

Dr. MATHER. No, 5 hours is the minimum. They may devote more time than that.

Ms. DONOHUE. In coordinator duties?

Dr. MATHER. If you are appointed as a coordinator, you have to be allowed at least 5 hours a week. For some it is more, and I think we need to call attention to the fact that at least two hospitals that I am aware of, the Bronx and Columbia, Missouri, have appointed full-time women veterans coordinators out of local facility resources without central funding.

So there will be additional coordinators, I think, as their value to the system becomes widely known.

Ms. DONOHUE. What other responsibilities do these coordinators have?

Dr. MATHER. One of the changes that has occurred within the last year or so is that we have recommended that coordinators be people who are directly involved with providing clinical services to women. I think that puts them in a position to understand what is going on within the facility. They will be primarily nurses and social workers who will be serving as nurses or social workers within the women's clinic when it meets or be a part of the primary care team.

Some coordinators do work in other capacities, but I think it is important that they be involved in the providing of clinical services to women.

Ms. DONOHUE. Do you think they should be involved in construction and renovation?

Dr. MATHER. Oh, yes, yes. I think definitely they need to review construction plans for renovation because sometimes they can see relatively simple solutions to a problem like simply locating the women's bedrooms near the bathrooms so they do not have to traipse up and down the hall past the men's bedrooms.

Ms. DONOHUE. Can you tell us what percentage of medical dollars are used to provide contract health services for women veterans?

Dr. MATHER. I do not have that information, but I will try to provide it for you for the record.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The percentage of medical dollars used to provide contract health (fee-basis) services for women veterans represented $5.6 million in fiscal year 1993 (2.8 percent of the total for VA).

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Joan, I might ask you to review also the efficiency of the TAP Program in reaching out to women who are still in the Armed Forces. We have held hearings in the past and learned that many women do not identify themselves as veterans. I think that will be important for the Department of Defense and the VA to make sure that early on women are included in that process and learn about the availability of benefits and VA medical services.

Ms. FUREY. Let me just make one comment about that, Mr. Chairman. I have met with Colonel Longnecker, who is with DACOWITS, the Defense Advisory Committee on Women in the Service. I will be attending their conference, and that is exactly one of the primary issues we talked about, which was to work in some kind of collaborative way with the Department of Defense counselors for women who are either retiring or separating out of the service, to be sure that they are aware of their benefits.

So I certainly concur with that as being a major initiative that we are going to focus on.

Dr. MATHER. And VBA has appointed a woman who is responsible for benefits issues, including TAP and VTAP.

Mr. EVANS. Doctor, we want to thank you and the panel for testifying before us. Before the next time we hold a hearing on women veterans obviously we are interested in having every medical center developing an adequate plan that is followed up by the local institutions with resources from the Department of Veterans Affairs.

That is our goal and we look forward to it being implemented in the near future.

Dr. MATHER. I understand.

Mr. EVANS. Thank you all very much.

Our fourth panel is comprised of Bette Davis, John Vitikacs, and Dave Gorman. Bette is President of the Nurses Organization of Veterans Affairs. John is Assistant Director, National Veterans Affairs and Rehabilitation Commission of the American Legion. Dave is Deputy National Legislative Director of Disabled American Veterans. Accompanying him is Pat Bracciale, National Service Officer, Detroit, MI.

Bette, we will start with you.

STATEMENTS OF BETTE L. DAVIS, PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS; JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DAVID W. GORMAN, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS ACCOMPANIED BY PATRICIA BRACCIALE, NATIONAL SERVICE OFFICER

STATEMENT OF BETTE L. DAVIS

Ms. DAVIS. Good morning. Mr. Chairman and members of the subcommittee, I am Bette L. Davis, clinical nurse specialist at the Washington, DC, Veterans Affairs Medical Center and President of Nurses Organization of Veterans Affairs.

Thank you for inviting NOVA to testify today on recent improvements in health care for women veterans. The seven VA facilities contacted by NOVA previously in June of 1993 were contacted again for today's testimony. It is professionally rewarding to report substantial progress is being made in providing health care services to women veterans.

Overall, more women veterans are being seen with more services offered. There is greater awareness, interaction, and focus on women's health issues in the VA.

Attempts are being made at each facility to define and evaluate standards and procedures for screening, diagnosing, and treating breast cancer. There are support groups, gender-specific drugs and pharmaceutical products and new GYN equipment for a growing number of GYN clinics and facilities.

Many clinics now have their own rooms. A few examples of improvement follow.

At one facility, a women's health clinic is now operational with gender-specific appointments, usually made within 2 weeks, as compared to a backlog of appointments of 9 to 12 months in June of 1993.

At another facility, a full-time female nurse practitioner is now assigned to a GYN and breast clinic, compared to 2 half-days twice

a week last fall. GYN appointments used to take 4 to 5 months. Now it is one week.

A non-staff gynecologist is available to the clinic twice a week and for GYN surgery, which usually is done in house. The nurse practitioner works closely and collaboratively with the gynecologist who reviews every record and sees any patient as indicated.

A half-time position is being requested for a staff salaried gynecologist.

On the down side, however, a new mammography machine and new GYN equipment and supplies are in storage. There is no radiologist in house who can read mammograms.

A larger GYN clinic room is indicated for the new examining table and equipment. The current room is very small with minimal walking space around the examining table. There are two chairs, desk, and small cabinets.

There is no space for teaching or counseling patients about sexually transmitted diseases, contraceptives, menopausal management, breast exams, et cetera. Most of the women patients seen have a primary psychiatric diagnosis and require additional time and space.

In a general medical clinic at another facility where both men and women are seen, the current backlog of appointments is one year, worse than before. In response, ambulatory care service is moving toward a primary care model and preparing primary care teams consisting of a staff mix of health care providers to increase access to care, decrease walk-ins, and backlog of appointments.

Lack of female pajamas, rooms, and bathroom facilities remain a problem affecting privacy and security. Local and national education and training programs for staff and veteran consumers have been enhanced. Education of staff to increase awareness about special needs of female veterans regarding cognition, response, and resources are underway.

A multi-disciplinary sexual trauma team is now available in the medical centers. Mental health staff is more receptive and better informed about veterans with sexual trauma issues. There is less trouble admitting women to psychiatry service. Although some difficulties still exist with medical administration service relating to eligibility, it is less problematic.

Improved national efforts toward education and communication for women veterans' coordinators was noted in general by those contacted. However, despite improvement, lack of half-time and full-time positions remain a problem.

At the local level, women veteran coordinators' duties for the most part are still on a collateral duty basis and include a broad variation in the amount of time, from a few hours a week—2 to 4—allocated for coordinators, or ranging up to a day or two a week. There is no big change in that area.

Some facilities still lack multi-disciplinary representation on women advisory committees, such as a female veteran consumer.

The growing number of women veterans becoming eligible for VA health care will affect VA's planning for services, particularly as national efforts toward health care reform are added to the picture. NOVA thinks it is unrealistic not to do a comprehensive women

veterans' study to define more clearly how VA can develop plans to meet health needs of this population.

We must continue to consider neglected areas of women's research, more recently, to the large and growing number of female veterans exposed to multiple chemicals which now appear to be affecting spouses and children, and to AIDS research for women.

In NOVA's July 2, 1992, testimony before this subcommittee, NOVA stated that in the 1990's, AIDS would be one of the five leading causes of death for women in the child-bearing age. AIDS is now the primary cause of death among women age 25 to 44 in nine major United States cities, and is the fourth leading cause nationwide for women in this age group. About half of all the adults who acquire HIV are women for the most part, and it is acquired through unprotected heterosexual activity in ages 15 to 24.

NOVA is concerned that budget cuts and FTE reductions will impact negatively on progress being made. Loss of funds and staff affect all services' budgets and delivery of care. Therefore, we have made the following number of recommendations which were carefully thought out and made by VA nurses and women veterans' coordinators contacted by NOVA and they are:

Development of guidelines for interaction of regional comprehensive health care centers with other VA medical centers within the region;

Provision of clerical help and MAS support;

Finer tuning of record keeping and monitoring of work as actual numbers do not always match computer numbers;

Establishment of a clearinghouse for identifying female discharges from military services and processing service-connected rating;

A more national dissemination of women's information to local VAs, relying less on individual facilities to assume this task;

And then, as mentioned, more time allotted for duties and responsibilities for local women veterans' coordinators.

Mr. Chairman and members, NOVA thanks you for the work represented in H.R. 3313 and is pleased to support all provisions.

Thank you.

[The prepared statement of Ms. Davis appears on p. 142.]

Mr. EVANS. Thank you, Bette.

John.

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Good morning, Mr. Chairman. Thank you.

The American Legion appreciates the continuing efforts of this subcommittee to assure that the health care requirements of women veterans are being carried out by the Department of Veterans Affairs in a timely and effective manner.

Mr. Chairman, the American Legion fully supported the enactment of the Veterans Health Care Act of 1992, Public Law 102–585, which included nine relevant sections addressing women veterans' health care.

We also support H.R. 3313 passed by the full House, which would make certain improvements to Public Law 102–585.

We believe there has been noticeable improvements made toward the provision of female health care services in VA over the past

several years. Due to the mandates of Public Law 102–585 and other actions, VA Central Office management has demonstrated a high level of commitment to furthering the provision of health care services for women veterans.

We wish this level of commitment was equally demonstrated throughout all VA facilities.

Mr. Chairman, VA is now spending nearly $12 million annually for the direct support of women veterans' health care programs. As the requirements for the further development of these programs increase, so too will the programs' resource base need expansion. It is difficult to build a proper foundation for a new program by shifting resources from other already underfunded programs.

Based on our discussions with VA field personnel, we believe the number of funded women veterans' coordinator positions must be increased to establish additional women veterans' comprehensive health care centers and to provide continuing outreach to women veterans.

Also, enactment of national health care reform could increase VA women veterans' workload and require VA to provide care to female dependents of veterans.

Mr. Chairman, VA must not only strengthen its current services to women veterans and be more consumer oriented, but also prepare for a possible increased role in treating female veterans and dependents.

The American Legion has several recommendations with regard to the advancement of women veterans' health care within VA, and they are:

One, criteria must be developed to further the expansion of women veterans' health care clinics throughout the Veterans' Health Administration.

Two, with regard to impending health care reform and its possible impact on VA, an updated market research study of women veterans' health care services within VA and the prevailing attitudes of both male and female veterans toward the VA medical care system must be accomplished.

We believe that while VA is undertaking great efforts to improve or, rather, to develop a health reform implementation plan, the greatest source of reliable information will come from the system's current and potential users.

Three, we believe that the current 2-year limitation on sexual trauma counseling from the date of military discharge should be lifted. We strongly believe that an open-ended time frame would best address the needs of sexual trauma victims.

Four, as the Veterans' Health Administration moves to reconfigure its four regional offices to 16 veteran service areas, we recommend that VA's special commitment to the women veterans' coordinator program is preserved.

And, five, a distinct women veterans' decentralized hospital computer program package would greatly improve current database reporting requirements and quality assurance activities.

Mr. Chairman, the American Legion looks forward to working with the subcommittee in the future in order to protect and promote further development of VA's women veterans' health care pro-

grams. We thank you for the opportunity to present our views today, and that concludes our statement.

[The prepared statement of Mr. Vitikacs appears on p. 149.]

Mr. EVANS. Thank you, John.

Dave.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. Good morning.

Before I begin, if I may, I would like to introduce sitting on my left Ms. Pat Bracciale, who is a national service officer in the DAV National Service Office in Detroit, MI, and with your permission, Mr. Chairman, I would like to go ahead and make some comments from my prepared statement and then turn it over to Pat to share some of her perspectives about women's health care with you.

Mr. EVANS. The subcommittee welcomes your comments.

Mr. GORMAN. I would say that it is a pleasure to be here. I think some of the testimony we have heard this morning has been reflective of what we have really heard about women's health care over the years, and it is certainly nothing new to this subcommittee, nor is it anything new to the veterans' service organizations.

I agree wholeheartedly with what Mr. Baine had to say and Mr. Trodden had to say as far as VA Central Office seemingly to have put out enough regulations and directives to the field regarding what has to be done regarding women's health care, but the problem seems to lie in the field as far as accountability of field managers to make those directives happen.

At this point, Mr. Chairman, the DAV would commend the Secretary of Veterans Affairs, Jesse Brown, for the actions he has taken to further the cause of women's health care within the VA, and also for establishing the position of woman veterans' program coordinator at VA Central Office. Clearly this is long overdue.

Ms. Joan Furey, recently appointed to that position, is a nationally recognized expert in the area of women's health care and specifically in the area of counseling and treatment of veterans experiencing PTSD.

Another vitally important attribute that Ms. Furey brings to this position is her nationally recognized position as an outspoken advocate for veterans. Joan is a long time friend of the DAV, and it gives us great pleasure to welcome her to her new position, to wish her the best of luck, and pledge to her, Secretary Brown, and Deputy Secretary Gober the DAV's assistance in any way possible to make our shared goal of providing quality, timely and compassionate medical care service to women veterans a reality.

Mr. Chairman, at this point I would mention what is really a continuation of the DAV's deep concern about the unique problems facing women veterans and inform you the DAV will be hosting a woman veterans' health care forum at our national service and legislative headquarters, scheduled for May 25, 1994.

The main purpose of our forum, which is being designed by a DAV woman veterans' advisory committee, is to bring top executives and legislative branch officials face to face with women veterans to develop short and long-term solutions to a variety of problems affecting VA's delivery of health care services to this growing segment of the veteran population.

The DAV woman veterans' advisory committee has met to discuss the general issues of interest that need to be addressed and the tentative process needed to develop a consensus building process to proactively address those issues.

Our committee felt it desirable to confine the 1-day forum to a broad issue of women's health care. Some of the concerns identified that will be addressed include sensitivity to gender-specific needs, uniformity of quality service delivery, standard common evaluations of services rendered, a visibility or outreach campaign, validation of female veterans, and systemic behavioral modification required of the VA.

Our committee has identified specific issues, Mr. Chairman, impacting women veterans in their quest to receive timely, quality and compassionate health care from the VA. Some of those identified are access to care, quality of care, safety issues, privacy issues, sexual trauma intervention, and post-traumatic stress disorder.

It is our every intention to conduct the forum in a proactive, action oriented manner. Our forum will be one of participation, Mr. Chairman. All attendees will be requested to come to the forum prepared to discuss in a work group setting specific predetermined interests of concern.

Our work groups will brainstorm, if you will, the issue toward the goal of reaching consensual agreement as to the necessary and desired action steps required to proactively address the issue.

Mr. Chairman, we are excited about the opportunity the forum will present to bring together individuals recognized as experts in the field of women's health care. We anticipate the participants, to consist of individuals from VA Central Office, the field, VA medical centers, the Department of Defense, Department of Labor, staff from the Veterans' Affairs Committees and other interested Hill staff, as well as the various veterans' service organizations, women advocacy groups, and of course, and most importantly, women veterans.

It is our belief and desire that by bringing together such a divergent group of individuals committed to active participation and discussion of the issues that we will be able to develop a proactive agenda with desired solutions and outcomes that will in the end benefit the way health care is provided to eligible women veterans.

With that, Mr. Chairman, if I may, I would like to introduce to you Pat Bracciale from our Detroit office. Pat is an Army veteran having served from 1967 to 1976 with a tour of duty in Thailand taking care of battlefield casualties from Vietnam. She worked for the Department of Defense for 5 years before going to work in medical administration for the Veterans' Administration, which that employment lasted 7 years.

Her current position as a DAV NSO commenced in 1990 with her training in our Detroit office, and she continues in that position today. So if I may, I will let Pat go ahead, Mr. Chairman, to describe her perspectives on a day-to-day basis in trying to deal with the issue of women's health care.

Mr. EVANS. Pat, Welcome to the committee. You may proceed.

Ms. BRACCIALE. Thank you, sir.

As stated by Mr. Gorman, I am also appreciative of the opportunity to testify before today's subcommittee. I have listened with

great interest to the preceding speakers and their comments relative to today's issues.

In my personal experience as a national service officer with the DAV dealing with women veterans and my own personal experience as a service-connected disabled veteran who utilizes the VA health care system on an almost exclusive basis, I must concur with Mr. Gorman's presentation the current GAO report and other testimony presented today that the VA health care system has made definite attempts to improve their service of quality and quantity to women veterans, for which these women are very grateful. We are very appreciative of the items that the VA has been able to address, for example, accessibility of supplies and toiletries and clothing from the canteen system and the medications that had previously not been available to them for their gender-specific needs.

There are quite a few success stories that are available out there, but unfortunately these success stories for women veterans are usually because of the dogged determination of national service officers and hospital service coordinators at the medical facilities who are determined to make the system work for these women veterans when they are available and do access and use the VA medical treatment facilities.

However, there is still more that needs to be done. I, in my experience and contact with dealing with women veterans, still hear, feel, and try to ameliorate problems and complaints from women veterans relative to the VA health care system that are the same as the problems and complaints prior to the enactment of Public Law 102–585 in November of 1992.

These women still have difficulties accessing VA health care. Recently one service connected disabled female veteran who was already a user of the VA health care system attempted to obtain outpatient treatment at a VA facility that was not her normal treatment facility. Even with her service-connected VA medical card from her primary treatment facility, she encountered so much administrative difficulty being picked up by that facility that she finally just gave up and left without getting treatment and went back to her original treatment facility which was not readily accessible to her at that point, and it was an emergency type situation.

Those kinds of conditions are deplorable for female veterans. They expect and they deserve better in some of the instances that do occur to them.

If the VA health care system cannot be user friendly for these women veterans already a part of the system, it is no wonder we still hear and try to assist women veterans with their accessibility to VA health care on a regular and ongoing basis.

Also, safety and privacy issues still remain a major bulk of the problems I have encountered from women veterans and their dealings with the VA health care system. I listened with interest to the GAO report of funds used for the purpose of obtaining privacy curtains around the exam tables. No amount of money made available to the VA health care system to correct these deficiencies will help to improve these privacy issues if they are not utilized.

I had one very distraught service-connected disabled veteran who went to the emergency room at the VA medical facility for her serv-

ice-connected condition. She was having extreme pain and projectile vomiting. She was service-connected for a peptic ulcer disease and went to the VA facility because of her very severe distress.

When she got there, during the examination, evaluation and treatment in that emergency room setting she experienced no curtains being pulled to separate her from a male veteran already in the emergency room on another gurney awaiting treatment and evaluation for his emergency symptoms. Her clothing was yanked up and down to exposure her entire abdominal area and pubic area for evaluation and examination purposes, and the entrance door to the emergency room treatment area was left wide open, exposing her to not only the male veteran on the adjoining gurney, but also to the passers-by on the outside walkway. Obviously this was very distressing to her and her service-connected disabled veteran spouse.

Other examples that I have encountered are no dressing rooms in the x ray department for patients, period, and when a female veteran comes in for a diagnostic x ray, she is shuffled off to a vacant x ray room with a floor to ceiling window with no curtains or shades for her to change and make herself prepared for the x ray evaluation.

If we are to make the VA health care system user friendly for women veterans, the VA must take a common sense approach to the treatment of these veterans and there must be accountability of facility directors. For many of the women that contact us, the episode has already passed and there is no way to ameliorate that situation. We advise them to do a written formal report to the hospital director of that facility, requesting a written response in return as to what action was taken. Unfortunately even in a personal experience that I encountered where I submitted a formal inquiry over 8 months ago, I have still not received a written response from the hospital director as to the results of that inquiry, and most of the female veterans that I have requested do this have also not received written responses.

Therefore, even this attempt to make hospital directors accountable for the actions of the employees under their supervision has been fruitless.

Most female veterans that I have encountered are more than willing to work within the system and tolerate those inconveniences that they would not encounter in a civilian sector hospital health care system, but the bottom line to all of their difficulties usually remains they want and need the same accessibility and quality of care as their male counterparts in the health care system and the consideration on a routine basis of their specific needs as women veterans.

Their final statements usually equate to "do unto us what you would want and expect done unto you."

Thank you for allowing me to be here today.

Mr. EVANS. Thank you, Patricia.

We thank you all, and, Dave, I want to salute the DAV for the conference you will hold on women's health care. I think it is very important and you are helping us blaze some trails with it. So we appreciate it very much and look forward to hearing from the people that participate in it.

The four regional women veterans coordinators will each be working to improve services at the local facilities in her region. If each of them had roughly the same number of medical centers, then each regional coordinator would be responsible for, in the range of 40 or so facilities, not counting independent outpatient clinics.

Do you all think this is sufficient resources for us to not only develop plans for women's health care in those institutions, but make sure those plans are implemented and enforced?

Mr. GORMAN. Probably not, Mr. Chairman. I think outreach seems to be one of the main deficiencies that the VA has. Some have pointed to only about 9 percent of all veterans ever using the VA, and I would think that the percentage of women using the VA services is far less than that, and it is probably because they do not know they are entitled to the services, but once they do, they are more than willing and happy to come in and get them in the majority of cases.

I think outreach is a continuing effort that needs to be made not by one person or one function or one office within the VA, but it's a continuing process within the system itself, with the individual facilities, and with the veterans' services organizations.

We need to be more aware of that and to practice this a lot more.

Mr. VITIKACS. Mr. Chairman, I would agree with Mr. Gorman. Forty facilities for one coordinator position does not really provide sufficient time not only for outreach, but for follow-up surveys of treatment rendered and problems encountered, and also the women veteran coordinators are probably in the best position to be aware of what deficiencies there are at particular hospitals or outpatient clinics, and I would think that being in that position, they can identify those concerns and pass them back through the regions and back to Central Office.

It seems to me that enforcement of regulations and guidelines is one of the major problems out there. So by going to 16 VSAs, these four coordinator positions really should be increased and the responsibilities per position reduced.

Ms. DAVIS. NOVA concurs with the previous comments, and I think our recommendation as outlined in our testimony would support the need for more than one full-time coordinator in each region.

Mr. EVANS. Regarding the women veterans' program office that has been set up, is that sufficient in its scope and its authority and its resources to do a good job or do we need, as Congresswoman Waters has suggested, a women's bureau with more authority and more resources?

Mr. VITIKACS. Mr. Chairman, I would have to defer answering that because it is probably, in my estimation, too soon yet to really make an accurate appraisal. Give us I would say a few more months of experience and maybe have a better answer for that, but maybe my other colleagues may have other insights into that issue.

Mr. GORMAN. I really do not know what the expectations are of that office, Mr. Chairman, as far as direct access and accountability to the Secretary. I think that is vital.

Again, the issue of accountability seems to be the pitfall that we run into whenever we talk about any of these programs. The best

laid plans and the well-intentioned people that seem to be trying to implement these things all go for naught if there is no accountability by the provider of services and the deliverer of services.

I would hope that office has direct access to the Secretary and that there is going to be an accountability factor involved. If not, then I would think we would have to look at something that would, in fact, put that in place. Perhaps Ms. Waters' legislation may be the vehicle down the road that we would have to look at.

Ms. DAVIS. NOVA is pleased that there is now an office with a director and with the appointment of Joan Furey. I am not familiar with the scope of the responsibility or expectations at this point and also would support any recommendations coming from that office.

Mr. EVANS. Minority counsel?

Ms. DONOHUE. No questions.

Mr. EVANS. Thank you all very much. NOVA is very important to us as providers and veterans' service organizations as representatives of those patients that use the VA hospitals. Your testimony is very valuable to us. Thank you very much.

The members of our final witness panel are Linda Schwartz, Terry Grandison and Dennis Cullinan. Linda is Chair of the Vietnam Veterans of America's Veterans Affairs Committee and Special Committee on Women Veterans. She has testified at virtually every hearing we have had on women veterans, if I am correct.

Terry is the Associate Legislative Director of Paralyzed Veterans of American.

Dennis is Deputy Director of National Legislative Service of the Veterans of Foreign Wars. We will start, Linda, with you once you are ready.

STATEMENTS OF LINDA SCHWARTZ, CHAIR, VIETNAM VETERANS OF AMERICAN VETERANS AFFAIRS COMMITTEE AND SPECIAL COMMITTEE ON WOMEN VETERANS; TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND DENNIS CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE U.S.

STATEMENT OF LINDA SCHWARTZ

Ms. SCHWARTZ. Good morning, Mr. Chairman.

My name is Linda Schwartz. I am the Chair of the Veterans Affairs Committee for Vietnam Veterans of America, and I have chaired their Women Veterans Committee for the last 4 years.

I am also a disabled veteran, and I do use VA services.

I would first like to say that we are greatly heartened by the action of Secretary Brown in appointing Joan Furey, and to create this office of women veteran programs within the VA.

For years we have noted that as we have come to this table we have again and again recounted the same kinds of problems that we have also heard today. One of the issues that we have addressed is that there is no accountability.

Our greatest hope is that with this creation and with Joan Furey we will see improvements and accountability for the first time coming to this table. I know because Joan Furey is there that we are

going to see some changes, and I hope that we will be able to give her the power that she needs to make those changes.

One of the things that I would really like to bring to the attention of the committee, and more or less as a prelude to our endorsement of Congresswoman Waters' H.R. 3013, is the fact that if we look over the history of some of the initiatives that this Congress has passed we see them unfulfilled. For example, in 1982 this committee and the Congress asked the VA to include women veterans in all research projects that they had, and that has not happened until just presently. I was greatly heartened by Dr. Mather's testimony in which she talked about the various research projects that are going on for women veterans. But, you know, that is 8 years later.

The second thing is the VA Advisory Committee on Women Veterans. This is a congressionally mandated committee, and for 18 months they did not meet at all. They are supposed to provide you with a report. They did not meet at all.

There are other VA advisory committees that were not mandated by Congress. They met. Why didn't the VA Women's Advisory Committee meet?

So our suggestion is that if we have this office, that you are going to have to provide this Director with power. Not only to women veterans' issues transcend the health care side of the house, but we also have veterans' benefits, and other women veterans issues. We are looking into the fact that there are also provisions at the Department of Labor for women veterans. One of the things that we addressed in our written statement is that DOL is mandated to do a survey of Vietnam era veterans, for the unemployment figures. A funny thing is that they are doing that, but they are not including women veterans. One of the things that we know from some of the older studies, for example, Lou Harris in 1985 studied women veterans who were in the post-Vietnam era and Vietnam era, is that one of the biggest problems they were having was finding a job.

With the unemployment in this country within the veteran population, it is important that Joan Furey also be able to go over to DOL and ask them why they are not doing that or help them to devise a survey that is meaningful and will provide the answers that this Congress needs to proceed.

Probably one of the things I think I have brought up every single time I have come here is that in 1986 this Congress, in the name of the people of America, passed a law saying that we should have a study of the effects of herbicides on women who served in Vietnam. Not only did Congress do that; they also funded it.

But for years that has not happened. There was a flicker of hope for the women who served in Vietnam, and now it is almost getting to be too late. Now what we actually need is a look at the health care needs of all women veterans so that this VA can plan as we move to the 21st Century what will be the needs of women veterans.

I have suggested to this committee, and I will suggest again, that one of the most cost effective ways of doing that is to go in with the Health and Human Services, develop a survey of questions to be included in all studies of women veterans that do look into mili-

tary service. Then we can see if they are different than other women who are in the general population.

I think one of the more outrageous things that happened was Congress passed a law creating the Office of Women Veterans and Minorities within VA, and for about 18 months no one knew where that was or there was no one assigned to do that. There was no one assigned to take that place. People at the VA did not even know what it was supposed to do, but it was the Office of Minorities and Women.

That is one of the things I think that brings me to the point where I believe we have to have this office of women veterans or bureau of women veterans just as put forth in H.R. 3013. That is what we need, direct access to the Secretary.

I believe that we would be derelict in our advocacy if we did not insist on legislative authority to insure that never again will America's women veterans have to beg for complete physicals or adequate privacy or for recognition for their service to this Nation.

We support H.R. 3013, and we want to publicly thank Congresswoman Waters and you, Mr. Chairman, for taking the initiative to introduce this legislation, because I believe we need to strengthen the position. We need to have something that we will know is effective from time and time again. I see that my time is almost up, but I hope you will let me finish this. I believe that Secretary Brown is on the side of the veterans, but there may be a day when he is not going to be the Secretary. I think this Congress needs to insure now and for the future that women veterans are taken care of adequately.

This will send a clear message that you no longer will tolerate the indifference, the disregard, and the lack of accountability on the part of the department to actually implement the things that you have created and legislated, because it is a lot of work to get a piece of legislation through.

And more than anything else, Mr. Chairman, whatever this Congress is willing to legislate and regulate for all the rest of the health care of America, what you are willing to legislate and fund and regulate for the VA is a real reflection of your values.

Thank you.

[The prepared statement of Ms. Schwartz appears on p. 158.]

Mr. EVANS. Terry.

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Mr. Chairman and members of the subcommittee, on behalf of the Paralyzed Veterans of America, it is an honor to participate in today's hearing.

There has been a significant increase in the number of women serving in the United States Armed Forces. Correspondingly, there has been a substantial increase in the number of women veterans.

The 1990 census identified 1.2 million women veterans, comprising 4.5 percent of the veteran population. The dramatic increase in women veterans presents the VA with an unparalleled challenge to meet the specialized health care needs of women veterans in what has historically been a male oriented health care system.

In addition, the VA faces the imminent challenge of national health care reform, which could have a profound effect on the structure of and the services within the VA system.

Mr. Chairman, if the VA is to compete successfully in a reformed health care system, VA health care facilities must be equipped and prepared to afford women veterans, as well as dependents of veterans who may soon be eligible for VA medical care, comprehensive health care services. Otherwise the VA stands the real risk of losing a substantial portion of its market share to other health care providers.

It is incumbent upon the VA to provide eligible women veterans and dependents timely, appropriate, gender-specific health care services. Although women represent 4.5 percent of the veteran population, they make up only 2.4 percent of all VA discharges. Why aren't women veterans seeking health care at the same rate as their male counterparts?

The reasons are multiple. First, women are unaware of the VA services available to them.

Second, eligibility status is even more confounding for female than for male veterans.

Third, women perceive the system as one oriented solely towards the needs of men.

And, finally, VA has not done enough outreach to women veterans to inform them of their eligibility and of the services they now provide.

PVA believes outreach efforts will help VA medical centers identify women's needs for services and provide information that is critical to VA managers in deciding how best to provide women's services. PVA strongly believes that assessing women's health care on current utilization rates is unreliable and likely to yield a gross underestimate of actual need.

VA must first make the effort to educate women veterans about their benefits before deciding that women simply do not use VA services enough to warrant the purchase of equipment or enhance the availability of women's clinics. This argument of lack of demand, which VA continues to use, is circular. Women will not come to a service that is not accessible and cannot fulfill their needs. Women will not come to a service they believe they lack eligibility for or that they are not aware exists.

VA medical centers must make a concerted effort to examine actual need among women veterans in their service areas before they justify not providing in-house services.

The climate seems ripe to make significant improvements in health care delivery to all veterans. Meaningful debate about health care reform has spurred both women and veterans health advocates to action. VA has an important and continuing role to play in the provision of health care, research and education in the Nation's health care system. Women are a growing part of VA's patient base. To ignore them would be to spurn a meaningful strategic plan for VA's future.

Women, a long neglected group even among veterans, should be among the first to share in the benefits from our new resolve to create a better health care system for all veterans.

Mr. Chairman, that concludes my testimony. I will be happy to answer any questions that I can.

[The prepared statement of Mr. Grandison appears on p. 164.]

Mr. EVANS. Terry, thank you.

Dennis.

STATEMENT OF DENNIS CULLINAN

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

To begin, I would like to thank you for conducting today's very important hearing regarding the VA responsiveness to women veterans and for including the VFW in this endeavor.

Today's discussion well reflects the objectives and concerns of the Veterans of Foreign Wars. So I'm just going to briefly touch upon some of the points in our written statement.

The VFW acknowledges that improvements have been made by the Department of Veterans Affairs in this regard. There are now labs investigating gender-specific issues. There are clinics providing care to women veterans, long overdue, but at last this is underway, an appropriate step.

VA is at long last compiling statistics on women veterans, and this should better enable them to better provide for women veterans into the future. It is my understanding that mammography services are available at major VA medical centers throughout the country, and it would seem that VA is at long last addressing the privacy issue. As was mentioned here today on numerous occasions, it is far from resolved, but they are moving in the right direction.

We still have concerns, however. The first and foremost would be inadequate funding, and that is VA-wide, and given that special attention to women veterans within VA is still in the nascent stage, it stands to reason that that could suffer the most in this kind of environment. This, of course, includes the cuts in research. It was asserted earlier today that research into women veterans will at least be funded on a proportional basis as far as other types of research that VA is undertaking. Again, we find this to be questionable, and even if it is so, a proportional share of not enough is still not enough. So, again, we are concerned about that.

And we are worried, too, that the women veterans' issue may become lost in the reorganization or decentralization shuffle. VA is decentralizing its power right now, and this could prove to be a boon. It could prove to be a true advantage in many areas because at along last VA administrators and managers at the local level will be given the power they need to take proper measures.

But then, again, in an area where there is, say, some built-in resistance to appropriate change, it could prove to be problematic. So I think that this is something that has to be monitored.

VFW also believes that legislation is still in order. As you know, the VFW has supported H.R. 3013, and given the years of neglect with respect to women veterans within VA, legislation is in order. Sexual trauma is one of the issues that we do not think will be properly addressed or may not be properly addressed without legislative remedies.

But in the final analysis, we also believe that what it boils down to is managerial initiatives. Certain privacy issues, providing a woman with a private dressing room, being more sensitive to gen-

der-specific needs, these are things that really do not lend themselves to proper remedy through legislation, through legal fiat. Really what we need is sensitivity on the local level. We need for the VA managers to get out there and do the right thing, and they need, of course, in some instances to be encouraged in this regard.

But the bottom line is managerial initiative, and the whole problem is not going to be solved by legislation alone.

With respect to the provision of care to women veterans by VA, there has been a problem with practice and there is a corresponding problem, and both of these have to be remedied simultaneously if VA is to truly appropriately and properly address women veterans' issues.

Mr. Chairman, that concludes my statement. Thank you.

[The prepared statement of Mr. Cullinan appears on p. 172.]

Mr. EVANS. Thank you.

Linda, first, I have encouraged NIH to identify veterans' status of women who have participated in research. Unfortunately their initial response basically citing the Privacy Act and the Paperwork Reduction Act has been unfavorable, but I am going to continue to press them to adopt that kind of approach that you have advocated.

Terry, next month the subcommittee plans to conduct a hearing on veterans' perceptions of VA health care. The General Accounting Office is expected to present testimony on the results of focus groups which it has conducted, and we look forward to PVA participating in the hearing and to reporting on the results of the focus groups which we understand you have conducted.

We know Linda's views on the proposed women's bureau. Would either of you two have a position on it in terms of whether the new office created by the Secretary has sufficient authority to bring these issues to the greater attention of the Secretary?

Mr. GRANDISON. Mr. Chairman, I have not had the time to really analyze the comprehensive nature of that department, but based on what I have heard today, it is a great step forward. I think that this is what is needed to make those initial steps, to place women's health care issues on a higher priority.

Mr. CULLINAN. Mr. Chairman, the VFW would agree. As long as there is a direct line of communication with the Secretary him or herself in the future. it should work. The word accountability was used earlier today. I do not want to come across as if we think a stick needs to be held over the head VA-wide to do the right thing, but nonetheless there has to be a sense of accountability for the thing to work.

Whether the office is going to succeed or not, that remains to be seen, but it's an appropriate step.

Mr. EVANS. Do you think it is likely that four regional women veterans' coordinators can deal with the various hospitals and outpatient clinics in an effective manner?

Mr. CULLINAN. It seems like they are being spread a little bit thin on that, but I do not know, to be frank with you, what kind of back-up staff they have and how smooth and fluid the line of communication is going to be. A lot hinges on that. They do not have any resources.

Mr. GRANDISON. Mr. Chairman, may I add on the issue of women veterans' coordinator, PVA and its independent budget co-authors,

have recommended that the VA add 50 additional women veterans' coordinators, because we really believe that the veteran coordinators would basically serve as a great liaison for women veterans, and would also function in the capacity of monitoring certain concerns, such as privacy standards, and serve as a conduit to direct women to different providers services in house, as well as outside the VA.

So we think that we need more. We certainly need more to really make this work.

Ms. SCHWARTZ. Mr. Chairman, Vietnam Veterans of America has for several years endorsed the concept that what you need to do is to dedicate women veteran coordinators for a period of about 2 years; that you have these folks in the field actually on probably a missionary mission to try to raise the consciousness of the people in the field and all of the hospitals, and to really actually turn the corner to begin to plan and help develop all the things that need to be done to have adequate health care for women veterans and adequate access for women veterans.

Then at the end of 2 years to assess whether you actually really need that because I sense that what we've heard today is that, while there are a lot of good programs in the VA, we really need to transport those to other places so people know how they work. The most cost effective way to do that would be to have women veteran coordinators. We believe 2 years would be enough to really turn this around.

Mr. EVANS. Minority counsel.

Ms. DONOHUE. To each of you, if you would please, would you agree that the problems with the establishment of women's health programs throughout the VA system lies in the inability of hospital administrators to overcome the prevailing culture?

Mr. CULLINAN. In a sense that is true, but the prevailing culture exists because women have not had access to the system through the years, nor have they come into the system. Again, it is a kind of circular kind of problem, not argument, but problem, and it is our assessment that as women are invited into the system, come into the system, and these hospital managers are being provided the centralized authority, that they should be able to act upon it in an appropriate manner.

It is a problem that has perpetuated itself, and we think now the means are in place for it to be properly resolved.

Mr. GRANDISON. I think that you can bifurcate that question, and I think, yes, there is administrative inertia there to prevail over the existing culture, but at the same time, we have to look at it systemically. We are looking at a system that has historically been for men, and I think the leadership, and I think Secretary Brown has really initiated such leadership, has to come from the top down to get to the VA managers and administrators, to basically stress the point that, at this time in the VA's history, VA will begin to actually meet the medical needs of women veterans, not fragmentedly or sporadically, but meet their needs in a comprehensive manner.

Yes, there is a problem with the management culture, but there is a systemic problem which has to be addressed from the highest

parts or segments of the VA administration to address it and to resolve inequitable treatment or services in the VA.

I would like to add also, again, if proper outreach has not been done and women are not being told or informed of the services being offered to them. If this is not corrected, we will never get over the hurdle of actually seeing women come into the system. So without that data, we cannot honestly measure the actual needs of women veterans.

We have to, in essence, put the horse first, ahead of the buggy, and take that type of approach, defining what are the real needs of women veterans out here, and once we find those needs, I think we can go on to the next step of turning this culture around.

Ms. SCHWARTZ. Today we have heard some people talk about privacy and cleanliness. I suggest to you that is not a woman's issue—it transcends gender. Some needs that have been discussed today are peculiar and are gender specific. I want you to know that I felt really bad to hear about the people from California because a couple of years back when I spoke before this committee, I received a question afterwards about, well, if you were going to put the women veterans' coordinators in certain places, where would you put them? So I went back over, since we have been pounding women veterans in the population of veterans, and I did a trajectory looking at where they are migrating to and where is the greatest need. It is California.

That is the way we need to start to allocate our resources, at the greatest need. I do not want to suggest to you that every VA hospital in America has to have a mammography machine, but every woman who comes there has to have access to it one way or another. Since the end of World War II, the VA has been the training ground of America's physicians and schools of medicine. I think it is time to turn around and ask them for some reciprocal agreements for this care of women veterans and the use of their mammography equipment at a university setting.

I am one who is pragmatic enough to come to you with the real needs. But at the same time I believe that as we go into the 21st Century, the VA is going to have to rely more and more on research and actual numbers than it is on rhetoric. I think that is why I was kind of disappointed to hear that although California has the greatest need, they are not getting what they need.

Ms. DONOHUE. To continue with you, Ms. Schwartz, in your opinion what effect would a shift to primary care have on the quality of health care services provided for women veterans?

Ms. SCHWARTZ. I actually believe that primary care would be good for all veterans. You skate in one month and you see somebody and skate out, and you do not see that person ever again. In my last visit, the doctor wanted to change my medications, but it was a resident. So I have to wait for 6 months to see another doctor to change my medications.

So I believe that primary care would be a very good thing for the system for everybody.

Mr. EVANS. I want to thank this panel for their testimony, and I look forward to working with you in the future.

That concludes our hearing. Dr. Mather, I am pleased you stayed throughout the hearing. That does not always happen with a VA

official, and it shows your interest, and I appreciate that very much.

[Whereupon, at 11:48 a.m., the subcommittee was adjourned, subject to the call of the chair.]

APPENDIX

Rep. Joseph P. Kennedy II
VA Health Care for Women Veterans
March 9, 1994

Good Morning. First of all, I would like to thank Chairman Evans for calling today's hearing and for leading this Subcommittee's efforts to make sure issues facing women veterans are addressed.

Over the last decade, the GAO and the VA Inspector General have chronicled a lackluster record of VA health services available to women veterans. Unfortunately, today, not enough progress has been to correct these deficiencies, and women vets still cannot rely consistently on the VA for their health care.

Yet, this comes while record numbers of women pledge to serve our country in the military in record-making ways. Just this past Monday, the Navy made its first assignment of 60 women to the combat ship USS Eisenhower. Today, more than 1.2 million women are veterans. Women now comprise nearly 12% of active duty and 14% of reservists and represent over 15% of incoming military personnel. Inadequate medical services for women veterans doesn't add up and must be changed.

The VA will testify that it has "always opened its door to the nation's women veterans." But, the sad fact is that is literally the case. One female veteran said, "I was the only female ... I had to undress in a room with a door that would not close while men were lined up and down the hallway." This sort of "open door policy" has got to stop.

I will acknowledge that the VA has taken steps to improve health care services to women vets by acquiring gender specific equipment, making improvements to ensure greater privacy for women in VA hospitals, and has made progress in providing women veteran coordinators.

But, in many areas, VA appears to be merely going through the motions. What good is guidance from VA headquarters if there is no monitoring or follow-up. It is incomprehensible, as the GAO found, that the VA would call on all medical centers to submit plans for cancer screening for women veterans and then neglect to correct faulty plans. Serious health matters cannot stand to be buried in mounds of VA paperwork.

The VA Inspector General found that even simple, low-cost actions -- like putting locks on doors and signs on bathrooms -- were not being carried out across the board. No longer can the health care needs of women veterans be overlooked. Much depends on the policies implemented by individual Medical Center Directors and follow-up by VA headquarters.

Last year, I was pleased to work with Reps. Schroeder, Evans, and other members of this Subcommittee in passing legislation in the House which would significantly expand the services to women veterans. Similar legislation is currently pending Senate floor consideration. I look forward to its enactment and ensuring that our women veterans receive nothing less than the best possible health care.

STATEMENT OF THE HONORABLE JACK QUINN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
MARCH 9, 1994

Thank you Mr. Chairman.

I am pleased to be here this morning to discuss VA actions to improve the provision of health care to women veterans and related issues.

I know we have a person who has contributed to these improvements here with us this morning. Dr. Joanne Sulewski, who will be testifying, serves as a shining example of what is going well with VA health care.

Dr. Sulewski is the Chief, Gynecologic Section, Department of Surgery at the Buffalo VA Medical Center. Dr. Sulewski has proven invaluable to the hospital and has been a true asset to women veterans' health care in Buffalo, Batavia and Rochester. Along with Mrs. Helen Jacob - who is also here today - these two women have really made things happen. They have worked tirelessly to bring change in the VA. And it is working. Our women vets in Western New York can feel comfortable with the care they receive.

Both serve on my Veterans Advisory Committee back in Buffalo - a group I put together to give me personal views of vets, feedback, and information about what is good or bad, what works and what doesn't. These kinds of comments are very helpful to me and I know will be helpful to the Subcommittee.

Dr. Sulewski has very positive things to say about VA. Dr. Sulewski believes in the system and had tried as hard as possible to make health care for women at the Buffalo VAMC a viable and pleasant experience.

I would therefore say that I am deeply disturbed that officials at VA didn't find portions of Dr. Sulewski's testimony acceptable and wanted her to change it. Mr. Chairman, Dr. Sulewski is what makes good things happen for women vets.

To have many of her comments - as one who is in the field and truly knows - considered not in line with a particular position, is upsetting to say the least.

Dr. Sulewski was to come here today to give us the benefit of her insight. She was to present her personal views as someone who must deal on a daily basis with our women veterans - not to serve as an advocate of policy. She came to discuss what is happening in Buffalo and the challenges she sees.

Mr. Chairman, Mr. Ridge and other members of this Subcommittee, I believe you would agree that we very much want to know what is really on the minds of the witnesses who come before this Subcommittee. How else are we to know what kind of job we should do?

I am proud to have Dr. Sulewski on staff at Buffalo. I know our female vets could do no better. I am very glad she is with us this morning. I think we will all be better off for her comments.

Once again Mr. Chairman, thank you for this opportunity. I appreciate your efforts.

TESTIMONY OF REP. PAT SCHROEDER (D-CO)

HOUSE VETERANS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

MARCH 9, 1994

VA'S PROVISION OF HEALTH CARE TO WOMEN VETERANS

Mr. Chairman, it has been almost a year since I testified before this subcommittee about the critical health care needs of our 1.2 million (and growing) women veterans. I want to thank you once again for your continued dedication to this issue, as evidenced by this hearing and all your other hard work.

It is simply bad policy to allow the gaps in women veteran's health care to continue, as the Veterans Affairs' department still seems to be doing. While only 4 percent of today's 27 million veterans are women, that number is expected to increase by 17 percent by the year 2010. Meanwhile, the number of male veterans is expected to decrease by 28 percent during that time. That means the problems we are experiencing now are only going to compound, especially if the VA must compete with the private sector under health care reform.

In preparing my testimony today, I've had the chance to hear about preliminary briefings from the VA Inspector General's office and the General Accounting Office on the extent to which women have been integrated into VA health services. And I must tell you I'm shocked that one of the key issues that has surfaced is the lack of cleanliness in certain VA medical centers. This is such a basic that we take for granted in private health care. And it's crucial to controlling the spread of infectious disease. I'm sure the IG's office will go into this in more depth, but I want to say that this goes right to the heart of the level of respect we accord our veterans -- women and men. And it further adds insult to injury to women veterans, who already get slighted by the VA medical system.

I have also come to the conclusion that women veterans will know they are taken seriously when they achieve something as simple as "potty parity" in VA medical centers.

The IG's office reported that on a recent tour of 10 medical centers, it found a number of filthy bathrooms, unisex bathrooms with no locks on the doors, women's bathrooms in hard-to-find places, bathrooms without gender signs, women and men uninformed that they were sharing the same bathrooms, and bathroom doors with keyholes big enough to see though to France. One woman veteran said she always cleaned whatever bathroom she was assigned to -- the facilities were routinely that dirty.

That's to say nothing of showers without curtains, and women unable to take showers because staff is unavailable to guard unlocked doors, and a host of other problems relating to privacy. Many of these are not big ticket items.

The briefings revealed that many of the problems the IG and the GAO identified to Congress in 1992 and 1993 continue to exist, despite some improvements. While women are grateful for a wider array of gynecological instruments, they wish they could be sure of finding stocked feminine hygiene machines and pajamas that weren't five sizes too big. And some of them wish they didn't have to travel 150 miles for a mammogram.

While the VA has funded a number of women veteran coordinators and there are apparently full-time coordinators at each regional office, many centers are without a full-time person to check on women's concerns and make sure they know of the services available to them. Some ad-hoc coordinators apparently spend as little as five hours a week -- not enough to reach all women. And even where there is no full-time coordinator, there doesn't seem to be any imaginative thinking out there about how to inform

women vets about the services available to them, even if it's by an inexpensive, preprinted card given to them at admission. coordinators to a VA training session scheduled for June, although training is badly needed. But will we see alternative, innovative, inexpensive efforts to connect these coordinators by other means -- say by mail, or conference calls, or satellite TV? Will we see some national guidelines for women vet coordinators and some PR to get women vets in for services? And will we see these coordinators brought onto the clinical executive boards so that they know what's going on and have some input?

The VA is still having a hard time shaking its gender bias. And women are still having a hard time believing the VA can treat them as veterans. Statistics show the VA medical center usage rate among female veterans -- 17 percent -- lags far behind the rate among male veterans at all ages -- 36 percent.

A commitment to making women's health care a priority has to pervade the VA, from the Secretary, to the medical directors, to the providers, to the housekeeping staff. And when any of the links in the chain doesn't follow through, that commitment must include disciplinary action beyond just a slap on the hand or a transfer.

In the 102nd Congress, we passed P.L. 102-585, which began to address the critical needs of women veterans. But it appears the VA virtually has not moved off point and in fact has hindered matters by not fully implementing P.L. 102-585.

Earlier in this Congress, I offered two amendments to set up strong programs in the VA for sexual trauma and physical health services for women veterans. After a long and painful process, the House VA Committee passed a bill that incorporated most of my ideas, except for ob/gyn and abortion services. I am still outraged that these vital services for women were left out.

We're not asking for all services for all women -- just the same eligibility for services as there is for men. The VA treats veterans with service-related disabilities and poor veterans. It doesn't ask which male organs are involved, and it often ends up treating male conditions that are not service-related. And when it comes to male veterans, we hear a lot less about the costs involved.

All this has got to change. And I am confident that it can, but only as you continue your aggressive oversight.

TESTIMONY FOR THE HOUSE VETERAN'S AFFAIRS SUBCOMMITEE ON OVERSIGHT AND INVESTIGATIONS HEARING IN ROOM 334, CANNON HOUSE OFFICE BUILDING, WASHINGTON, D.C. AT 8:30 A.M. ON WEDNESDAY, MARCH 9, 1994, BY KAY DENNIS.

The closing of the Martinez VA Medical Center in northern California, with its new and outstanding women's clinic, has been a real tragedy.

Traditionally women veterans have been greatly under served in a Veterans Administration medical system that has been, and in many cases still is, designed and run solely for male veterans even though women represent the fastest growing group of veterans. Approximately 140,000 women veterans live in California, the highest number of any state, with 64,000 residing in northern California.

In 1985 the Women's Clinic was established in the Martinez VA Medical Center. A Primary Care Clinic for Women Veterans, and the first of its kind in California, it served as a model for other primary care women's clinics. VA hospitals from all over the western United States sent representatives to study its programs. It was the only VA Hospital to have a permanent Gynecologist on Staff but he retired when the hospital was closed in 1991.

I was a member of the California State Commission on Women Veterans which existed from 1988 until the funding was canceled in 1991, due to state budget deficits. We held hearings up and down California on the availability of services to women veterans such as home loans, vocational counseling and particularly medical care. We had a questionnaire that was distributed to thousands of women veterans through every possible source, 2130 of which were completed, returned and tallied. We all were appalled again and again to find that a significant number of women veterans, at the time of discharge, were not aware of their rights as veterans with two exceptions - they all knew they were entitled to educational benefits and a G.I. Home Loan.

With the establishment of the Martinez VA Medical Center Women's Clinic, women veterans were finally receiving care for problems uniquely theirs. For example: when a man enters a VA Medical Center or hospital he is usually offered a routine prostate examination regardless of why he is there. Women, however, could not find any routine gynecological care such as pelvic and breast examinations, mammograms, Pap smears and bone density scans, even though this care should be just as routine for women.

I must explain here that my interest in, and dedication to, the cause of medical care for women veterans is the result of losing two very dear friends to uterine cancer. They were members of the California State Veterans Home in Yountville and both women had been bleeding for two or three months. The only gynecologist available for consultation through the VA system was one from Stanford Hospital who was available to the Palo Alto VA Hospital one afternoon a week. These two women tried repeatedly for over two months to get an appointment but were always told that he was not coming in that week or his calendar was full. They tried to get permission to see a gynecologist in Napa, with the VA paying the bill because neither woman could afford it. They were told it would have to be at their own expense. Finally someone reminded one of the veterans that she was a retired Army Major and could go to Letterman Hospital at the Presidio in San Francisco. They immediately performed a hysterectomy and then told her that they wished they had seen her a month or two earlier - the cancer had metastasized and they could not get it all. Both women left the Veterans Home and moved to Loma Linda in southern California where one died of a cerebral hemorrhage and the other died screaming every time the morphine wore off.

Since the Martinez VA Medical Center closed, I keep wondering just how many women veterans in Northern California are ignoring blatant signs of trouble because they must travel such great distances to get surgical consultation and care. About a month ago I talked to a World War II friend in Yreka, Just 57 miles south of the Oregon border, who had to have surgery after Martinez closed and was forced to travel 382 miles one way from Yreka to Palo Alto for all pre surgical and post surgical consultations and for the surgery. She was lucky, She had a family member who could take her. How many are there who are bleeding, or feel a lump in a breast and have absolutely no one to help them? One is too many, ten is horrifying!!

WE CAN'T WAIT UNTIL 1999 - OR THE YEAR 2000 - OR ONE YEAR FROM NEVER - TO GET A REPLACEMENT FOR THE MARTINEZ VA MEDICAL CENTER. WE - FEMALE VETERANS AND MALE VETERANS - NEED IT YESTERDAY!!

Statement of Toni Lawrie, RN
Women Veterans Coordinator
VAMC Bay Pines, Florida
Before the
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
House of Representatives
Regarding
VA Actions to Improve the Provision
of Health Care to Women Veterans and Related
Issues

March 9, 1994

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to report on VA actions to improve health care to women veterans. While I represent only one hospital program, it is based in Florida, which is second only to California in the number of women veterans residing in the state (85,400). In 1983, then Florida Medical District #12, designated "Womens Counselors" in all it's health care facilities, two years before VA recommended appointment of Women Veterans Coordinators. There are estimated to be 17,000 women veterans in the Bay Pines Service area, 7,000 of them in Pinellas county alone.

I have worked at Bay Pines since 1981 in various positions in Nursing Service and watched the program for women grow from no organized program to one of some positive celebrity in the VA system. A visit from the VA Advisory Committee on Women Veterans to Bay Pines in October of 1987 was probably the catalyst for raising our consciousness about the unmet needs of women veterans. I feel that VA's commitment to enhancing services for women is sincere and evidenced by support of womens programs, in an era of downsizing, through appointment of Women Veterans Coordinators regionally and locally, and with some facilities appointing full-time coordinators from within existing resources. VA recognition of the need for sexual trauma counseling along with other comprehensive health care services including contraception, screening and prevention, health maintenance and restoration, and

psychosocial interventions, combined with the publication of the VA "Women Veterans Health Care Guidelines" are compelling indications of intent.

However, major barriers continue to block access to VA health care for the majority of our 27.2 million living veterans who were uninjured, not yet victims of an impending chronic disease, and healthy when they left active duty military service. The major barriers are the confusing array of rules for eligibility and entitlement. All 1.2 million women veterans VOLUNTEERED for military active duty. Almost half of them volunteered for service during a time of war, and left the military when the threat diminished. None were drafted. This patriotism long went unrecognized and unrewarded for World War I and II veterans, for women who served in Korea and Vietnam, and more recently in Grenada and Panama. If they come to VA, we were largely unready to serve them. In this age of health care reform, VA has the opportunity to put its might and money into a mutually beneficial pact with women veterans. The many women who currently seek services through our VA are pleased with the care provided but frustrated by the lack of access to comprehensive outpatient care needed to restore or maintain health.

Changes must continue to evolve in the culture of VA care to women in issues of sensitivity and privacy. Counseling of women for the trauma and sequela of sexual abuse is now generally delivered in the "Mental Health Clinic" setting. For many women this means that because they were raped or otherwise sexually abused in the military, their first encounter with the VA health care system will probably be associated with a "mental health" visit, which might prejudice their future care. Similarly, admitting women to locked, male dominated psychiatric wards for treatment of the aftermath of sexual trauma is inappropriate. Some VA's however have no alternative at present. Changes needed in structural privacy are relatively easy to recognize. Our daily

practices are moro subtle and truly require the paradigm shift so often invoked as I was reminded. One day as I was discussing a young (33 year old) woman's dissatisfaction with her treatment in our ER, she asked me, "Would you feel comfortable in a six bed observation room, with men in four of the beds listening to your symptoms of abdominal pain?" I began with the standard reassurance that I would, reconsidered, and "shifted my paradigm". We now have physically separate spaces for acutely ill men and women in our Evaluation Area. Listening too, changes behaviors.

Overall, Mr. Chairman, my feeling is that VA on a national level, and Congress with passage of Public Law 102-585, is responding with alacrity to identified needs and issues of women veterans. Funding for eight Women Veterans Comprehensive Health Centers, sexual trauma counselors in the Vet Centers, full-time Women Veterans Coordinators, training/sensitizing VA health care professionals regarding women's issues, authorization to provide gender related services not available at VA facilities are not steps, but leaps in the right direction. A follow-up study to the 1985 "Survey of Female Veterans" by Harris et. al. is still needed to determine general policy and planning issues in the care of the growing population of women veterans, and more specifically to address issues as they relate to elderly and minority women.

VA also needs to identify several centers of excellence (VA or non-VA) in the care of women in each Region and arrange for staff likely to be asked to examine women, to be updated on relevant assessment skills. Provider staff in some VAMC's and out-patient clinics might not have had occasion to perform breast or vaginal examinations during their VA career.

I believe from my experience and my association with other women veterans and women veterans coordinators, that strong support for these program is growing at the local levels in VA. We will be able to change the culture and environment of VA to accommodate all

veterans who seek our services if we can be freed of many of the bureaucratic regulations that bind and confound us. We only need opportunity to reach consensus and that is the plan as we transition to Primary Care and continue to focus on improving care to women. Thank you for this opportunity to make my statement.

T E S T I M O N Y
MS. MARY JEAN REED
GOVERNOR'S ADVISORY COMMITTEE ON WOMEN VETERANS
STATE OF OHIO
before the
U.S. HOUSE OF REPRESENTATIVES
House Veterans' Affairs Subcommittee on
Oversight and Investigations
Wednesday, March 9, 1994 8:30 A.M.

GOOD MORNING CHAIRMAN EVANS AND MEMBERS OF THE HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS. I AM MARY JEAN REED, LIEUTENANT COLONEL, RETIRED, UNITED STATES AIR FORCE. I AM HERE TODAY, REPRESENTING THE GOVERNOR'S ADVISORY COMMITTEE WOMEN VETERANS IN OHIO, OF WHICH I AM A MEMBER.

IN JANUARY, I ATTENDED A PUBLIC HEARING AT THE VA HOSPITAL IN CHILLICOTHE, OHIO WHERE CONGRESSMAN EVANS AND CONGRESSMAN STRICKLAND WERE PRESENT. MANY QUESTIONS FROM THE AUDIENCE WERE RAISED REGARDING VARIOUS ISSUES AND CONCERNS WITH RESPECT TO THE CARE AND TREATMENT RECEIVED BY VETERANS AT VA FACILITIES. HOWEVER, NOT SO MUCH TO MY SURPRISE BUT RATHER DISAPPOINTMENT, I WAS THE ONLY PERSON WHO RAISED QUESTIONS CONCERNING SPECIFICALLY THE TREATMENT OF WOMEN VETERANS AT THOSE SAME FACILITIES. AT THAT TIME, CONGRESSMAN EVANS INFORMED ME OF THIS HEARING AND I AM PROUD TO HAVE BEEN INVITED TO TESTIFY BEFORE THIS SUBCOMMITTEE.

THE GOVERNOR'S ADVISORY COMMITTEE FOR WOMEN VETERANS IS AN UNFUNDED COMMITTEE AND WAS ESTABLISHED IN JANUARY, 1993. IT IS COMPRISED OF WOMEN VETERANS AND ACTIVE DUTY SERVICEWOMEN - INCLUDING NATIONAL GUARD AND RESERVE - WHO HAVE SERVED IN THE MILITARY FROM WORLD WAR II THROUGH THE PRESENT. THIS COMMITTEE, ESTABLISHED BY GOVERNOR GEORGE V. VOINOVICH, WAS ASKED TO PROVIDE THE GOVERNOR WITH RECOMMENDATIONS ON THE ISSUES, NEEDS, AND CONCERNS OF OHIO WOMEN VETERANS.

TO BEST FULFILL THE GOVERNOR'S REQUEST, WE HAD TO FIRST DEVELOP SOME GOALS AND SET AN AGENDA. THE COMMITTEE DECIDED THAT IT MUST DO THE FOLLOWING:

1. IDENTIFY AND ASSESS THE SPECIAL NEEDS OF WOMEN VETERANS;

2. PROVIDE INFORMATION WHICH WOULD MEET THE NEEDS OF WOMEN VETERANS, INCLUDING BENEFITS AND ENTITLEMENTS, EDUCATION, AND TRAINING FOR UNEMPLOYMENT THROUGH REFERRAL PROGRAMS; WE WOULD RESEARCH AND ASSESS THE NEEDS OF WOMEN VETERANS, IDENTIFY SERVICES CURRENTLY OFFERED, AND DETERMINE WHAT SERVICES ARE LACKING;

3. RECOMMEND AND PLAN EVENTS HONORING WOMEN VETERANS WHO HAVE SERVED AND THOSE CURRENTLY SERVING IN THE MILITARY: THESE EVENTS WOULD BE UTILIZED FOR DEVELOPING AND ENHANCING A POSITIVE IMAGE OF WOMEN VETERANS; AND,

4. COORDINATE AND MONITOR EFFORTS TO ACCOMPLISH ALL OF THE ABOVE GOALS AND OBJECTIVES: POINTS OF CONTACT WITH VARIOUS ORGANIZATIONS NEEDED TO BE ESTABLISHED TO ACQUIRE INFORMATION AND AVOID DUPLICATE EFFORTS.

ONCE THESE GOALS WERE DEVELOPED, THE COMMITTEE THEN NEEDED TO FORMULATE A CONTINUING MEANS BY WHICH TO ACCOMPLISH THEM. THE COMMITTEE FORMED FOUR SUBCOMMITTEES WITH EACH FOCUSING ON A SPECIFIC AREA:

* THE SUBCOMMITTEE FOR IDENTIFYING OHIO WOMEN VETERANS WAS CREATED BECAUSE IN ORDER TO ADDRESS THESE ISSUES, THOSE WHO WOULD BE AFFECTED BY OUR INITIATIVES NEEDED TO MAKE US AWARE OF THEIR CONCERNS. CURRENTLY THERE ARE AN ESTIMATED 40,000 WOMEN VETERANS IN OHIO. UNLESS THESE WOMEN ALREADY CONSIDER THEMSELVES TO BE VETERANS, WHICH UNFORTUNATELY IT HAS BEEN REPORTED THAT THEY DO NOT, AND THEY UTILIZE THE SERVICES OF THE VA CENTERS, OHIO'S BUREAU OF EMPLOYMENT SERVICES OR REGISTER WITH THE VETERANS COUNTY SERVICE OFFICES, WE DO NOT HAVE A WAY TO IDENTIFY THEM.

* A HEARING AND SURVEY SUBCOMMITTEE FOCUSED ON COORDINATING STATEWIDE HEARINGS WITH THE INTENTIONS OF DRAWING WOMEN VETERANS TO TESTIFY BEFORE THE COMMITTEE AND PRESENT THEIR EXPERIENCES, SPECIAL INTERESTS AND NEEDS, OR IDEAS THAT THE COMMITTEE COULD STUDY AND CONSIDER WHEN MAKING RECOMMENDATIONS. THE SUBCOMMITTEE ALSO CAREFULLY CRAFTED A SURVEY WHICH INCLUDES SEVERAL DIFFERENT CATEGORIES IN AN EFFORT TO GATHER AS MUCH INFORMATION AND ENCOMPASS AS MANY AREAS AS POSSIBLE WHICH WOULD ASSIST IN ACCOMPLISHING OUR GOALS.

* THE AWARENESS AND PUBLICITY SUBCOMMITTEE IS RESPONSIBLE FOR SENDING PRESS RELEASES TO THE MEDIA, CONDUCTING EDITORIAL BOARDS, WRITING ARTICLES FOR VARIOUS PUBLICATIONS, AND CONSEQUENTLY PREPARING TESTIMONIES FOR CONGRESSIONAL HEARINGS.

* OUR SUBCOMMITTEE ON WOMEN VETERANS HEALTH CARE HAS THE RESPONSIBILITY TO IDENTIFY PROBLEM SITUATIONS WHICH WOMEN VETERANS HAVE ENCOUNTERED AT VA CLINICS AND HOSPITALS. THIS SUBCOMMITTEE ALSO WORKS TOWARDS KEEPING ABREAST OF WHAT TYPES OF CARE AND BENEFITS ARE OFFERED AT THE VA FACILITIES.

I APPRECIATE YOUR PATIENCE WITH THE OVERVIEW OF WHAT OUR COMMITTEE ENTAILS. THE RELEVANCE IS THE CLOSE CORRELATION AMONG EACH OF THE GOALS AS WELL AS THE TASKS OF THE SUBCOMMITTEES.

TO DATE, OUR COMMITTEE HAS DISTRIBUTED OVER 4000 SURVEYS, AND HAS RECEIVED CLOSE TO A 25% RETURN, SOMETHING WE ARE VERY PROUD OF. THESE SURVEYS WERE NOT SHORT. THEY HAD SIXTY-FIVE QUESTIONS COVERING SEVEN PAGES, AND TOUCHED THE BASES OF EDUCATION, INCOME, MARITAL STATUS, HEALTH CARE, AND DATES SPENT IN THE SERVICE. EVENTUALLY THIS INFORMATION WILL BE ENTERED INTO A DATABASE.

FROM MANY OF THE SURVEYS WE ARE ACCUMULATING, MOST OF THE QUESTIONS WHICH ASKED FOR SOME SORT OF WRITTEN RESPONSE WERE FILLED IN. THESE ANSWERS, WHICH HAVE BEEN VERY CONSISTENT, CLEARLY ADDRESS THE ISSUE THAT THERE IS

A PROBLEM WITHIN VA HEALTH CARE FACILITIES WITH RESPECT TO THE TREATMENT OF WOMEN. ALTHOUGH, THERE WERE GENERAL COMMENTS WHICH COULD BE APPLICABLE TO ANY VETERAN, HERE ARE JUST A FEW RELATING TO WOMEN VETERANS:

ONE WOMAN EXPLAINED THAT "WHILE IN THE HOSPITAL FOR SHOULDER RECONSTRUCTION, I HAD TO SHARE A BATHROOM WITH A MALE VIETNAM VET"

"THE THERAPIST BEGAN MAKING SNIDE COMMENTS ABOUT ME BEING A WOMEN TO THE OTHER MALE VETS IN THE ROOM AND PROCEEDED TO ABRUPTLY REMOVE MY SLING & SWATH BEFORE I WAS READY AND ALLOWED MY ARM TO FALL QUICKLY TO MY SIDE. I SCREAMED IN PAIN AND BEGAN TO CRY AND THEN THE THERAPIST SARCASTICALLY SHOUTED AT ME, 'THE YOUNG LADY HAS OBVIOUSLY NOT HAD HER PAIN MEDICATION, SO WHY DOESN'T SHE GO BACK TO BED AND COME BACK WHEN SHE CAN HANDLE THE EXERCISES.'"

OR IT IS FELT THAT "IN MANY CASES WE SERVED OUR COUNTRY AS WELL AS IF NOT BETTER THAN SOME MEN AND WE HAVE EQUAL RIGHT TO ALL AVAILABLE BENEFITS. I HAVE BEEN MADE TO FEEL THAT BECAUSE I'M A WOMAN, IT'S A WASTE OF GOVERNMENT MONEY FOR ME TO RECEIVE DISABILITY AND DEPENDENTS BENEFITS"

ANOTHER WOMAN VETERAN TRAVELS APPROXIMATELY 70 MILES TO "DEAL WITH FACILITIES NOT EQUIPPED FOR WOMEN, EMPLOYEES UNWILLING TO ACCEPT WOMEN AND, IN MY OPINION, BELOW AVERAGE MEDICAL CARE. IN 99% OF MY EXPERIENCES I WAS MADE TO FEEL LIKE AN ANIMAL".

"I THINK IT IS DUE MOSTLY TO A SYSTEM SET UP FOR MEN, BY MEN AND THEY DIDN'T QUITE KNOW WHAT TO DO WITH US...WE HAVE BEEN TREATED LIKE ODDITIES TOO LONG."

FROM A WOMEN VETERAN WHO CANNOT RECEIVE TREATMENT WITHIN HER LOCAL AREA: "MUST TRAVEL TO NEAREST VA HOSPITAL FOR TREATMENTS NOT HANDLED IN LOCAL VA CLINIC, WHICH ONLY IS SET UP MAINLY FOR MALE VETERANS."

"THEY DON'T REALIZE THEY ARE VETERANS AND MOST CLINICS ARE SET UP FOR MEN ONLY"

IN A FEMALE VIETNAM VETERAN'S RESPONSE REGARDING HER EXPERIENCE WITH VA MEDICAL FACILITY, SHE COULD ONLY WRITE: "BELIEVE ME THERE IS TOO MUCH TO SAY FOR THIS LITTLE SPACE!! MY STAY IN THE HOSPITAL FOR 4 DAYS WAS A COMPLETE NIGHTMARE."

"THE VA MEDICAL CENTER NEEDS TO BE SET UP BETTER AND MORE UNDERSTANDING OF CARE FOR WOMEN"

THE TOLEDO OUTPATIENT CLINIC SENT OUT A SEPARATE SURVEY, AND RECEIVED SIMILAR REACTIONS WITH PROBLEMS WOMEN VETERANS HAD AT THE CLINIC:

ONE WOMAN VETERAN ENCOUNTERED PROBLEMS "FROM AN ORTHOPEDIC DOCTOR WHO QUESTIONED ME AS TO WHY I SAT WASTING TIME; THAT I SHOULD COME TO HIS OFFICE WHERE HE HAD ALL THE NECESSARY EQUIPMENT TO HELP ME." SHE REPORTED HIM.

"FEMALE VETERANS (SERVICE CONNECTED DISABILITY) NOT TREATED ON SAME LEVEL AS MEN."

THE WOMEN ALSO RESPONDED TO QUESTIONS ASKED ABOUT THE GYNECOLOGICAL CARE SHARING THAT:

IN ONE INSTANCE A WOMAN VETERAN "WENT TO ANN ARBOR, NO GYN DOCTOR, JUST A GENERAL PRACTICE DOCTOR - COULD NOT ANSWER VARIOUS QUESTIONS ON WOMEN'S CONCERNS."

ANOTHER WOMAN COULD NOT RECEIVE CARE BECAUSE "I DIDN'T HAVE A REGULAR APPOINTMENT. I'VE HAD A HYSTERECTOMY SO IT PROBABLY ISN'T AS NECESSARY."

IN ANOTHER CASE, THE WOMAN VETERAN RECEIVED "NO FOLLOW-UP, NO MAMMOGRAM."

LAST SUMMER, OUR COMMITTEE CONDUCTED SEVEN HEARINGS THROUGHOUT THE STATE. FROM THE TESTIMONIALS PROVIDED TO THE COMMITTEE SEVERAL WITNESSES EXPLAINED THE FOLLOWING:

"I WAS THE ONLY FEMALE...I HAD TO UNDRESS IN A ROOM WITH A DOOR THAT WOULD NOT CLOSE WHILE MEN WERE LINED UP AND DOWN THE HALLWAY."

"I ENCOURAGE FOR WOMEN TO HAVE PRIVACY IN THE VA HOSPITALS...CLOSE THE DOORS"
THE FINAL BOTTOM LINE CAN BE SUMMARIZED WITH "THE WAY THE WOMEN ARE TREATED IS TERRIBLE"

AND I ASSURE YOU OUR LIST GOES ON. IT IS PLAINLY EVIDENT THAT THESE ARE AREAS AND ISSUES WHICH NEED TO BE BROUGHT TO YOUR ATTENTION AND YOU HAVE THE POWERS TO MAKE A POSITIVE IMPACT. THIS IS THE TYPE OF INFORMATION OUR COMMITTEE IS SEARCHING FOR, SO THAT WE CAN HELP THESE WOMEN, AND ALLEVIATE SOME OF THE HORROR STORIES AND UNEQUAL TREATMENT.

ALTHOUGH OUR COMMITTEE IS IN ITS INFANT STAGES, WE ARE DEDICATED TO WORKING ON OUR INITIATIVES. IT IS ALSO APPARENT THAT OHIO IS NOT THE ONLY STATE WHICH IS TRYING TO ACCOMMODATE ITS WOMEN VETERANS TO THE EQUALITY OF THE MALE VETERAN. AS YOU CAN SEE, I HAVE ATTACHED VARIOUS NEWSPAPER ARTICLES FROM ALL DIFFERENT PARTS OF THE UNITED STATES WHICH HAVE ALSO STIRRED SOME INTEREST.

IT IS OUR HOPE THAT AFTER HAVING BEEN INVITED TO TESTIFY BEFORE YOUR COMMITTEE, YOU CONTINUE TO STUDY THE TYPE OF CARE WHICH IS PROVIDED TO THE WOMAN VETERAN, CONSIDER THE COMMENTS RECEIVED BY WOMEN VETERANS, AND ADDRESS THESE ISSUES BOLDLY!

THANK YOU ONCE AGAIN, AND I WOULD BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

WOMEN VETERANS FIELD SURVEY

Dear Women Veteran:

The Governor's Advisory Committee on Women Veterans has been established by the Governor's Office of Veterans' Affairs. We have been asked to make recommendations on issues, needs, and concerns of Ohio women veterans. Our recommendations will help direct Ohio in improving services, health care, other benefits, and public awareness of women veterans' service to our country.

The Committee is made up of women veterans and active duty service women-- including those in the National Guard and Reserves-- who have served in the military from World War II through the Persian Gulf War. To ensure our recommendations are based upon the needs of all Ohio's women veterans, we have developed this field survey to identify your needs. This is not just another survey; this survey could have an impact on all Ohio women veterans. Please take a few minutes to complete one copy of this survey. If you receive two, please pass one along to another women veteran. For additional information or comments, please attach an additional sheet of paper or write to our Committee at any time. The information you provide will be used to formulate our recommendations for the action Ohio should take to meet your needs. Thank you for your time and assistance.

Please submit any correspondence to:

GOVERNOR'S OFFICE OF VETERANS' AFFAIRS
ATTN: COMMITTEE ON WOMEN VETERANS
77 SOUTH HIGH STREET, 30TH FLOOR
COLUMBUS, OHIO 43266-0601

Oral and written testimonies will be taken during the months of June through August 1993. Please see the last page for information and schedules. Written testimonies are always welcome.

PLEASE CIRCLE, CHECK, OR FILL IN YOUR RESPONSE AS APPROPRIATE.

DEMOGRAPHIC DATA

1. PLEASE INDICATE THE COUNTY WHERE YOU LIVE:_____

2. YOUR AGE GROUP IS: 18-21 22-29 30-39 40-49 50-59 60+

3. ARE YOU: MARRIED WIDOWED DIVORCED/SEPARATED NEVER MARRIED

4. RACE/ETHNIC GROUP: WHITE BLACK HISPANIC ASIAN PACIFIC NATIVE AMERICAN OTHER_____

5. DO YOU HAVE CHILDREN? YES NO
   NUMBER UNDER AGE 12____ AGES 13-17____ AGE 18+____
   NUMBER OF CHILDREN 18-23 IN SCHOOL_____ DISABLED_____ OTHER DEPENDENTS_____

6. YOUR EDUCATION: ___8th GRADE OR LESS ___SOME HIGH SCHOOL
___HIGH SCHOOL GRAD ___GED ___VOCATIONAL/TECHNICAL/TRADE SCHOOL
___SOME COLLEGE - CIRCLE YRS COMPLETED: 1 2 3 4 5 6 7 8
___ASSOC DEGREE ___BACHELOR'S DEGREE ___MASTER'S DEGREE ___DOCTORATE

7. ARE YOU PROFICIENT IN A FOREIGN LANGUAGE? YES NO WHICH LANGUAGE(S)_____

8. DO YOU: OWN YOUR HOME RENT LIVE WITH FAMILY OTHER:_____

9. ARE YOU THE ONLY SOURCE OF INCOME IN YOUR FAMILY? YES NO

10. IF YOU ARE MARRIED, IS YOUR SPOUSE YOUR ONLY SOURCE OF INCOME? YES NO

11. WHAT IS YOUR HOUSEHOLD ANNUAL INCOME RANGE?

LESS THAN $5,000.00	( )	$20,000.00 TO $29,000.00	( )
$5,000.00 TO 9,000.00	( )	$30,000.00 TO $39,000.00	( )
$10,000.00 TO 14,999.00	( )	$40,000.00 TO $49,000.00	( )
$15,000.00 TO 19,999.00	( )	$50,000.00 AND UP	( )

MILITARY BACKGROUND

12. BRANCH OF SERVICE (CIRCLE ALL THAT APPLY): ARMY AIR FORCE NAVY MARINES COAST GUARD RESERVES
    WAC WAAC AIR WAC WASP NATIONAL GUARD WAF WAVES SPARS

13. WERE YOU AN ___OFFICER, ___ENLISTED, OR ___WARRANT OFFICER?

14. YOUR MILITARY OCCUPATION WAS_____ YOUR CURRENT CIVILIAN OCCUPATION IS_____

15. DID YOU SERVE IN: WWI WWII KOREA VIETNAM PEACETIME PERSIAN GULF OTHER:_____

16. YOUR TYPE OF DISCHARGE_____

17. DID YOU SERVE (CHECK ALL THAT APPLY):
__OUTSIDE THE CONTINENTAL U.S. ___PEACE TIME OR ___WAR
__INSIDE THE CONTINENTAL U.S. ___PEACE TIME OR ___WAR
__DURING WARTIME IN A HOSTILE MILITARY ZONE
__DURING PEACETIME IN A HOSTILE MILITARY ZONE

18. DO YOU RECEIVE VA COMPENSATION FOR A SERVICE-CONNECTED DISABILITY? NO YES - ____%

19. IF NOT RECEIVING COMPENSATION, HAVE YOU EVER APPLIED FOR A VA DISABILITY RATING? YES NO

20. HAVE YOU EVER APPLIED FOR DISABILITY CONSIDERATION/RATING WITH ANOTHER STATE OR FEDERAL AGENCY? YES NO

21. ARE YOU HANDICAPPED OR DISABLED? YES NO

22. DO YOU CONSIDER YOURSELF TO HAVE A HANDICAP OR DISABILITY WHICH AFFECTS YOU IN OBTAINING EMPLOYMENT? YES NO

23. WHAT DO YOU FEEL THE STATE OF OHIO NEEDS TO ADDRESS TO IMPROVE BENEFITS, EMPLOYMENT OPPORTUNITIES, AND EDUCATION FOR THE HANDICAPPED/DISABLED? _____

EDUCATIONAL BENEFITS

24. WERE YOU ELIGIBLE FOR EDUCATIONAL BENEFITS WHEN YOU LEFT THE MILITARY? YES NO

25. DID YOU USE VA VOCATIONAL REHABILITATION BENEFITS TO ATTEND SCHOOL? YES NO

26. DID YOU USE YOUR VA (GI BILL) EDUCATIONAL BENEFITS TO ATTEND SCHOOL? YES NO

27. DID YOU PARTICIPATE IN A VA WORK-STUDY PROGRAM TO ATTEND SCHOOL? YES NO

28. DID YOUR VA EDUCATIONAL BENEFITS EXPIRE BEFORE YOU WERE ABLE TO ATTEND SCHOOL OR COMPLETE A PROGRAM OF STUDY? YES NO

29. IF AN EDUCATIONAL PROGRAM WHICH REDUCED EDUCATIONAL COST FOR WOMEN VETERANS WERE AVAILABLE, WOULD YOU ENROLL IN SCHOOL? YES NO
IF YES, WHAT COURSE OF STUDY?_____
WOULD THIS PROGRAM BE: VOCATIONAL ASSOCIATE DEGREE LICENSES BACHELOR'S DEGREE CERTIFICATE OF COMPLETION POST GRADUATE

30. DO THE EDUCATIONAL OPPORTUNITIES IN OHIO MEET YOUR NEEDS? YES NO

31. WHAT WOULD YOU LIKE TO SEE OR RECOMMEND THAT OHIO SHOULD CONSIDER TO MEET YOUR EDUCATIONAL NEED?_____

VETERANS BENEFITS

32. DO YOU CURRENTLY HAVE MEDICAL COVERAGE FOR:__SELF __FAMILY

33. DO YOU KNOW IF YOU ARE ELIGIBLE TO RECEIVE MEDICAL CARE FROM A VA FACILITY? KNOW DON'T KNOW

34. DO YOU KNOW WHERE THE CLOSEST VA FACILITY IS? YES NO

35. ARE YOU CURRENTLY RECEIVING TREATMENT AT A VA MEDICAL FACILITY? YES NO

36. HOW FAR DO YOU TRAVEL FOR TREATMENT?_____

37. HAVE YOU EXPERIENCED ANY PROBLEMS/DIFFICULTIES WHILE RECEIVING CARE AT A VA MEDICAL FACILITY? YES NO
EXPLAIN:_____
_____

38. DO YOU BELONG TO ANY VETERANS' ORGANIZATION(S)? YES NO
IF YOU DO NOT BELONG TO A VETERANS' ORGANIZATION, WHAT WOULD ENCOURAGE YOU TO BECOME A MEMBER?
_____
IF YOU DO BELONG, WHICH ONE(S)?_____

39. ARE YOU FAMILIAR WITH THE EFFORTS TO BUILD TWO MEMORIALS TO WOMEN VETERANS IN WASHINGTON D.C.?
WINSA: YES NO VIETNAM: YES NO

40. IF YOU ARE FAMILIAR WITH THE EFFORT, DO YOU SUPPORT THE EFFORT? YES NO
(FOR WINSA INFORMATION OR REGISTRATION FORMS CALL 1-800-222-2294)
(FOR VIETNAM INFORMATION CALL 1-202-328-7253 OR WRITE: VIETNAM WOMEN'S MEMORIAL PROJECT, 2001 SOUTH STREET, SUITE 302, WASHINGTON, D.C. 20009)

41. WHAT AREAS DO YOU FEEL THE STATE OF OHIO NEEDS TO ADDRESS OR CHANGE TO MEET YOUR NEEDS IN LEARNING ABOUT YOUR VETERAN BENEFITS?_____

42. WHAT DO YOU FEEL NEEDS TO BE DONE TO IMPROVE PUBLIC AWAPENESS OF WOMEN VETERANS? _____

43. WHY DO YOU FEEL THAT WOMEN VETERANS DO NOT UTILIZE ALL OF THEIR VETERAN BENEFITS? _____

44. THE FOLLOWING IS A LIST OF VETERANS' BENEFITS AND PROGRAMS. PLEASE CIRCLE 1 IF YOU ARE NOT AWARE OF THIS BENEFIT; 2 IF YOU ARE AWARE OF THE BENEFIT, BUT HAVE NOT USED THIS BENEFIT; OR 3 IF YOU HAVE USED THIS BENEFIT.

	NOT AWARE	AWARE	USED
JOB SERVICE VETERANS' EMPLOYMENT UNIT	1	2	3
VETERANS' PREFERENCE 5 & 10 POINTS	1	2	3
VETERANS READJUSTMENT APPOINTMENT (VRA)	1	2	3
TARGETED JOBS TAX CREDIT (TJTC)	1	2	3
VETERANS RE-EMPLOYMENT RIGHTS (VRR)	1	2	3
VA EDUCATIONAL BENEFITS	1	2	3
VA VOCATIONAL REHABILITATION	1	2	3
VA HOME LOAN	1	2	3
SMALL BUSINESS ADMINISTRATION LOAN (SBA)	1	2	3
DISCHARGE UPGRADE	1	2	3
GOVERNOR'S OFFICE OF VETERANS' AFFAIRS	1	2	3
VET CENTER	1	2	3
VA MENTAL HEALTH CARE	1	2	3
VA DISABILITY CLAIM	1	2	3
VA DENTAL CARE	1	2	3
VA SUBSTANCE ABUSE (DRUG/ALCOHOL)	1	2	3
VA BURIAL BENEFITS	1	2	3
VA NON-SERVICE CONNECTED PENSION	1	2	3
DEPENDENCY INDEMNITY COMPENSATION (DIC)	1	2	3
VA WORK STUDY PROGRAM	1	2	3
COUNTY VETERANS SERVICE OFFICE	1	2	3
VA COMPENSATION	1	2	3
RE-ENLISTMENT WAIVER	1	2	3
EMERGENCY FINANCIAL ASSISTANCE THROUGH COUNTY VETERANS SERVICE OFFICE	1	2	3
WOMEN'S CENTER	1	2	3
ORIENTATION TO NON-TRADITIONAL OCCUPATIONS FOR WOMEN (ONOW)	1	2	3
WOMEN'S ABUSE CENTER	1	2	3
CRISIS CENTERS/SHELTERS	1	2	3
DISLOCATED HOMEMAKERS PROGRAM	1	2	3
WOMEN'S BUREAU	1	2	3
VIETNAM ERA VETERANS' READJUSTMENT ASSISTANCE ACT (DOL)	1	2	3
OHIO VETERANS' HOME	1	2	3

EMPLOYMENT BENEFITS

45. ARE YOU CURRENTLY: EMPLOYED UNEMPLOYED RETIRED IF EMPLOYED, ARE YOU WORKING: FULL TIME PART TIME
DO YOU CONSIDER YOURSELF UNDER-EMPLOYED: YES NO

46. WHEN SEEKING EMPLOYMENT, WHAT SOURCES DID OR WILL YOU USE? OHIO JOB SERVICE TEMPORARY AGENCIES
NEWSPAPERS FRIENDS PRIVATE EMPLOYMENT AGENCY VET CENTERS WOMENS' CENTERS
JOB TRAINING PARTNERSHIP ACT (JTPA) OTHER_____

47. ARE YOU CURRENTLY USING OR HAVE YOU EVER USED THE OHIO JOB SERVICE (OBES)? YES NO

48. WAS IT A POSITIVE EXPERIENCE? YES NO
WOULD YOU USE OBES AGAIN? YES NO

49. DID YOU RECEIVE A JOB REFERRAL? YES NO
IF YES, WAS IT IN YOUR OCCUPATION? YES NO

50. WERE YOU ASKED IF YOU WERE A VETERAN? YES NO

51. DO YOU FEEL THE OHIO JOB SERVICE PROVIDED ADEQUATE AND COURTEOUS SERVICE? YES NO
EXPLAIN_____

52. ARE YOU AWARE THAT VETERANS SHOULD RECEIVE PRIORITY SERVICE AND EMPLOYMENT ASSISTANCE FROM OBES? YES NO

53. DO YOU FEEL THAT A LACK OF TRANSPORTATION PRESENTS AN OBSTACLE FOR YOU IN OBTAINING EMPLOYMENT? YES NO

54. DO YOU OWN OR HAVE ACCESS TO A CAR IN ORDER TO TRAVEL BACK AND FORTH TO WORK? YES NO

55. IS PUBLIC TRANSPORTATION ACCESSIBLE TO WORK? YES NO

56. DO YOU KNOW THE OCCUPATIONS THAT ARE BEST SUITED TO YOUR ABILITIES? YES NO

57. ARE YOU AWARE OF HOW YOUR SKILLS RELATE TO THE JOB MARKET? YES NO

58. DO YOU NEED MORE INFORMATION IN ORDER TO CHOOSE AN OCCUPATION? YES NO

59. IF AVAILABLE IN YOUR AREA, WOULD YOU BE INTERESTED IN ATTENDING A THREE DAY WORKSHOP ON HOW TO LOOK FOR WORK? YES NO

60. IF AVAILABLE IN YOUR AREA, WOULD YOU BE INTERESTED IN TALKING TO A VOCATIONAL SPECIALIST ABOUT TRAINING, EDUCATION, OR EMPLOYMENT OPPORTUNITIES? YES NO

61. PLEASE CLASSIFY YOUR TYPE OF OCCUPATION.

PROFESSIONAL	( )	TECHNICAL	( )
MANAGERIAL	( )	CLERICAL	( )
SALES	( )	SERVICE	( )
AGRICULTURAL	( )	PROCESSING	( )
MACHINE TRADES	( )	BENCHWORK	( )
HOMEMAKER	( )	OTHER:_____	

62. WHAT CAN THE STATE OF OHIO DO TO IMPROVE UPON OR MEET YOUR EMPLOYMENT NEEDS? _____

_____

63. PLEASE LIST WHATEVER AREAS OF CONCERN YOU HAVE THAT HAVE NOT BEEN ADDRESSED IN THIS SURVEY, AND ANY RECOMMENDATIONS YOU MAY HAVE._____

_____

64. WHAT RECOMMENDATIONS DO YOU HAVE OR WHAT WOULD YOU LIKE TO SEE THAT WOULD BRING A POSITIVE IMAGE TO WOMEN VETERANS? _____

_____

65. PLEASE LIST ANY ADDITIONAL COMMENTS, POSITIVE OR NEGATIVE EXPERIENCES, THAT YOU FEEL WOULD BE IMPORTANT FOR THIS COMMITTEE TO CONSIDER IN OUR RECOMMENDATIONS._____

_____

Again, we would like to express our appreciation for your time, recommendations, and comments. This Committee is always available to accept any written testimonies from you. If we may be of assistance to you, please do not hesitate to contact us. Thank you.

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*************************************************************
*              GOVERNOR'S OFFICE OF VETERAN AFFAIRS         *
*              ATTN:  COMMITTEE ON WOMEN VETERANS           *
*              77 SOUTH HIGH STREET, 30TH FLOOR             *
*                   COLUMBUS, OHIO 43266-0601               *
*************************************************************
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PLEASE INDICATE THE COUNTY IN WHICH YOU LIVE._____

WOULD YOU BE WILLING TO SERVE ON A SUB-COMMITTEE OR VOLUNTEER TO WORK ON PROJECTS TO IMPROVE CONDITIONS OR BENEFITS FOR WOMEN VETERANS? YES NO

IF YOU HAVE ANSWERED YES TO THE ABOVE QUESTION, WE NEED YOUR ADDRESS AND PHONE NUMBER TO CONTACT YOU. TO KEEP YOUR SURVEY CONFIDENTIAL, PLEASE MAIL THIS RESPONSE IN A SEPARATE ENVELOPE.

NAME_____
ADDRESS_____
CITY/STATE_____ ZIP_____
DAY PHONE(_____)_____
NIGHT PHONE(_____)_____
BEST TIME TO CONTACT_____

Thank you. We look forward to working with you to improve life for women veterans.

2 November 1993

Honorable George V. Voinovich
Governor of Ohio
Columbus, Ohio 43215

Dear Governor Voinovich:

On January 14, 1993, the Governor's Advisory Committee for Women Veterans was established. The committee is comprised of women veterans and active duty servicewomen - including National Guard and Reserve - who have served in the military from World War II through the Persian Gulf War (See TAB A). You asked the committee to provide you with recommendations on the issues, needs and concerns of Ohio women veterans. The committee developed the following goals:

a. Identify and Assess the special needs of women veterans in Ohio.

b. Provide information meeting the needs of women veterans, including benefits and entitlements, education, and training for unemployment through referral programs: The committee will research and assess the needs of women veterans, identify services currently offered, and determine what services are lacking - to include benefits and entitlements, education, employment training, and referral programs.

c. Recommend and plan events honoring women veterans who have served and those currently serving in the military: The committee will utilize these events as a way of developing and enhancing a positive image of women veterans.

d. Coordinate and monitor efforts to accomplish all of the above goals and objectives: The committee decided to establish points of contact with various organizations to acquire information and avoid duplicate efforts.

This constitutes an interim report on committee activities thus far.

The committee met seven times in 1993. During this timeframe, the committee established points of contact with various organizations to acquire information concerning women veterans and to avoid duplication of effort with other organizations who deal in serving women veterans. Of an estimated 50,000 female veterans in the State of Ohio, the committee has been able to identify by name and current address only 7,000. This effort is ongoing and a database has been established to provide a system to permanently identify and track women veterans. Additionally, the committee developed and distributed 4,000 Women Veteran Field Surveys (See TAB B) to assist in the identification of women veterans' needs. However, this effort is at a standstill as the cost of reproducing and mailing surveys has been prohibitive beyond the current distribution. In order to keep this effort ongoing, additional funding must be provided.

During the months of June, July, and August, the committee held eight public hearings (See TAB C) throughout the State of Ohio. In those areas where the media was not responsive to news releases, few women veterans testified. In those areas where the testimonials were widely publicized, twenty or more women veterans testified. General responses and feedback from women veteran testimonials include:

a. Women veterans want a "female" veteran organization.

b. Women veterans are ill-informed of their veteran benefits.

c. Women veterans are under-employed.

d. Women veteran military job skills do not easily translate into the civilian environment.

e. Women veterans want more flexible educational benefits.

f. Women veterans need a one-source reference for available benefits.

At this time, it is too soon to analyze the results of some 1,000 surveys returned as the sampling is too small.

Overall, committee members felt that the public hearings were successful and will attempt to hold hearings again in 1994. Media support would increase the likelihood of women veteran attendance during these testimonials, and the committee will work toward this goal.

The committee estimates that it will take at least another 12-18 months to obtain the goals established and make recommendations which will help direct Ohio in improving services, health care, other benefits, and public awareness of women veterans' service to our country. Recently, the state of Oregon published and distributed a country-wide Women Veterans Coordinators Directory (See TAB D). It is apparent that several states are working toward the same goals and that there is a need for a one-source national committee. Insofar as the committee is an all-volunteer effort, countless "women-hours" have been devoted to committee activities thus far. The National Guard and OBES have been supportive in providing services to cover some of the cost of survey reproduction and postal services. However, additional support is required in these areas to reach as many women veterans as is possible. Women veterans seem hesitant to identify themselves as such, which also causes problems in assessing the needs of this population. In those instances where women veterans could articulate a specific problem or need, the committee has been immediately responsive and attempted to assist the female veteran through referral to the appropriate agency and follow-up where necessary.

The committee will next meet in January 1994.

Respectfully submitted,

CHRISTINE M. COOK
MAJOR, OHIO ARNG
Chairperson

(THIS LETTER WAS RECEIVED WITH A SURVEY, RETYPED VERBATIM FOR FORMAT)

I am a 24 year old female veteran who served as a musician from August 1986 - August 1987. Due to an unfortunate physical training accident, I was medically discharged with a 30% service connected disability. Although my experience on active duty was limited, my dealings with the Veterans Administration is not. I am currently a 40% and am receiving Vocational Rehabilitation to obtain my teaching certificate in secondary education. These benefits, however, only came about by years of fighting and frustration with the system. I decided to write this letter to share my experiences and allow you to make your own decision about if the system is fair women veterans or not. (or fair to all veterans for that matter).

First I will cover my experience with the VA Medical Centers and doctors. I have an unstable shoulder joint from my injury in the Army and three years ago it began giving me a lot of trouble. I waited patiently for the three 8 hour days of actually getting to see an orthopedic resident before they examined me and determined I need shoulder surgery as soon as possible. (My shoulder was practically falling out of the joint and I had little feeling in 2 of my fingers & part of my arm) All necessary tests were done before the surgery (while I took off a lot of work to drive 1 1/2 hours to the VA Hospital twice a week). My 3 hour surgery turned into 6 or 7 hours of surgery while they reconstructed everything. (I faintly remember hearing Led Zeppelin music blasting in the Operation Room before I was put under) I then had to spend the next 4 days sharing my bathroom with a morphine-addicted male Vietnam Vet. On the fourth day, I was given my exercises by my doctor and was sent to the Physical Therapy room with out having been medicated for 7 hours (I beeped for 30 minutes & no one came) The therapist began making snide comments about me being a woman to the other male vets in the room and proceeded to abruptly remove my sling & swath before I was ready and allowed my arm to fall quickly to my side. I screamed in pain and began to cry and the therapist sarcastically shouted at me, "The young lady has obviously not had her pain medication, so why doesn't she go back to bed and come back when she can handle the exercises." I came back in the afternoon just so I could be quickly discharged to get away from there.

During my recuperation, I tried to return to work for a short time, but I was unable to perform my normal work as a typist at first. This company had also placed me on probation for missing work due to the number of my appointments, but I informed them I had spoken to the Governor's Office and found out is was illegal to fire me for missing work due to my disability. (I lied and they believed me. I had talked to the Governor's Office, but I was told that the law I was quoting had been dissolved with the last administration). The company I worked for, however, made my life miserable by forcing me to carry stacks of heavy files from one side of the building to the other when they knew I was unable to hold them. I eventually found a part-time position at an insurance agency after I was almost fully recovered.

Six or seven months after the surgery, (March 1992), I felt instability returning and a pain I had not experienced before the surgery. The residents prescribed 600 mg Motrin and placed me on a heavier physical therapy program. Over a two month period, my occupational therapist noted my pain doubled and my range of motion decreased by half. She tried to get me to see the shoulder specialist, but we were both met with male residents with ego trips. I cannot even begin to count how many residents insisted that if they couldn't explain my problem that no one else would be able to either. Some made comments about not believing my injury occurred in the Army, why don't I just have my husbands insurance take care of it, and one recommended I visit the "Pain Clinic" -- a pseudonym for a psychological analysis chamber.

Besides my monthly 6-8 hour orthopedic appointment, every treatment known to modern medical technology was tried. Last summer I was missing 6-8 hours a week from my part-time job because I had to drive to Wade Park 3 times a week for 8 am appointments. Due to the long drive, I did not get into work until 10-11 am and I was supposed to start at 9:30. My boss grew very impatient and wondered why I could not make my appointments on my own personal time. I tried to explain the VA system to him and that the hospital was only open from 8-4:30 for appointments, but people who have experienced a VA hospital first hand are not capable of understanding it. I was forced to resign under duress in January of this year. The next day, however, I received the letter from the VA stating my 2 year appeal was successful and I was awarded a 40% rating. I immediately registered for a college course. I had contacted a lawyer about my job, but obviously my boss had too because the next Monday he called to offer my job back. I declined the offer knowing the only reason was because he didn't want to be sued.

Finally, a female resident took the time this spring to research my case history and my type of problem and finally got the head of orthopedics at both Wade Park and University Hospitals to look at me. He and she recommended surgery to correct the 1st surgery which placed my shoulder joint off balance. They described the type of surgery I would have and I asked for a second opinion. The head ortho surgeon -- not a shoulder specialist by the way -- gave me the name of the physician who does all the shoulders for area athletes, etc. at the Cleveland Clinic. My visit to him was very enlightening. I knew my first surgery had been screwed up, but I didn't know how badly. This doctor told me they did the WRONG surgery for my condition the first time and it never should have taken 6 hours. After the surgery, my arm was placed in the wrong healing position and I should not have had any exercises for 2-3 months. When I described the surgery the head ortho surgeon at the VA wanted to do to correct my problem, this physician said that surgery only had a 30% success rate and probably would have made my condition much worse. He suggested I have the surgery I should have had the first time, a full capsular shift, and it should only take 2 hours. I will be placed in a partial body cast for 6 weeks to keep my arm & shoulder completely immobile.

I am now, however, afraid of having this surgery done at the VA hospital. Obviously no one there knows how to do the correct procedure and I really do not want them using me as a guinea pig. Unfortunately, I have a long hard fight ahead of me because fee basis will not contract out a surgery if it can be done at the VA hospital. My husband's insurance will not pay for it because he is in the process of changing jobs and I will be under a one year pre-existing condition exclusion once his new insurance kicks in. If you have any idea the best route I could take regarding this problem, please contact me.

Now that you know my medical experiences, I will briefly describe my administrative problems. For as long as I have been dealing with the VA, I have come across people who think because I am a female, I do not deserve the same benefits other (male) veterans have. The best example I can give you is when I was applying for Vocational Rehabilitation, my counselor was a man in his sixties who told me he didn't think women were allowed to receive dependents allowances. He blatantly asked me, "Well, how much does your husband make? Can't you afford to attend college with his income?" My first response to him was, "If I was a male veteran sitting here would you ask him if his wife made more than he did and could afford to send him to college?" I caught him off guard and after he recovered, he wisely stated, "Oh, of course I would." Yeah, right...tell me another one. He was surprised to find out that I was eligible to receive a dependence subsidence--just as if I was a male veteran. This attitude is all over the veterans administration. It doesn't seem to matter that I was an excellent soldier who scored higher in all areas of training than almost all of my male counterparts. It doesn't matter that my roommate, who also was a musician, was sent to the Persian Gulf to cover a position that was held by a girl in the States who wasn't sent over BECAUSE she was a girl. (tell me what sense that makes).

I know it is difficult to change male attitudes about women's function in the military, but we are no longer considered active duty "Ornaments". VA physicians, counselors, and administrative personnel need to be reminded to look at each case without a sexual bias. Laws also need to be changed to protect all veterans in their jobs--especially disabled veterans. Employers have to be made to understand that if they accept a government incentive to hire disabled veterans that they have to be willing to put up with treatment schedules and disability accommodations. If this is not possible, then change the way veterans are medically treated. The one-hundred mile rule needs to go. (If you live within one-hundred miles of a VA Medical Facility, you cannot be treated anywhere else unless you can pay for it yourself). Disability and handicap accommodation laws are fine, but I think more disabled lose jobs due to the type of treatment they receive and the time it takes for the number of their appointments. In my case, I basically lost two jobs in two years because I was given the wrong surgery and useless treatment. I have been in constant pain which limits daily activities because the government has allowed the VA hospitals to become training grounds for all inexperienced doctors and surgeons. Do you think that is fair?

I hope my experiences have provided some insight as to how the VA system is toward not only women veterans, but all veterans. People who have never held a job in their life get better treatment on welfare than people who sacrificed to serve their country. Please do something.

PLEASE CIRCLE, CHECK, OR FILL IN YOUR RESPONSE AS APPROPRIATE.

DEMOGRAPHIC DATA

1. PLEASE INDICATE THE COUNTY WHERE YOU LIVE: Delaware

2. YOUR AGE GROUP IS: 18-21 22-29 (30-39) 40-49 50-59 60+

3. ARE YOU: MARRIED WIDOWED DIVORCED/SEPARATED NEVER MARRIED

4. RACE/ETHNIC GROUP: (WHITE) BLACK HISPANIC ASIAN PACIFIC NATIVE AMERICAN OTHER_____

5. DO YOU HAVE CHILDREN? NO (YES)
NUMBER UNDER AGE 12 ___ AGES 13-17 3 AGE 18- 1
NUMBER OF CHILDREN 18-23 IN SCHOOL 1 DISABLED ___
OTHER DEPENDENTS _____

6. YOUR EDUCATION: ___ 8th GRADE OR LESS ___ SOME HIGH SCHOOL
___ HIGH SCHOOL GRAD ___ GED ___ VOCATIONAL/TECHNICAL/TRADE SCHOOL
✓ SOME COLLEGE - CIRCLE THE COMPLETED: 1 (2) 3 4 5 6 7 8
___ ASSOC DEGREE ___ BACHELOR'S DEGREE ___ MASTER'S DEGREE
___ DOCTORATE

7. ARE YOU PROFICIENT IN A FOREIGN LANGUAGE? YES (NO)
WHICH LANGUAGE(S) _____

8. DO YOU: OWN YOUR HOME RENT (LIVE WITH FAMILY)
OTHER: _____

9. ARE YOU THE ONLY SOURCE OF INCOME IN YOUR FAMILY? YES (NO)

10. IF YOU ARE MARRIED, IS YOUR SPOUSE YOUR ONLY SOURCE OF INCOME? YES NO

11. WHAT IS YOUR HOUSEHOLD ANNUAL INCOME RANGE?

LESS THAN $5,000.00	( )	$20,000.00 TO $29,000.00	( )
$5,000.00 TO 9,000.00	( )	$30,000.00 TO $39,000.00	( )
$10,000.00 TO 14,999.00	(✓)	$40,000.00 TO $49,000.00	( )
$15,000.00 TO 19,999.00	( )	$50,000.00 AND UP	( )

MILITARY BACKGROUND

12. BRANCH OF SERVICE (CIRCLE ALL THAT APPLY):
(ARMY) AIR FORCE NAVY MARINES COAST GUARD RESERVES
WAC WAAC AIR WAC WASP (NATIONAL GUARD) WAF WAVES SPARS

13. WERE YOU AN ___ OFFICER, ✓ ENLISTED, OR ___ WARRANT OFFICER?

14. YOUR MILITARY OCCUPATION WAS M-6 Tay
YOUR CURRENT CIVILIAN OCCUPATION IS unit Clerk in hospital

15. DID YOU SERVE IN: WWI WWII KOREA VIETNAM
PEACETIME (PERSIAN GULF) OTHER: _____

16. YOUR TYPE OF DISCHARGE Honorable

17. DID YOU SERVE (CHECK ALL THAT APPLY):
✓ OUTSIDE THE CONTINENTAL U.S. ___ PEACE TIME OR ✓ WAR
___ INSIDE THE CONTINENTAL U.S. ___ PEACE TIME OR ___ WAR
✓ DURING WARTIME IN A HOSTILE MILITARY ZONE
___ DURING PEACETIME IN A HOSTILE MILITARY ZONE

18. DO YOU RECEIVE VA COMPENSATION FOR A SERVICE-CONNECTED DISABILITY? NO YES - ___ %

19. IF NOT RECEIVING COMPENSATION, HAVE YOU EVER APPLIED FOR A VA DISABILITY RATING? YES NO

20. HAVE YOU EVER APPLIED FOR DISABILITY CONSIDERATION/RATING WITH ANOTHER STATE OR FEDERAL AGENCY? YES (NO)

21. ARE YOU HANDICAPPED OR DISABLED? YES (NO)

22. DO YOU CONSIDER YOURSELF TO HAVE A HANDICAP OR DISABILITY WHICH AFFECTS YOU IN OBTAINING EMPLOYMENT? YES (NO)

23. WHAT DO YOU FEEL THE STATE OF OHIO NEEDS TO ADDRESS TO IMPROVE BENEFITS, EMPLOYMENT OPPORTUNITIES, AND EDUCATION FOR THE HANDICAPPED/DISABLED? _____

EDUCATIONAL BENEFITS

24. WERE YOU ELIGIBLE FOR EDUCATIONAL BENEFITS WHEN YOU LEFT THE MILITARY? (YES) NO

25. DID YOU USE VA VOCATIONAL REHABILITATION BENEFITS TO ATTEND SCHOOL? YES (NO)

26. DID YOU USE YOUR VA (GI BILL) EDUCATIONAL BENEFITS TO ATTEND SCHOOL? (YES) NO

27. DID YOU PARTICIPATE IN A VA WORK-STUDY PROGRAM TO ATTEND SCHOOL? YES (NO)

28. DID YOUR VA EDUCATIONAL BENEFITS EXPIRE BEFORE YOU WERE ABLE TO ATTEND SCHOOL OR COMPLETE A PROGRAM OF STUDY? YES (NO)

29. IF AN EDUCATIONAL PROGRAM WHICH REDUCED EDUCATIONAL COST FOR WOMEN VETERANS WERE AVAILABLE, WOULD YOU ENROLL IN SCHOOL? (YES) NO

IF YES, WHAT COURSE OF STUDY? Nursing

WOULD THIS PROGRAM BE: VOCATIONAL ASSOCIATE DEGREE LICENSES
(BACHELOR'S DEGREE) CERTIFICATE OF COMPLETION POST GRADUATE

30. DO THE EDUCATIONAL OPPORTUNITIES IN OHIO MEET YOUR NEEDS? (YES) NO

31. WHAT WOULD YOU LIKE TO SEE OR RECOMMEND THAT OHIO SHOULD CONSIDER TO MEET YOUR EDUCATIONAL NEED? _____
I am currently enrolled in Nursing school working towards my associate degree

VETERANS BENEFITS

32. DO YOU CURRENTLY HAVE MEDICAL COVERAGE FOR: ___SELF ___FAMILY

33. DO YOU KNOW IF YOU ARE ELIGIBLE TO RECEIVE MEDICAL CARE FROM A VA FACILITY? KNOW (DON'T KNOW)

34. DO YOU KNOW WHERE THE CLOSEST VA FACILITY IS? YES (NO)

35. ARE YOU CURRENTLY RECEIVING TREATMENT AT A VA MEDICAL FACILITY? YES (NO)

36. HOW FAR DO YOU TRAVEL FOR TREATMENT? ___

37. HAVE YOU EXPERIENCED ANY PROBLEMS/DIFFICULTIES WHILE ARCEIVING CARE AT A VA MEDICAL FACILITY? YES NO

EXPLAIN: VA refuses to take care of my dental problems that occured during Persian Gulf war. Even though I have papers telling me I get compensated for this care !!!

38. DO YOU BELONG TO ANY VETERANS' ORGANIZATION(S)? YES (NO)

IF YOU DO NOT BELONG TO A VETERANS' ORGANIZATION, WHAT WOULD ENCOURAGE YOU TO BECOME A MEMBER? yes

IF YOU DO BELONG, WHICH ONE(S)? ___

39. ARE YOU FAMILIAR WITH THE EFFORTS TO BUILD TWO MEMORIALS TO WOMEN VETERANS IN WASHINGTON D.C.?

WIMSA: YES (NO) VIETNAM: YES (NO)

40. IF YOU ARE FAMILIAR WITH THE EFFORT, DO YOU SUPPORT THE EFFORT? YES (NO)

(FOR WIMSA INFORMATION OR REGISTRATION FORMS CALL 1-800-222-2294)

(FOR VIETNAM INFORMATION CALL 1-202-328-7253 OR WRITE: VIETNAM WOMEN'S MEMORIAL PROJECT, 2001 SOUTH STREET, SUITE 303, WASHINGTON, D.C. 20009)

41. WHAT AREAS DO YOU FEEL THE STATE OF OHIO NEEDS TO ADDRESS OR CHANGE TO MEET YOUR NEEDS IN LEARNING ABOUT YOUR VETERAN BENEFITS? Send more information

42. WHAT DO YOU FEEL NEEDS TO BE DONE TO IMPROVE PUBLIC AWARENESS OF WOMEN VETERANS? ___

43. WHY DO YOU FEEL THAT WOMEN VETERANS DO NOT UTILIZE ALL OF THEIR VETERAN BENEFITS?

yes

44. THE FOLLOWING IS A LIST OF VETERANS' BENEFITS AND PROGRAMS. PLEASE CIRCLE 1 IF YOU ARE NOT AWARE OF THIS BENEFIT; 2 IF YOU ARE AWARE OF THE BENEFIT, BUT HAVE NOT USED THIS BENEFIT; OR 3 IF YOU HAVE USED THIS BENEFIT.

	NOT AWARE	AWARE	USED
JOB SERVICE VETERANS' EMPLOYMENT UNIT	(1)	2	3
VETERANS' PREFERENCE 5 & 10 POINTS	(1)	2	3
VETERANS READJUSTMENT APPOINTMENT (VRA)	(1)	2	3
TARGETED JOBS TAX CREDIT (TJTC)	(1)	2	3
VETERANS RE-EMPLOYMENT RIGHTS (VRR)	(1)	2	3
VA EDUCATIONAL BENEFITS	1	2	(3)
VA VOCATIONAL REHABILITATION	(1)	2	3
VA HOME LOAN	1	(2)	3
SMALL BUSINESS ADMINISTRATION LOAN (SBA)	(1)	2	3
DISCHARGE UPGRADE	(1)	2	3
GOVERNOR'S OFFICE OF VETERANS' AFFAIRS	(1)	2	3
VET CENTER	(1)	2	3
VA MENTAL HEALTH CARE	(1)	2	3
VA DISABILITY CLAIM	(1)	2	3
VA DENTAL CARE !!	(1)	2	3
VA SUBSTANCE ABUSE (DRUG/ALCOHOL)	(1)	2	3
VA BURIAL BENEFITS	(1)	2	3
VA NON-SERVICE CONNECTED PENSION	(1)	2	3
DEPENDENCY INDEMNITY COMPENSATION (DIC)	(1)	2	3
VA WORK STUDY PROGRAM	(1)	2	3
COUNTY VETERANS SERVICE OFFICE	(1)	2	3
VA COMPENSATION	(1)	2	3
RE-ENLISTMENT WAIVER	(1)	2	3
EMERGENCY FINANCIAL ASSISTANCE THROUGH COUNTY VETERANS SERVICE OFFICE	(1)	2	3
WOMEN'S CENTER	(1)	2	3
ORIENTATION TO NON-TRADITIONAL OCCUPATIONS FOR WOMEN (ONOW)	(1)	2	3
WOMEN'S ABUSE CENTER	(1)	2	3
CRISIS CENTERS/SHELTERS	(1)	2	3
DISLOCATED HOMEMAKERS PROGRAM	(1)	2	3
WOMEN'S BUREAU	(1)	2	3
VIETNAM ERA VETERANS' READJUSTMENT ASSISTANCE ACT (DOL)	(1)	2	3
OHIO VETERANS' HOME	(1)	2	3

EMPLOYMENT BENEFITS

45. ARE YOU CURRENTLY: (EMPLOYED) UNEMPLOYED RETIRED

IF EMPLOYED, ARE YOU WORKING: FULL TIME (PART TIME)

DO YOU CONSIDER YOURSELF UNDER-EMPLOYED: YES (NO)

46. WHEN SEEKING EMPLOYMENT, WHAT SOURCES DID OR WILL YOU USE?

OHIO JOB SERVICE TEMPORARY AGENCIES NEWSPAPERS FRIENDS

PRIVATE EMPLOYMENT AGENCY VET CENTERS WOMENS' CENTERS

JOB TRAINING PARTNERSHIP ACT (JTPA) OTHER_____

47. ARE YOU CURRENTLY USING OR HAVE YOU EVER USED THE OHIO JOB SERVICE (OBES)? YES NO

48. WAS IT A POSITIVE EXPERIENCE? YES NO

WOULD YOU USE OBES AGAIN? YES NO

49. DID YOU RECEIVE A JOB REFERRAL? YES NO

IF YES, WAS IT IN YOUR OCCUPATION? YES NO

50. WERE YOU ASKED IF YOU WERE A VETERAN? YES NO

51. DO YOU FEEL THE OHIO JOB SERVICE PROVIDED ADEQUATE AND COURTEOUS SERVICE? YES NO

EXPLAIN_____

52. ARE YOU AWARE THAT VETERANS SHOULD RECEIVE PRIORITY SERVICE AND EMPLOYMENT ASSISTANCE FROM OBES? YES NO

53. DO YOU FEEL THAT A LACK OF TRANSPORTATION PRESENTS AN OBSTACLE FOR YOU IN OBTAINING EMPLOYMENT? YES NO

54. DO YOU OWN OR HAVE ACCESS TO A CAR IN ORDER TO TRAVEL BACK AND FORTH TO WORK? YES NO

55. IS PUBLIC TRANSPORTATION ACCESSIBLE TO WORK? YES NO

56. DO YOU KNOW THE OCCUPATIONS THAT ARE BEST SUITED TO YOUR ABILITIES? YES NO

57. ARE YOU AWARE OF HOW YOUR SKILLS RELATE TO THE JOB MARKET? YES NO

58. DO YOU NEED MORE INFORMATION IN ORDER TO CHOOSE AN OCCUPATION? YES NO

59. IF AVAILABLE IN YOUR AREA, WOULD YOU BE INTERESTED IN ATTENDING A THREE DAY WORKSHOP ON HOW TO LOOK FOR WORK? YES NO

60. IF AVAILABLE IN YOUR AREA, WOULD YOU BE INTERESTED IN TALKING TO A VOCATIONAL SPECIALIST ABOUT TRAINING, EDUCATION OR EMPLOYMENT OPPORTUNITIES? YES NO

61. PLEASE CLASSIFY YOUR TYPE OF OCCUPATION.

PROFESSIONAL	(✓)	TECHNICAL	( )
MANAGERIAL	( )	CLERICAL	( )
SALES	( )	SERVICE	( )
AGRICULTURAL	( )	PROCESSING	( )
MACHINE TRADES	( )	BENCHWORK	( )
HOMEMAKER	( )	OTHER:_____	

62. WHAT CAN THE STATE OF OHIO DO TO IMPROVE UPON OR MEET YOUR EMPLOYMENT NEEDS?_____

63. PLEASE LIST WHATEVER AREAS OF CONCERN YOU HAVE THAT HAVE NOT BEEN ADDRESSED IN THIS SURVEY, AND ANY RECOMMENDATIONS YOU MAY HAVE.

I would like to know why after 2 long years the Va refuses to help with or even care about my rental problems. I served 6 months in Saude and I come home and the Army, Va and National Guard Could care less!!! Thank you Uncle Sam!!

64. WHAT RECOMMENDATIONS DO YOU HAVE OR WHAT WOULD YOU LIKE TO SEE THAT WOULD BRING A POSITIVE IMAGE TO WOMEN VETERANS?

Give ~~[illegible]~~ me deserve wether it's medical, ~~mental or whatever~~. I don't feel the Va cares about this. I have papers to prove it and 2 yrs. of fighting with nothing to show for it.

65. PLEASE LIST ANY ADDITIONAL COMMENTS, POSITIVE OR NEGATIVE EXPERIENCES, THAT YOU FEEL WOULD BE IMPORTANT FOR THIS COMMITTEE TO CONSIDER IN OUR RECOMMENDATIONS.

Take care of your veterans wether they are male or female.

Again, we would like to express our appreciation for your time, recommendations, and comments. This Committee is always available to accept any written testimonies from you. If we may be of assistance to you, please do not hesitate to contact us. Thank you.

I have no faith in the system. I have called Va for help and was told there was nothing they could do. Enclosed are photo copies of original orders upon my release from Desert Shield and comments from my guard unit. So you tell me what to do to resolve this!

NOTES/COMMENTS
PUBLIC HEARINGS OF THE GOVERNOR'S
ADVISORY COMMITTEE ON WOMEN VETERANS

VETERANS NAME: _____ PLACE: Cleveland DATE: 930708

HEALTH CARE/ VA MEDICAL FACILITIES	VA BENEFITS	EMPLOYMENT	EDUCATION	OTHER
- Works at VA Hospital - No facilities for females - Same Ward as the men - Can't lock the doors - Only in detox Center Are the doors locked - Women have been turned away from being treated there. - Attends the VA Hospital		- hard to get a government job - Used VRA - Used Veterans Counsellor	- Chpt 31 - 30% for School - Disabled Veteran - Currently going to School.	- Was in the Air Force for 9 years - Got out in December of 190

RESULTS OF SURVEY QUESTIONNAIRE FOR FEMALE VETERANS

The following information was compiled as a result of the survey mailed to all female veterans in the TOPC database. There were a total of 450 questionnaires mailed (see attached survey). 77 responses were received which represents a 17.1% response rate; 74 responses were undeliverable by the USPS which represents 16.4% of the total surveys mailed.

1. From the 77 respondents returning the questionnaire, their ages ranged from 22 to 86 years. The model age was 49 and 53.3 was the mean (average) age of all female veterans responding.

2. *Period of Service:

World War I - 0 (0%)	Vietnam - 3 (3%)
Vietnam Era - 4 (5%)	World War II - 30 (39%)
Post-Vietnam - 10 (13%)	Korea - 14 (18%)
Persian Gulf - 4 (5%)	**Other - 18 (23%)

(*) Some respondents had more than one tour of duty.
(**) Includes peace-time, Grenada, Middle East Crisis, active duty for training only, etc.

3. 54 or 70.2% of the respondents replied that they were receiving care at the Toledo Outpatient Clinic; *23 or 29.8% responded that they were not currently receiving treatment at TOPC.

*See attached narrative responses.

3a. Of the 54 respondents receiving care at TOPC, types of care provided are listed below:

General Medicine - 47 (81%)	Physical Therapy - 7 (9%)
Dental - 7 (9%)	Mental Health - 9 (12%)
Optometry/Ophthamology- 12 (16%)	Podiatry - 13 (17%)
Subspeciality Clinics - 5 (6%)	

4.& 5. The date of the last known pelvic examination and/or mammography of the female veterans responding were too varied to mention. Response rate was 50%.

6. When asked if their last gynecologic examination received at TOPC was thorough, 17 or 31.4% responded YES; *6 or 11% responded NO; **31 or 57.4% responded NOT APPLICABLE.

*See attached narrative responses.

**The not applicable response revealed that many female veterans were receiving their examinations from a private physician or not receiving gynecological care at all.

7. When asked physician preference for providing gynecologic care, out of the 77 respondents 3 or 3% preferred a male physician; 42 or 53% preferred a female physician; and, 33 or 42% had no preference.

8. When asked if they had experienced any difficulties obtaining care at TOPC only 54 respondents answered this question. *17 or 31.4% responded (YES) that they had experienced difficulties while receiving care at TOPC; 38 or 64.6% responded (NO) that they had not experienced any difficulty receiving care at TOPC.

* See attached narrative responses.

9. When asked if they would be interested in attending a health fair with other female veterans, of the 23 respondents not currently receiving care at TOPC 18 or 78.2% responded YES; 4 or 17.3% responded NO. Of the 54 respondents receiving care at TOPC, 33 or 61% responded YES; 16 or 29.6% responded NO.

10. The educational topics preferred are listed below:

VA Benefits - 45 (58.4%)	Female Cancers - 25 (32.4%)
Weight Loss - 28 (36.3%)	Menopause - 13 (16.8%)
Premenstrual Syndrome- 10 (12.9%)	PTSD - 10 (12.9%)
*Other - 13 (16.8%)	

*Includes smoking cessation; arthritis; stress; diabetes; exercise; cholesterol; counselling; career options; general gynecology; itches; Vitality-in-Motion program; physical problems of offensive work environment.

SUMMARY/RECOMMENDATIONS

The Women Veterans' Questionnaire was mailed out February 16, 1993 to approximately 450 known female veterans in the TOPC data base. The purpose of this survey was to assess the potential interest our female veterans had in participating in a Women's Health Fair as well as determine how effective our Women's Health Clinic and TOPC services are delivered to this population. As previously indicated, the response rate was 17.1% with an almost equal number of questionnaires returned as undeliverable, 16.4%. As the results indicate, 70.2% of the women responding to the survey are currently being treated at the Toledo VA Outpatient Clinic and 31.4% perceive the delivery of gynecologic services adequate. A significant number of respondents (57.4%) replied that they were receiving their gynecologic care through community resources because they either did not know that we provided limited gynecologic care at this facility, or that they were eligible to receive such care.

66.2% of the respondents expressed an interest in attending a health fair designed to provide information on a number of topics. Overwhelmingly, 58.4% of the respondents preferred to learn more about VA benefits; other preventive health issues such as weight loss, female cancers, etc. were second and third, respectively.

The narrative responses provided a mix of concerns with regard to clinic services that included quality of care, eligibility, waiting times, physician preference, access to services, and explanations of care received; these were among the most frequently cited concerns.

We recommend that our current ten-week next available appointment date for the Women's Health Clinic be adjusted to bridge the gap in appointment availability and that we provide for the presence of a Gynecologist at least once monthly to address our female veterans' health concerns. We recommend that a (mailer) or some other device be developed that can be used and sent to female veterans notifying them of the lab results from their gynecological examinations in a confidential manner. We also recommend that a pamphlet for women veterans that outlines the services offered at TOPC also be developed. We further recommend that the TOPC QA Coordinator follow-up on all QA related issues and concerns and report her findings and recommendations to the TOPC QA Committee as well as the Quality Assurance Board.

Based on the information we received, we would like to recommend that a Women's Health Fair in late September be planned and we would like to design the program to incorporate a blend of topics as indicated in the survey results. We propose to conduct a Saturday program which would facilitate providing a more relaxed atmosphere as well as the time commitment needed to address health topics for female veterans more thoroughly. Prior to implementing the program, a cost analysis of opening the clinic after hours, as well as staffing requirements needed to conduct the health fair will be provided for approval by top management.

Overall, the results of this survey are important in that they allow us to increase our awareness and sensitivity of the unique nature of women veterans health care needs and better enable us to enhance the services we can provide within existing resources.

DEBRA L. CONAN

NARRATIVE RESPONSES TO QUESTIONNAIRE

3. Are you currently receiving care at the Toledo VA Outpatient Clinic? If no, why not?

"Went to clinic - refused service after first two visits - later was billed $89.00 for services rendered.

"Because they said I earn too much money."

"Don't need care, have insurance."

"Returned to active duty in 1992."

"Because the last time I was up there, I didn't get all my medicine I needed."

"I plan to come back for care again, the last time was in '88."

"You threw me out because of budget limitations."

"I have a mental health center in Fremont that I attend."

"I didn't know that I was still able to receive care there."

"I'm not ill. I came to the VA Toledo Clinic about 3 1/2-4 years ago for backpain."

"I needed to see a gynecologist and none was available. I would have to go to Ann Arbor, MI."

"I felt I needed a specialist in neurology to help receive best treatment possible to control seizures (night time) and the only treatment I received was blood test and renewal of medications to help control seizures."

"I did not know that I could receive care at the VA clinic."

"I seek medical help elsewhere."

"I did not like waiting most of a day at the clinic. I live in Findlay so have quite a drive."

"Because it takes hours to be seen."

"VA wrote and said that I could no longer be in their care."

"Was pregnant and they didn't have the capability to serve me."

"Transportation problems."

"Didn't think I was eligible as I do not have a disability. Would go to the clinic for pelvic and mammogram if available."

6. If you receive gynecologic care at the clinic, did you feel your last examination was thorough? If no please explain.

"Will not be examined by male physicians at clinic."

"No results ever given following x-rays, tests, etc."

"Went to Ann Arbor, no GYN doctor, just a general practice doctor - could not answer various questions on women's concerns."

"In November when I asked for a pap appointment, the 1st available date was March. Since there are not that many women vets, why so long?"

"I didn't have a regular appointment. I've had a hysterectomy so it probably isn't so necessary."

"Have Medicare and State Farm. Go to a family physician of 30 years."

"Never received results."

"Was not even mentioned."

"I went to VA hospital in Ann Arbor for GYN exams and surgery."

"My hips were so bad, I could not get an exam. (They have been replaced.)"

"I was told that the clinic here in Toledo did not do this type of exam anymore."

"I think I've explained reason."

"Go to family doctor."

"No follow-up, no mammogram."

"M.D. did my examination, not gynecologist."

"I have not received this type of treatment there."

"I was told by VA driver GYN was not available through your facility."

8. Have you experienced any problems/difficulties while receiving care at this clinic? If yes, please explain.

"In 1989, poor diagnosis by a VA female doctor. Had my blocked coronary arteries. A male VA doctor at Toledo correctly read the EKG and sent me to Ann Arbor VA Hosp."

"Only from an orthopedic doctor who questioned me as to why I was wasting time; that I should come to his office where he had all the necessary equipment to help me. I reported him."

"Female veterans (service connected disability) not treated on same level as men."

"I had to wait over 2 1/2 hours to receive emergency dental work and it was woefully inadequate."

"Well because they told me I wasn't disabled when I came out of the service not entitled to some care. I am now disabled, heart, kidney, diabetic condition."

"Having to catch van real early at 8:00."

"Travel pay clinic employees are very slow or he looks at you - then goes outside to smoke. It happened once."

"You have to wait too long, alot of confusion just having the doctor prescribe me for a lab test."

"I feel certain doctors need to stop being so abrupt in certain situations. I always felt I wasn't taken seriously."

"I thought Dr. was going to fall asleep midway thru my appointment. I find the nurses care competent than the doctors."

"Too slow in doing things - make us wait too long."

"I feel as though I have been "put down" as inferior by two doctors."

"Keep changing medicine."

"Long waits, wrong diagnosis, incomplete exam."

"Went to ER clinic 12-15-92 for laryngitis a new female doctor examined me and said it would go away and did not give me any medication. I had to go to a private clinic to be treated for "strep" throat, they almost admitted me!!!"

"Came in for a pelvic exam, my doctor did not come down from Ann Arbor. The doctor that was seeing in-patients indicated to I would take to long and found another doctor to see me."

"One of the doctors (female) acted as if she didn't care. She just wanted me in and out as fast as possible. Maybe she had a bad day but, I will do my best to receive care from a different doctor next time."

"An analysis of my blood for thyroid medication is virtually never disclosed to me as such. I'm not sure I receive the proper dosage."

WOMEN VETERANS' QUESTIONNAIRE

DEPARTMENT OF VETERANS AFFAIRS
Toledo Outpatient Clinic
3333 Glendale Avenue
Toledo, OH 43614

1. Age ____

2. Period of Service: ____ Vietnam ____ Vietnam Era

____ World War I ____ World War II ____ Post Vietnam

____ Korean ____ Persian Gulf ____ Other

3. Are you currently receiving care at the VA Toledo Outpatient Clinic?
____ Yes ____ No

If yes, what type(s) of care? (check all that apply)

____ General Medicine ____ Physical Therapy ____ Dental

____ Mental Health ____ Optometry/Ophthalmology (eyes)

____ Podiatry (feet) ____ Subspecialty Medicine

If no, why not? _____

_____

4. Date of last pelvic examination: _____

5. Date of last mammogram: _____

6. If you receive gynecologic care at the clinic, did you feel your last examination was thorough?
____ Yes ____ No ____ Not applicable

If no, please explain: _____

_____

7. Which physician would you prefer to provide your gynecologic care?
____ Male ____ Female ____ No preference

8. Have you experienced any problems/difficulties while receiving care at this clinic? ____ Yes ____ No

If yes, please explain: _____

_____

9. Would you be interested in attending a health fair with other women veterans? ____ Yes ____ No

10. What educational program topics would interest you?

____ VA Benefits ____ Female Cancers ____ Weight Loss

____ Menopause ____ Premenstrual Syndrome (PMS)

____ Post Traumatic Stress Syndrome (PTSD)

____ Other Topics (specify): _____

11. Name (Optional): _____

Social Security #: _____

Address: _____

City _____ State _____ Zip Code _____

READ THE BACK OF THIS PAGE FOR RETURN INSTRUCTIONS

Women Vets Win Battle on Health-Care Front

New Clinic at S.L. VA Center Is Just What the Doctor — And Needy Patients — Ordered

By Laurie Sullivan
THE SALT LAKE TRIBUNE

For years female veterans faced indignities and inequities in the Veterans Administration medical system nationwide. Salt Lake was no exception.

It would begin at the front desk. She would be asked where her husband was, or more simply: "Where's the veteran?" Military meant male.

Next came a waiting room filled mostly with men.

For obstetrics-gynecology care, women were sent across Foothill Boulevard to University Hospital and back, carrying their charts, X-rays or Pap smear tests with them.

The VA had no women's gowns or pajamas, no sanitary napkins and no examining room with a curtain.

"The VA has never been geared to taking care of women," said Leigh Neumayer, a VA general surgeon. "There's a perception that it's mostly a facility for old men."

Men in general, maybe. But not anymore.

The VA Medical Center in Salt Lake City opened its new Women's Clinic on March 18 to serve the 4,800 to 6,500 female veterans in Utah, and more from surrounding states who come to the regional hospital for care.

Admittedly, it has been a long time coming.

Directives and authorizations have streamed from Washington for more than a decade, but funding has not kept pace, said Veda Jones, an Air Force retiree who became a voice for Utah's female veterans as an outreach and employment representative with Davis County Job Service.

Salt Lake's VA Medical Center plowed forward, naming its first women's veterans coordinator in 1983 and forming a Women Veterans Program Committee some years later.

This past year, the clinic jelled. The dozen-plus members of the committee determined the needs and went after them, led by Dr. Neumayer and Jan Schade, chief nurse for surgical intensive care and the "collateral duty" (unpaid, voluntary) women's coordinator.

"This has been a very pro-active group," said hospital spokesman Wayne Murdoch.

Staff and space always had been in place, said Dr. Neumayer. "It just needed somebody to say we can do this here."

It also needed a gynecologist, and Paul Summers of the University of Utah now is on board during the clinic's hours from noon to 4 p.m. every other Monday.

□□□

Making a Difference: Except for Dr. Summers and the male interns or residents who rotate through, the staff is all female.

Located on the third floor of the main building in the ambulatory surgery department, the clinic is not obvious. The difference to women veterans is.

Breast examinations, Pap smears and pelvic exams now are available at the VA in a private room with a curtain. A female nurse stays with the patient at all times, except when she is changing clothes. The hospital also has speculums and a colposcope machine for biopsies of abnormal Pap tests. Mammograms still must be handled by University Hospital since demand has not justified the expense of the required equipment.

But the VA has sanitary napkins and women's hospital clothing. Female inpatients are given "goody bags" with brushes and combs. And each is brought a rose.

Two other changes are credited largely to the Persian Gulf War, in which larger numbers of women had more visible roles than ever.

The VA clinic does not provide prenatal or infertility care, but it will supply birth-control services — an area of obvious import to the young gulf-vet generation.

And with awareness of sexual trauma heightened by the experiences of female gulf veterans, the hospital also is moving to provide better treatment for women suffering abuses ranging from assault to harassment.

The Utah VA is sending five staffers to a national conference on sexual trauma being conducted by the Department of Veterans Affairs in Baltimore later this month. "Some women can be so traumatized they wouldn't want to come to the VA, but even though we don't have a special program staff, we have a special interest in women's issues," said Dr. Neumayer.

□□□

Gulf Fallout: While such trauma "surfaced more recently in vets who returned from the Persian Gulf," she said, "any woman who was in the service was prone to it."

Veda Jones was. Years later, she also recalls helping a female service member in Oregon who, after being gang-raped, was sent to a military clinician whose first words were: "Now listen here, honey . . . "

"Military service is such that they say you shouldn't have put yourself in that position," Ms. Jones said.

In the Salt Lake VA's plans, counseling would occur under the auspices of the clinic and through the VA's mental-health program, which provides treatment and counseling for males and females.

"We hope to make it so it's a natural referral thing," Dr. Neumayer said.

Now, four months into the life of the clinic, it is scheduling eight patients for appointments every other week. In September, it will move with ambulatory services to a new tower on the main facility's north side.

□□□

Supply and Demand: The system was overdue for change, said the 33-year-old Dr. Neumayer, given the increasing number of women in the military. Women account for about 4% of the nation's 26 million veterans, but make up 11% of the active-duty force.

Nationwide, the VA, under Secretary Jesse Brown, is taking notice. A series of health-care initiatives for women veterans was announced in June, 11 years after the General Accounting Office warned that VA hospitals were neglecting women. Three weeks ago, the VA's inspector general concluded women's health care still was inconsistent and often poor.

(MORE)

Salt Lake's program should not be classified among them, according to Veda Jones, who knows the system as patient and adviser. She also represents the state in national women's veterans affairs.

"Our is the best in the country," she said. "They're doing their very best with the funding they get to help us out. They've extended a hand and asked what can we do to help you ladies, and the ladies are now telling them."

Testimony of Carolyn Rennert

Congressional Subcommittee Hearing on Women's Healthcare in the VA

March 9, 1994

Chairman Evans, Members of the Committee:

My name is Carolyn Rennert. I am a 100% service connected disabled veteran. I am a lifetime member of Disabled American Veterans, Chapter 84 in Vacaville, Ca., a member of The National Association for Uniformed Services, Chapter 4 in Fairfield, Ca., and 3rd Vice-president of the United Veterans Memorial Assoc. in Vacaville, CA. I am also the Vice-Chairwoman of Operation VA.

I am a chronically ill veteran who was medi-vaced home during Viet Nam and have been dealing with the VA health system ever since. Chronic illnesses limit, disable and blind. They age, robbing the ill of any resemblance of normal life. Chronic illnesses are incurable and will not go away. Healthy people do not understand what life is like for someone like myself. People look at the ill differently and do not seem to realize that we are still functioning, worthwhile human beings, even if we are no longer able to work. The VA has labled me "Disabled". I have had to adjust my life, and in the process I have learned to hold all my feelings and pains inside because most people do not know how to react to those who are ill.

In addition to dealing with my disability on a daily basis, the frustrations that I, or any other women veteran, encounter when seeking medical treatment in the VA system is appalling. Women veterans are not treated with respect. At the present time, there is a six to nine month wait for an appointment with the one part-time gynecologist who sees the more than 64,000 women veterans in Northern California. If a woman veteran cannot wait the six months, she is seen by one of the general medicine doctors, who are usually not versed in women's health care issues and appear displeased with treating a woman due to this reason.

Mr. Chairman, it saddens me deeply to report to you that women's health care has not improved or been addressed by the out-patient clinic in Sacramento, Ca., the clinic that is nearest to my home, a 50 mile trip one-way. Routinely, women veterans are not offered breast exams or mammograms or any other procedure inherent to women's health care. If I seek treatment for a condition outside general medicine, I am referred to a facility 175 miles away in Palo Alto. This referal starts a lengthy process to provide me with the care mandated by congress for my service-connected condition.

My most recent hospitalization, in November, was at the VA in San Francisco. I was the only woman veteran in the hospital, and privacy was at a premium. I had to share the same communal bathroom as the men. When it was time for me to use the facilities, there was pandemonium clearing out the bathroom and shower so that I could use it. Items available for women, and men, were almost non-existant--no toothbrush, no soap, no washbasin, no emesis basin. In fact, when I asked for a water glass I was given a sterile urine cup. As far as I could ascertain there were no gender specific items available.

In addition to the lack of facilities for women veterans, the disrespect and neglect of woman is exemplified in this story from a fellow woman veteran. At the age of 19, she was raped by a man who she tells me was her ex-commanding officer. After the attack, she made her way back to her barracks to inform the Charge of Quarters; she was met with disbelief. She went to the hospital and again was treated poorly. She was given a cursory pelvic exam without another woman present, and she was not given the opportunity to speak with a rape crisis counselor. But! She was given an Article 15 and discharged with a general discharge from the service. Needless to say, the man was not reprimanded, discharged, or demoted. This woman veteran now describes the last 25 years of her life as a "loss" because she has lost every emotion. In the last year she has applied for a srevice-connected disability for Post Traumatic Stress disorder.

She has been denied. How many other women have had to suffer such an injustice? When is the government and the VA going to take their heads out of the sand, look at the needs of the woman veteran, and stop treating us as nonpersons which the dictionary defines as, "a person regarded by the government as not existing."

The most pressing need, for woman veterans, is a coordinated and professional program that would identify women veterans in every state and determine their needs and advise them of the veterans benefits to which they are entitled. However, it is surely apparent, that despite the VA's somewhat aggressive actions to ensure equal access for women for all treatment and medical programs and address their unique needs, the problem of informing women veterans of their benefits still seems to resist the VA's best outreach efforts. A survey of 1545 women veterans in California revealed that only 14% of them ever contacted a women's coordinator now stationed in all California VA hospitals. The survey confirms that outreach and education should be the VA's highest priority. Women veterans have historically made a significant contribution to the United States and the state of California. It is incumbent upon our nation to ensure that these woman are located and advised of their entitlements and that they recieve equal access to veteran's benefits.

The issues that affect women veterans not only affect them, but all other veterans. The outpatient clinics in Northern California are so overburdened and backlogged that there is usually a four to six hour wait even if there is a scheduled appointment. We veterans wait in long lines for the simplest procedures, if we can get them at all. Is it any wonder that only 8% of the veteran population in the United States even attempts to use the VA medical system?

Every chronically ill veteran realistically knows that further hospitalizations will be necessary. In such a person's life there is always turmoil and frustration when one knows that

once again medical help must be sought. Now in Northern California, with the added burden of not knowing where we will go for that medical care, the anger and frustration already felt is heightened.

The hospital in San Francisco is old and sorely in need of renovation. The 200 bed facility serves over 500,000 veterans. In 1991, within 120 days, the VA closed down the Medical Center in Martinez, California. At the time of closure, there were 250 patients that had to be either discharged or transferred to the already critically overcrowded VA in San Francisco.

As I previously stated, I am Vice-Chairwoman of Operation VA, a group which was formed in the spring of 1993 to help insure that the funding for the replacement hospital at Travis Air Force Base is appropriated. The ensuing battle for the appropriation of funds has been a long hard fight. We veterans have waited three years for a replacement facility. The completion date for the hospital is scheduled for December 1998.

This time line is unacceptable to every veteran living in Northern California. The California State Legislature, Senators Feinstein and Thompson, Congressmen Hamburg and Fazio, veteran's organization around the country, to name a few, endorse Operation VA. We intend to keep pushing for the funds to build this hospital. There are some of us who might not see this hospital become a reality, but the veterans of Northern California will continue to rally and fight for this critically needed hospital. I feel it is my duty to report that there have been documented cases of veterans dying in Northern California because they had no VA facility to get comprehensive medical care.

Mr. Chairman, thank you for giving me the opportunity to come to Washington and report to you the unsatisfactory condition of women's health care in the VA system. All around this room today you are seeing the many women veterans who were willing to give their all in their service to our great country.

We implore you to take our stories to other members of our government and to make them aware of the atrocities that we have incurred and still continue to live with on a day to day basis.

Testimony before the House Veterans' Affair Subcommittee on Oversight and Investigation.
Submitted by:

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March 9, 1994

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VA provision of gender specific health care to women veterans and problems encountered by women veterans in obtaining VA provided health care.

Health care for women is undergoing change. An integration rather than a fragmentation of services like cardiology, dermatology, rehabilitation medicine, gynecology, etc is advocated. The VA is providing the leadership for a primary care approach to health care for women. This year a fellowship program on womens health will be offered at 5 VA Medical Centers. The Buffalo VA hopes to be selected as one of the centers.

Patient education services are limited for women veterans. Nurse educators, equipment, facilities and staff are needed to provide this resource. Through a women veterans advisory committee at each VA facility such needs can be identified.

Access to health care should be streamlined. No one should have to wait several hours in the emergency room to register and undergo a triage evaluation to be scheduled for the gynecology clinic some weeks later for the mammogram, originally requested by the patient, to be scheduled. Similarly, health care for women veterans who are VA employees should be streamlined and confidential; although, confidentiality is always difficult in any institution. Some women veterans who are employees feel tossed between employee health and VA clinics. The women veterans coordinator and the women veterans health care provider facilitate health care delivery at our VA.

Services for rape survivors have improved at the Buffalo VA. Women patients are examined by a physician in the emergency room and accompanied by an advocate in an unmarked vehicle to the county hospital for specialized care with follow-up care provided by counselors at the VA.

Mammogram results could be available the day of the examination and shared with the patient. Private facilities provide results to women the day of the examination. We are trying to provide similar services for our women veterans. We are exploring developing a shuttle service that provides round trip transportation to nearby VA facilities in order to facilitate services to women veterans in Western New York.

Availability in VA facilities of personal hygiene products: toiletries, cosmetics, clothing and other gender specific items used by women veterans.

Inpatient pajamas, gowns and bathrobes have been improved for women patients at the VA. These are color coordinated in pink, peach, teal, blue or yellow and are of high quality texture.

Patient gowns in the ambulatory care area are small or medium in size. The larger patient often is exposed because larger sized gowns are not available. This need has been identified at the Buffalo VA and will be corrected.

Large bulky diapers rather than thin, highly absorbent liners are provided to women who require protection from incomplete bladder control. We are ordering the appropriate protective items.

To secure a personal hygiene item, a woman must ask the nurse in the unit or purchase the items herself in the canteen during business hours, unless a supply area for such items can be made accessible to the women. The bathrooms for women lack dispensers for personal hygiene items of women. We are aware of these concerns and are trying to adjust to meet these needs.

Canteen goods, toiletries, clothing and cosmetics are costly and seem geared toward employees rather than patients. The items often are imported.

VA provided counseling for women veterans who are victims of sexual trauma.

There is some difficulty in ascertaining survivors of sexual trauma. Health care providers have not been trained to elicit this information. The VA has taken a leadership role to provide such training.

Once identified, any time limitation on counseling services subjects the women patient to inadequate treatment. Survivors on an average take 7 years to report sexual trauma. They often suffer from physical and emotional difficulties until later in life.

Counselors, physicians and other health care providers need more training and education on sexual trauma in order to provide appropriate therapy for women patients. More trained health care providers are needed for treating the increasing numbers of identified survivors.

The effectiveness of VA's Women Veterans Coordinator Program.

The program started through an Act of Congress in 1983. Coordinators were appointed at most facilities and were expected to and did assume the additional duties. Primarily they were administrators, secretaries, nurses, technicians, physicians, etc. This past year the preference has been to assign social workers or nurse practitioners as women veterans coordinators.

In the 6 years in which I have participated in women's health care at the VA the women veteran coordinators program has significantly advanced the delivery of health care to women veterans. National conferences are held biannually. Conferences for the region have been held in Buffalo in alternate years when national conferences were not held. More educational programs and conferences are needed to update and train women veteran coordinators.

A regional Women Veterans Coordinator has been appointed to Region I this past year.

Newly hired women veteran coordinators at VA facilities need special training aside from national and regional conferences. The Buffalo VA is in the process of developing small-group training sessions.

Special conferences (eg. Sexual Trauma held in 1993) train health care providers to benefit women veterans. Yet all women veterans coordinators did not have access to the conference. Women veteran coordinators should be invited to all national conferences pertaining to womens health care.

Women veteran coordinators to be effective should have access to the VA Medical Center Director. This has been particularly helpful at the Buffalo VA in promoting womens health care. Mr. Richard Droske, Medical Center Director, Buffalo, NY, has been exceptionally supportive and creative in promoting womens health care for veterans.

Women Veteran Coordinators need training, authority, and priority given for women veteran's health care issues. They need to be able to cut red tape. They need to know women veterans issues, womens concerns and preferably have some medical training skills. They are a valuable asset to the VA's womens health care program.

When a women's health care program is developed in a VA facility, there are few ways to promote the program within the community. Except for recruiting nurses, there is no advertising budget for promoting the health care benefits and programs to which women veterans are entitled. Our primary access to women veterans has been through the Erieco Womens Post #1586, American Legion. Mrs. Helen Jacob, who founded the Post, has been an invaluable asset to the VA, women veterans, and to me personally in developing a womens health care program.

<u>VA medical facility accommodation of women veteran patients.</u>

Our facility is approximately 50 years old. More than 2 private rooms with showers are needed among 34 beds in a wing.

Women veteran patients are given priority for private rooms with showers. If one of the private rooms is used for medical isolation or special medical treatment then there is only one room on the wing for a women patient. Wings are oriented according to services like surgery or medicine in order to provide the highest skilled personnel and to centralize specialized equipment.

When a women veteran enters the hospital for surgery, she may spend her pre-operative time on another floor while arrangements on the surgical floor are made to accommodate her. More private rooms with bathroom facilities are need for the VA to be competitive with non VA facilities.

One telephone on each wing is wheeled by nurses to patients' bedsides. This is an inexcusable use of nurses' time and illustrates the spartan accommodations provided veterans. With the assistance of Congressman Jack Quinn, the problem has been solved for the Buffalo VA. Bedside phones are in the process of being installed through a cooperative effort, which he arranged, between unions and the VA.

<u>The incidence of cancer among women veterans and their non veteran peers</u>.

The Harris Study, a telephone survey, of nearly a decade ago, found the incidence of cancer among women veterans to be almost twofold that of non veteran peers. Cancer of the reproductive organs occurred more frequently than cancer of the breast, opposite the occurrence among non veteran peers. The incidence of skin cancer was greater among women veterans than non veteran peers.

The Harris study was retrospective. Neither a prospective study nor any other study has been done to verify or update the findings since the Harris Study.

The VA lacks a central tumor registry. The majority of comprehensive VA Medical Centers have a registry but the reports are not made to a central tumor registry. This can be corrected through the Decentralized Hospital Computer Program. One or two individuals are needed at Central Office to operate the computerized tumor registry. The program to collect data is available and is used at the Buffalo VA.

If there were a central tumor registry, more information could be ascertained on the incidence, types, and stages of cancer among women veterans. If cancers detected were more in the later stages, improved patient education and tumor screening would be needed. If the number of women veterans with breast or pelvic organ cancers were known it would help determine how many oncology trained specialists in surgery, gynecology or radiology were needed. Multiple other parameters similarity can be evaluated with a central tumor registry.

A VA Medical Center, like Buffalo, barely meets the basic number of mammograms required to provide proficiency in interpretation among the radiologists. There is little incentive for radiologists or other physicians to improve their skills, in interpreting mammograms, performing needle localization of tumors or needle core biopsies, etc, unless they are supported by the VA to update their professional skills.

SUB-COMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE VETERANS AFFAIRS COMMITTEE

March 9, 1994

CHAIRMAN: THE HONORABLE LANE EVANS

Testimony of Val Ulstad, MD
Women Veterans Comprehensive Health Care Center
Minneapolis Veterans Affairs Medical Center
Minneapolis, Minnesota

WOMEN'S HEALTH CARE IN THE DEPARTMENT OFVETERANS AFFAIRS

Good morning and thank you. Mr. Chairman and Members of the Committee I would like to discuss my experience with women's health care, specifically at the Minneapolis VAMC. I am a physician who trained at the University of Minnesota system receiving part of my residency and fellowship training at the Minneapolis VAMC. I am a board certified specialist in internal medicine and sub specialist in cardiology. My interest in cardiovascular disease in women brought me to greater involvement in women's health care in general. My perspective on women's health care in VA comes from my experience in the Minneapolis VAMC's, Women Veterans Comprehensive Health Center (WVCHC).

I was privileged to join the WVCHC staff in August, 1993 when the clinic was initially developing. The WVCHC at the Minneapolis VAMC grew out of a history of serving women veterans beginning with the delivery of gynecologic services in 1974 through a contractual arrangement with the University of Minnesota. This clinic offered regular pap/pelvic examinations and gynecologic consultations. The Minneapolis VAMC then became the first VA facility to offer on-site mammography to women veterans in 1985, when under the leadership of Dr. Neil Wasserman (Radiologist), the Breast Cancer Detection Clinic was started. In this clinic, regular screening of women veterans by clinical breast examination and mammography was done annually. In 1988, Dr. Kristin Nichol (Chief, Section of General Internal Medicine) and Linda Daninger R.N., developed the Women's Preventive Medicine Clinic (WPMC) which offered cancer screening, cardiovascular risk factor screening, counselling on smoking cessation and immunizations. The WPMC worked with the Breast Cancer detection clinic and the gynecologic clinic to begin to coordinate preventive care for women veterans. These clinics were made part of the new WHCHC which opened on August 31, 1993. Dr. Kristine Ensrud, a leading investigator in the

field of osteoporosis and the most recent Director of the WPMC, provided the leadership for the center's formation and is now serving as the medical director of the Minneapolis WVCHC. We have seen patients for six months, and currently have an enrollment of 1,086 women veterans.

Whom do we serve? Our patients range in age from 20 to 90 years of age. Of the women veterans over 40 years of age, we see the following distribution of the major killers and disablers of women - 28% have known heart disease, 26% carry a current or past diagnosis of cancer and 20% have osteoporosis. Cardiovascular disease is the number one killer of women. This subset of the women veterans population (> 40 years of age) has a high prevalence of risk factors for cardiovascular disease - 61% are overweight, 42% have high blood pressure, 36% have a high cholesterol, 14% have diabetes and 28% are still smoking.

The most important part of the mission of WVCHC is to provide comprehensive primary and preventive health care services to women veterans in order to enable them to attain or maintain their optimum state of health. Two internists, (myself and Dr. Ensrud), and a Physician Assistant, Patricia Olson, are the health care providers. While all three providers participate in the delivery of primary health care to women veterans, our P.A. is the backbone of the preventive health portion of our clinic. In her preventive clinic, she sees each woman veteran on a yearly basis. The annual visit consists of assessment of individual health issues, cancer and cardiovascular risk factors and mental health needs; physical examination, clinical breast examination and instruction in breast self-examination, and pap and pelvic examination. When indicated, according to established guidelines, mammography is performed immediately after the preventive clinic visit.

The two internists provide care for women with active medical problems and consultative care. Gynecologic consultation services continue to be provided through a contractual arrangement with the University of Minnesota, however, we hope to hire a gynecologist in July 1994. The gynecologist will provide gynecologic consultation and perform necessary gynecological surgery at the medical center.

Support from our dietitian, social worker, medical administration clerk, administrative secretary, clinical psychologist, Women Veterans Coordinator, research assistant and nurses are critical to delivering comprehensive care to our women veteran clients.

The WVCHC is dedicated to fostering improvement in women's health care through efforts in research, education and quality assurance. Currently our research efforts are directed primarily at describing our population. The eight comprehensive centers are cooperating to develop uniform research methodology to allow for studies generalizable to the women veteran population at large. In our center, both internists are involved in national clinical trials on important areas of womens health care including the Study of Osteoporotic Fractures, the Fracture Intervention Trial and the Womens Health Initiative. In our institution, other investigators are encouraged to cooperate with us. Dr. Maureen Murdoch in our General Medicine section for example, is studying domestic violence in the women veteran population. Educational efforts are ongoing at many levels. We hope to have medical students and medical residents regularly participating in the center. Each staff member serves to educate her peers in womens health. This includes active education in the medical, nursing, social work and mental health areas. Quality indicators are in place for pap smear, pelvic exams, and mammography. Monitoring results are routinely evaluated and the quality assurance program will be expanded. Recently we studied an aspect of our breast cancer detection program by comparing historical data on breast cancer risk factors obtained by our P.A. with those obtained by the mammography technicians.

The Minneapolis WVCHC is committed to notifying all eligible women veterans in the Minneapolis VAMC service area through outreach efforts. This has proven to be challenging because there is no one master list of women veterans. Our Women Veterans Coordinator, Nancy O'Brien, has been creative in finding potential patients. She has coordindated multiple meetings at local conferences to get the word out. We have relied on the county veterans service officers to help spread the word in the areas outside the Twin Cities metro area. We regularly see women veterans who

have not been getting health care because they had no where to go. The burden of untreated medical and emotional problems has been alarming. For example, 32 women received counseling for sexual trauma in FY 93.

We believe in serving the physical and emotional needs of women veterans in a gender sensitive setting. In our center, the women have a place to come for any physical or mental health concern. They embrace this concept and enjoy the opportunity to interact with known and trusted providers and staff. I often hear "finally a place for us!" We are currently surveying patient satisfaction among our patients to help us identify what our clients feel we are doing well and what areas of services might be improved.

Specific benefits of multidisciplinary comprehensive care include; the ability to coordinate patient appointments to avoid multiple visits; the ability to discharge patients from busy subspecialty clinics and the ability to streamline medication prescriptions due to enhanced understanding and communication amoung clinical disciplines. More centralized care for women veterans allows us to decrease the fragmentation of care, and provides an excellent way to coordinate our services with the mental health service. It has been very rewarding to have patients report feeling safe enough to allow the complete disclosure of their health needs. As health care providers, we continue to be impressed by the prevalence of serious mental health concerns in this population. We are currently gathering data to better understand the magnitude of this problem in order to enhance our services to meet the needs identified.

Finally the Minneapolis WVCHC acknowledges our role as a vanguard program and realizes that we must serve as a model for other VAMCs in their efforts to establish women's health care programs. A variety of individuals from other VA facilitiies have done mini-residencies with us. Dr. Ensrud and I have participated on a variety of satellite teleconferences to offer our experiences. We also serve as a model of comprehensive health care delivery in our own VAMC. I believe that the multidisciplinary WVCHC offers an opportunity to demonstrate that the comprehensive preventive and

primary care model of health care delivery may be a better way to serve all veterans.

Thank you

STATEMENT OF
BARBARA SICAFOOSE, MSN RNCS ANP
ADULT NURSE PRACTITIONER/FEMALE VETERAN CO-COORDINATOR
& WOMEN'S HEALTH CLINIC COORDINATOR
VAMC, SALEM, Virginia
BEFORE THE
HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
March 9, 1994

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to present information on the female veterans health care programs available at the Salem VA Medical Center. I am an Adult Nurse Practitioner assigned to the Day Unit as well as the Female Veteran Co-Coordinator and Women's Health Clinic Coordinator for the Medical Center.

Gender Specific Health Care to Women Veterans

Since the first VA publication devoted to female veterans health care was published in 1986 (M-2,Part 1, Chapter 29), the role, visibility, and number of women serving in the military have increased significantly. Since that time, more women than ever before are seeking care in VA facilities. The staff at the Salem VAMC, in 1991, recognized the potential need for a Women's Health Clinic (WHC) based upon the following: increase in the number of women seeking care at our facility; the Medical Center emphasis on providing care to all veterans; and the Veterans Health Administration (VHA) focus on equity of access, service and benefits to the growing number of women veterans. The feasibility of developing a WHC which would heighten care already provided at our Medical Center was discussed with all levels of administration and an interdisciplinary task force was created to develop a proposal for such a clinic. In order to determine the need for WHC services, an analysis of our catchment area was conducted. A letter with survey was mailed to all female veterans, notifying them of the potential availability of health services. Respondents were requested to return the survey if interested in clinic enrollment. The task force first met in November 1991. A program proposal was developed and approved. The clinic was established and appointments were scheduled, initially giving priority to women determined at high risk based upon clinical criteria. The clinic was opened on June 28, 1992, and is currently in operation 2 days per week.

Resource Allocations

One unique aspect of Salem's Women's Health Clinic is that it was established predominantly within existing resources. Physical space, equipment, and consumer focused needs were major resource issues. The decision was made to use one private patient room in

the newly established Same Day Surgery/Procedure Clinic as the "Women's Health Clinic." Decorations for the area were donated by private individuals and service organizations. The room is now assigned to the WHC twice a week and the remainder of the time it supports other out-patient services. Gender specific equipment for use in the WHC was collected from throughout the Medical Center and centralized within the Women's Health Clinic. The clinic has an adjoining bath, thus meeting VHA criteria for privacy during female examinations. A pleasantly appointed, comfortable, and quiet waiting area is provided.

Currently, Salem's Women's Health Clinic is operational two (2) days per week. Staffing requirements to support this are:

1.0 Nurse Practitioner
1.0 Registered Nurse
1.0 MAS
0.1 MD

For the remaining three (3) days per week, the above resources are shared with Primary Care and Same Day Surgery/Procedure Clinics. Total staffing required for a five (5) day per week clinic would be 3.1 FTEE.

Consultative services to interdisciplinary support are initiated on an as needed basis.

Services Provided

The WHC was designed to provide a specialized and comprehensive interdisciplinary program to assess, treat, and/or refer female veterans for such illnesses as oral, breast, cervical, and colorectal cancer; hypertension; diabetes mellitus; osteoporosis; and identification of risk factors such as hypercholesterolemia. Education regarding lifestyle changes is one component of the program.

In addition to routine screenings provided, services available include hormone replacement therapy (HRT), information on and treatment of sexually transmitted diseases (STDs), and education and counseling for sexual and physical abuse, menopause, breast self-exam (BSE), aging, sexuality, nutrition, smoking cessation, diet counseling, exercise, etc.

Process and Outcomes

Upon admission to the clinic, a history/data base, initial assessment, and laboratory tests (ordered by the Nurse Practitioner) are obtained by the RN. Further assessment and physical examination are performed by the Nurse Practitioner (NP), who provides appropriate consultations with other disciplines as indicated. Gynecological services needed and not available at our

facility are contracted out to a local health care facility. Reports of diagnostic studies are reviewed by the Nurse Practitioner in consultation with the Physician-Liaison when indicated.

Specific forms, such as History & Physical Exam forms, Log Sheets, Statistics Sheets, overprinted Follow-up letters, Satisfaction surveys, and QI monitors were developed and are used to assure adequate, concise documentation and appropriate case management for all patients. The patient is notified in writing of all results by the NP, and consultation and/or referrals for treatment of abnormal findings are initiated as indicated. Patient satisfaction surveys and quality improvement monitors are ongoing and are used to modify services in order to enhance care provided in the clinic. Women attending the clinic have repeatedly commented on how pleasurable it is to attend a clinic which recognises their gender specific needs and concerns.

Health Care Education in Primary Care Delivery Models

The WHC is utilized for training and education of medical residents, staff, and students. The residents rotate through the WHC as part of their Primary Care assignment. Post-Graduate Nurse Practitioner students preparing for advanced practice roles also rotate through the WHC, gaining experience in providing gender specific care within the Primary Care Delivery Model. The WHC has great potential for research projects. This is recognized and being actively pursued.

Communication Strategies

In keeping with the "Clinical Affairs Women Veterans Coordinators Program Guide--October 7, 1991," an interdisciplinary Women Veterans Advisory Committee was established in September 1993. The committee meets monthly and consists of the Female Veteran Co-Coordinators, two Nurse Practitioners, two MD's, two RN's, one PhD, an Occupational Therapist, and a Service Officer (who is a female veteran) from a local veterans service organization. One major focus of the committee has been more comprehensive communication strategies focused on increasing knowledge of available services to all female veterans in our area. We have sponsored two annual open house programs which focused on services available, how to access the system, expectations from care provided, individuals to contact for answers to questions, tours of the WHC, etc.

Through collaboration with local Veterans Service Organizations (VSO), concerns over formal participation and low or non-attendance of women in post meetings have been identified. This presents a significant communication deficit for enhanced sharing of

information regarding available female veteran care services at this facility. Several communication strategies have been initiated, including: development of a promotional Women's Health Clinic brochure; VSO involvement in Medical Center programs for women veterans (including Open House Programs; dinner for participants of the "March to Washington" in support of the Women's Vietnam War Memorial Dedication; and recognition reception for Female Veteran employees at our Medical Center). In March 1994 State Officers of the DAV will tour our Women's Health Clinic. They will evaluate our program and share their findings with respective posts.

Not only have we communicated our services at the local and State level, we have also shared our program with other VAMC's across the nation. In September 1992, I participated in a panel on "How to Establish A Women's Health Clinic" at the National Female Veterans Coordinators Conference. In preparation for the presentation, a handout was developed on the specifics of how our clinic was established, including the original proposal, all forms used in the clinic, invitations used for the open house, the initial survey, etc. Eighty handouts were distributed during the conference with the request for fifty more when they could be mailed. A minimum of one-hundred and fifty (150) copies of this handout have been mailed to VAMC's across the United States. To date, in excess of forty facilities have, through written or verbal confirmation, acknowledged use of Salem's Program Model for development, implementation, and/or modification of their WHC programs.

Effectiveness of VA's Women Veterans Coordinator Program

Our Medical Center has two Female Veteran Coordinators. There are shared responsibilities of the position, including: visitation to all new female veterans admitted to the Medical Center; participation in the Eastern Region Women Veteran Coordinators conference calls; completing surveys on women's health care issues; Chairing the Female Advisory Committee; follow-up on female issues and concerns; collaborative communication of services to female veterans; etc.

Other Specific Services Provided

Gender Specific Items for Women Veterans

The Salem VAMC carries a complete line of products used by female veterans, including personal hygiene products, toiletries, cosmetics, and clothing. The Medical Center recognized the need for hair care for our women and contracts to have a beautician see our inpatients on a weekly basis. The VAMC provides a station car and an employee to accompany our women patients to the beauty shop

to have their hair care needs met weekly.

Counseling for Women Veterans Who are Victims of Sexual Trauma

The Salem VAMC has a forensic psychologist who specializes in sexual and/or physical abuse. She is available to the WHC by consultation and on an emergency basis. We recently revised our history and physical exam form to include the following questions: 1. When you were a child or an adolescent, did an older person or an adult ever touch you in a way that felt sexual or was unwanted or made you feel uncomfortable?; and, 2. As an adult, including the time you served in the military, did anyone ever attempt to make unwanted sexual contact with you? If we receive a positive response from either question, we inform the veteran of the services available and offer to refer her to our psychologist if she desires. We had five women undergoing individual counseling luring FY 1993 for sexual abuse. There is also a support group lirected by a Psychiatrist and a Clinical Nurse Specialist. The roup meets weekly to help women deal with physical and mental buse issues. Enrollment in this clinic varies and averages five omen per week.

Facility Accommodation of Women Veteran Patients

cause our facility is a tertiary referral center for psychiatry, receive a significant number of female psychiatric patients. propriate placement of female psychiatric patients, including fety and self-dignity issues, has been of primary concern for our dical Center. After much planning, a proposal was submitted and nding appropriated to develop an eight bed unit for female terans in psychiatry. Renovation for the unit is to begin in 94. The unit will be managed by a female psychiatrist who has a ng standing involvement and interest in women's health care.

Primary Care Team for Women Veterans

outgrowth of the WHC has been the development of a Primary Care am for Women. This clinic opened in January 1994, is managed by Nurse Practitioner, and provides comprehensive managed care of ite and chronic medical problems. Like the WHC, the Primary Care am for Women Veterans was initiated using existing resources, and currently in operation one day per week.

Summary

The Women's Health Care Clinics in Salem, using an interdisciplinary approach, is an attempt by the staff to provide comprehensive managed care while conceivably reducing health care costs and decreasing unnecessary suffering, illness, disability, and premature death from potentially preventable diseases. Ongoing screening, counseling, and education are provided for a large number of individuals in an accessible, coordinated, and sensitive manner. With members of the interdisciplinary team working together as partners in prevention and health maintenance, we can provide our female veterans with a potentially healthier future.

Womens Health Care Clinic

" A Center of Excellence for Women's Health"

Advancing Women's Health through Women's Health Care Clinics

Veterans Affairs Medical Center
Salem, Virginia

Knowing the Facts

Services We Provide

Comprehensive Health Care and Screening

Pap Smears
Pelvic Exams
Breast Exams
Mammography
Colorectal Cancer
Hypertension
Cholesterol
Oral Screening
Diabetes
Osteoporosis
Coronary Artery Disease
Acute/Chronic Medical Problems
Hormone Replacement Therapy
Contraception
PMS
Sexually Transmitted Disease

Education, Counseling and Support Groups

Sexual and Physical Abuse
Menopause
Breast Self - Exam
Aging
Sexuality
Nutrition
Smoking Cessation
Diet Counseling
Exercise

Clinic Location

Women's Health Care Clinics

Building 143
Second Floor

For appointments and additional information contact:

Women's Clinic
Monday - Friday
6 A.M. - 6 P.M.

Please call 982-2463 Ext. 2152/2153

Female Veterans Co-Coordinators

Margaret Shelly, MSW
982-2463 Ext. 2526

Barbara Zicafoose, RNCS, MSN, ANP
982-2463 Ext. 2030

Eligibility

You are eligible for services if you...

* Are a veteran of the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard.

* Served in the Women's Army Auxiliary Corps (WAAC) in 1942-43.

* Flew as a Woman's Airforce Service Pilot (WASP) in 1942-43.

* Were a telephone operator, clerk, dietitian or reconstruction aide with the Army in Europe during World War I .

Your Clinic Staff

Barbara Zicafoose, RNCS, MSN, ANP
Christina Stephenson, RNCS, MSN, FNP
Patricia Mekus, RNCS, MS, ANP
Ruby Thompson, RN
Jean Hardy, RN
Doug Linnerch, M.D

We are the Nurses in Advanced Practice and staff providing specialized care. We offer health screening, education , treatment and or prevention of disease for all women veterans. Our emphasis is health promotion and Comprehensive Care for Women!

" Your Comprehensive Health Care is Why We Are Here"

Did You Know?

* 1 in 9 Women will get Breast Cancer
  The Good News: Nearly 9 out of 10 women could survive
* Lung Cancer is the 1 ending Killer of Women
  The Good News: 40,000 Women can be saved each year
* 77,000 new cases of Colon and Rectal Cancer each year
  The Good News: Finding out early can save 3 out of 4 individuals
* Osteoporosis usually goes unnoticed until a bone is broken
  The Good News: Treatment with hormone replacement therapy can delay bone loss and prevent fractures
* Nearly 2,600 women die each year from Melanoma, a serious skin cancer
  The Good News: Most Skin Cancers can be cured

Veterans Affairs Medical Center
Salem, Virginia

WOMEN'S HEALTH CLINIC STATISTICS

(6/92 - 12/92)		(1/93 - 12/93)	
Total Number of Visits	53	Total # of Visits	489
Unique Visits	(?)	Unique Visits	437
Total # of Pap Smears	46	Total # of PAP Smears	348
Total # of Mammograms	29	Total # of Mammograms	179
Number of Women on HRT	3	Number of Women on HRT	27
Referrals to Local Health Care Facility	7	Referrals to Local Health Care Facility	25
Other Referrals	8	Other Referrals	46

In the Women's Health Clinic, we use the American Cancer Society recommendations for mammography screening, which are: all women age 40-49, mammography every 1-2 years and women age 50 and older, mammography yearly.

During 1993, of the 437 unique visits seen, 179 mammograms were done. This is 40 % of the total unique visits to the WHC. That percentage reflects 100% of all women age 50 and older, in addition to 10% deemed at high risk.

United States General Accounting Office

GAO

Testimony

Before the Committee on Veterans' Affairs,
United States House of Representatives

For Release
on Delivery
Expected at
8:30 a.m. EDT,
Wednesday,
March 9, 1994

VA HEALTH CARE FOR WOMEN

In Need of Continued VA Attention

Statement of David P. Baine, Director of Federal Health
Care Delivery Issues, Health, Education,
and Human Services Division

GAO/T-HEHS-94-114

SUMMARY

In a limited follow-up to its January 1992 report on improvements needed in the Department of Veterans Affairs' (VA) provision of health care services to women veterans, GAO found that

-- VA's central office has repeatedly stressed the need for its facilities to improve services for women veterans and has issued guidance to its medical centers intended to address the problems identified in the January 1992 report.

-- VA's greatest success has come in improving privacy for women veterans. It has completed or funded 131 projects in this area at a cost of more than $672 million during the last three fiscal years. Another 205 projects, estimated to cost about $800 million, are planned; most of which will be funded before the turn of the century.

-- VA's central office has not effectively monitored field facilities to ensure that facilities improved services for women veterans. For example, even when medical centers submitted inadequate plans for improving women veterans' cancer screening examinations in response to one central office directive, the central office did not notify the medical centers of its findings. In addition, it has not followed through on plans to disseminate best practices for improving the thoroughness of examinations and monitor the provision of mammography services.

Under VA's health reform proposal, each veteran would be assigned a primary care physician. This step, which is not dependent on implementation of health reform, should improve the thoroughness of women veterans' cancer screening examinations. But, real progress in improving services for women veterans depends on the leadership provided by individual VA medical center directors.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) long-standing problems in meeting the health care needs of women veterans and the implications the problems have for VA's role in a reformed national health care system. As you know, we first identified problems in VA's provision of health care services to women veterans in 1982 and identified continued problems in a 1992 follow-up report.[1]

Our January 1992 report focused on four problem areas: (1) patient privacy, (2) cancer screening examinations for women veterans, (3) dissemination of information on successful approaches for improving the thoroughness of the cancer screening examinations, and (4) quality assurance for mammography services. Our comments this morning will be based on limited follow-up at VA's central office to determine the extent to which VA followed through on the promises it made to improve health care services for women veterans. While our work focuses on central office actions, you will also be hearing this morning from VA's Inspector General on what progress is being made at the facility level.

Since issuance of our 1992 report and enactment of the Veterans Health Care Act of 1992 (P. L. 102-585), VA's central

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[1]Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits (GAO/HRD/82-98, Sept. 1982); VA Health Care for Women: Despite Progress, Improvements Needed (GAO/HRD-92-23, Jan. 23, 1992).

office has repeatedly stressed the need for its facilities to improve services for women veterans. In fact, it issued guidance to its medical centers intended to address the problems identified in our report.

VA's greatest success has come in improving privacy for women veterans. It has completed or funded 131 projects in this area at a cost of more than $672 million during the last three fiscal years. Another 205 projects, estimated to cost about $800 million, are planned; most of which will be funded before the turn of the century.

But, the VA central office has not effectively monitored field facilities to ensure that facilities improved services for women veterans. For example, even when medical centers submitted inadequate plans for improving women veterans' cancer screening examinations in response to one central office directive, the central office did not notify the medical centers of its findings. In addition, it has not followed through on plans to disseminate best practices for improving the thoroughness of examinations and monitor the provision of mammography services.

Under VA's health reform proposal, each veteran would be assigned a primary care physician. This step, which is not dependent on implementation of health reform, should improve the thoroughness of women veterans' cancer screening examinations.

But, real progress in improving services for women veterans depends on the leadership provided by individual VA medical center directors.

VA CENTRAL OFFICE ACTS TO IMPROVE SERVICES FOR WOMEN

Since issuance of our follow-up report, VA's central office has

-- issued directives to medical centers to develop action plans for improving services and privacy for women veterans;

-- established a newsletter on women veterans' health programs;

-- established a full-time women veterans coordinator in each of its four regional offices;

-- funded 15 full-time women veterans coordinator positions at medical centers, all but three of which are in place;

-- established a task force on sexual trauma;

-- established a Women Veterans Health National Training Program;

-- created a Women's Health Science Division in the National Center for Post Traumatic Stress Disorder (PTSD);

-- funded eight Women Veterans Comprehensive Centers; and

-- issued, in September 1993, Women Veterans Health Care Guidelines.

Clearly, these actions should result in improvements in services provided to women veterans. But a continuing problem limits the effectiveness of efforts to improve the quality of VA services: failure to monitor medical centers to ensure that corrective actions are taken. It is this problem--which we highlighted in our transition series report on VA--more than any other that threatens the success of VA's health reform plans and the quality of care likely to be provided under those plans.[2]

CORRECTION OF PRIVACY LIMITATIONS

One area in which VA appears to have made significant progress is correcting privacy limitations. When we first reported, in 1982, on VA's efforts to meet the health care needs of women veterans, many VA programs could not accommodate women because of the lack of private or semiprivate rooms with separate bathrooms. Problems were most evident in domiciliaries and psychiatric wards.

[2]Veterans Affairs Issues, GAO/OCG-93-21TR, Dec. 1992.

Ten years later, we reported that women could be accommodated under all domiciliary programs, but were surprised to find that even a recently renovated facility paid little attention to the privacy of women patients.

Renovation of one of the medical/surgical wards at the Tampa medical center had been completed shortly before our visit in December 1990. The renovated ward, however, retained the congregate showers for use by both male and female patients. Although the medical center had both a women veterans coordinator and a women veterans committee, neither was involved in the review and approval of renovation and construction projects.

Women at the Bay Pines medical center may similarly be required to use the same congregate showers as male patients. One of the women at the medical center when we visited explained that, when they wanted to take a shower, they used a magic marker to write "woman in shower" on a paper towel and taped it to the shower door. She said that while most male patients respected their privacy when the note was posted, male patients in some cases still entered the showers while women were using them.

We recommended that VA issue guidance to medical centers on (1) identifying privacy deficiencies in accommodations for women veterans and (2) instituting a mechanism for tracking corrective actions. We stated that the women veterans coordinator or women

veterans advisory committee or both should be involved in the approval process for construction and renovation projects to help address the privacy needs of women patients.

In March 1992, VA directed its medical centers to survey the privacy provisions of all clinical areas to identify those that might not respect women's privacy. The directive noted that the women veterans coordinator or a member of the facility's women veterans advisory committee should participate in the survey.

In response to the directive, medical centers identified 336 projects at 128 VA facilities which would improve privacy for women veterans. The estimated cost of the projects totaled almost $1.5 billion. Many medical centers, such as the Tampa and Bay Pines medical centers discussed above, submitted plans to quickly correct specific problems. Corrective actions range in cost from $1,000 to install privacy curtains around an examination table to $169 million for renovation and construction at the Philadelphia medical center. Among the most common projects were eliminating communal showers and improving privacy in examination rooms.

As of October 1993, 131 of the 336 planned projects had been completed or funded, at an estimated cost of over $672 million. Medical centers expect to fund most of the 205 additional projects before the turn of the century. Projects delayed until after the

turn of the century generally involve new construction or major renovation.

FURTHER ACTIONS NEEDED TO IMPROVE THOROUGHNESS OF CANCER SCREENING EXAMINATIONS

Cancer screening examinations are critically important for women veterans for two primary reasons. First, women veterans for some unknown reason experience an unusually high incidence of cancer. Second, treatment is more likely to succeed if the cancer is detected early. For example, early detection dramatically increases the 5-year survival rates of women with breast cancer. Additionally, with early detection, the 5-year survival rate of women with cervical cancer is 88 percent, but in women whose cancers are not detected early, the 5-year survival rate is only 13 percent. Similarly, since the introduction of the Pap test--the principal method for early detection of cervical cancer--in the 1950s, the cervical cancer mortality rate has declined by 70 percent.

Despite this strong evidence that cancer screening should be an important part of women veterans' health care, VA made little progress in improving the thoroughness of physical examinations during the 10 years between our 1982 and 1992 reports. For example, in reviews conducted in 1988 and 1989, VA's own Medical

District Initiated Peer Review Organization found that from 20 to 86 percent of women patients in the five districts reviewed did not receive breast and pelvic examinations, Pap tests, and mammograms when required.

Because of the limited progress in improving women's physical examinations during the 10 years between our two reports, our 1992 report contained a very specific recommendation: VA should require each medical center, as part of its quality assurance program, to develop and implement an action plan for improving compliance with the requirement that each woman inpatient receive a complete physical examination, including pelvic and breast examinations and a Pap test, at appropriate intervals. We stated that these action plans should, at a minimum, address (1) the use of nurse practitioners and gynecologists to perform physical examinations, (2) the education and training of medical center staff on the importance of women-specific services, and (3) quality assurance monitoring. Finally, we recommended that VA's central office review and approve the action plans.

VA followed through on its promise to require medical centers to submit revised plans for the care of women veterans, but did not analyze and provide feedback to medical centers on those plans. In March 1992, VA's central office directed its medical centers to revise their plans for the care of women veterans and to develop quality indicators to monitor compliance with the examination

requirements. Medical centers were required to submit their plans and quality indicators to the Director of the Women Veterans Program by August 1992.

We found no evidence of VA's central office review of 132 of the 155 plans obtained from VA. Our review of the 155 plans showed that

-- 34 addressed all three of the minimum requirements cited in our recommendation;

-- 69 discussed the use of nurse practitioners and gynecologists to perform the cancer screening examinations;

-- 62 cited staff education and training as an integral part of their plan; and

-- 150 mentioned quality assurance, but only 99 included quality indicators to monitor compliance with the examination requirements as required by the directive.

Frequently, the plans merely restated the requirements contained in the central office directive without outlining an action plan for improving compliance with the requirements.

Although VA promised, in response to our report, to provide feedback to the medical centers on their action plans, it did not notify the medical centers of the deficiencies in their plans. Nor did it do any monitoring to determine whether the thoroughness of examinations was improving.

VA's Assistant Chief Medical Director for Environmental Medicine and Public Health acknowledged that many of the plans were inadequate--the plans frequently reiterated the requirements cited in the central office directive--and told us that VA developed, and disseminated to medical centers in September 1993, women veterans health care guidelines to provide additional guidance to the medical centers. The guidelines encourage medical centers to establish women's clinics and women veterans primary health care teams. These teams would include a core group made up of a physician, nurse, or nurse practitioner, social worker, and the women veterans coordinator.

We believe these teams, if established by the medical centers, could improve the thoroughness of the cancer screening examinations. VA central office has not, however, required medical centers to establish such teams. VA is currently gathering data on the number of medical centers that have established women veterans primary health care teams.

The VA guidelines state that "quality indicators should be developed to monitor aspects of women veterans health care" but provide no further elaboration on quality assurance monitoring.

INNOVATIVE PRACTICES NOT DISSEMINATED

Our report noted that some of the VA medical centers visited had developed innovative efforts to improve compliance with the examination requirements. Although VA agreed with our recommendation that it identify, disseminate, and, where appropriate, require systemwide implementation of such innovative approaches, it has not implemented the recommendation.

VA initially planned to disseminate innovative practices through a November 1992 information letter to its medical centers but later decided that it would be more appropriate to disseminate such information through a quarterly women veterans health programs newsletter. This type of periodic newsletter would, in our opinion, be a good forum for disseminating information on best practices. Neither of the first two issues of the newsletter (July and December 1993), however, contained any information on innovative approaches for improving compliance with the physical examination requirements.

The December 1993 newsletter did contain data on the number of pap smears, mammograms, and gynecologic examinations performed at

each VA medical center. The data are of minimal use in assessing how well the medical centers are following the examination requirements, however, because they do not include data on the numbers of women who should have received the services. In addition, the reliability of the data appears questionable, with some large medical centers reporting no services.

MONITORING QUALITY OF MAMMOGRAPHY SERVICES

In our January 1992 report, we noted that VA medical center's compliance with mammography standards generally exceeded that of private providers. We noted, however, that some improvements were needed and recommended that VA, as part of its quality assurance activities, monitor centers' compliance with its September 1991 circular on mammography services.

VA agreed and said that it would (1) review plans for provision of breast screening services submitted by VA medical centers and (2) develop periodic monitoring of quality control and quality assurance aspects of mammography services and equipment.

VA, however, did not follow through on this recommendation. As I mentioned earlier, VA did not review and provide feedback to the medical centers on their plans for providing breast screening services. And, we identified no VA central office efforts to monitor medical centers' compliance with quality control and

quality assurance aspects of mammography services. Central office officials told us that they lack the resources to conduct such monitoring.

IMPLICATIONS OF HEALTH REFORM

Before closing, I would like to discuss the implications of health reform on the women veterans' program. Under VA's health care reform proposal, the most critical deficiency in the women's program--failure of facilities to provide appropriate cancer screening examinations--may largely be overcome through primary care. Each woman veteran would have a primary care physician and be entitled to a comprehensive set of health care services. Under such an arrangement, a doctor/patient relationship should develop in which physicians will no longer be reluctant to perform the examinations. While VA's planned move to primary care is linked to the President's health reform proposal, VA does not need to wait for health reform to implement a primary care system.

One of the factors VA's officials frequently cite as contributing to poor compliance with cancer examination requirements is physicians' reluctance to conduct breast and pelvic examinations when their specialties are in some other field of medicine. Mr. Chairman, this is another example of the types of problems created by the current hospital-based VA health care eligibility system. The focus of cancer screening examinations

should not be on inpatients, but on outpatients. Focusing on providing cancer screening services to inpatients undoubtedly causes VA to miss cancers in women veterans who may go 5 years or more without an inpatient episode of care--well beyond the recommended screening periods. Under a managed care plan, women veterans would no longer need to be hospitalized to receive routine cancer screening tests.

In the future, VA will rely even more than it does now on individual facilities to ensure the quality of care to both male and female veterans. Consequently, the long-standing problems in getting many VA medical centers to implement corrective actions to improve women veterans health care services may continue.

The final point on health care reform I would like to discuss this morning is coverage of a routine pregnancy. Currently, women veterans of child-bearing age may be reluctant to rely on VA for their health care because routine pregnancies are not covered. While VA would be required to cover routine pregnancies under a managed care plan, women may still be reluctant to sign up for care from a VA health plan that does not ensure continuity of care in private-sector hospitals. In other words, the VA gynecologist/obstetrician would need to have admitting rights to the hospital contracted to provide maternity care.

In summary, Mr. Chairman, VA's central office continues to stress the need to improve services for women veterans. Real improvements, however, depend more on the commitment of medical center directors than on directives from central office. The absence of complete, comprehensive action plans to improve services to women raises serious doubts about the potential for VA health plans to attract women veterans.

Mr. Chairman, that concludes my statement. We will be glad to answer any questions that you or members of the Subcommittee may have.

STATEMENT OF THE HONORABLE STEPHEN A. TRODDEN

VA INSPECTOR GENERAL

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

OVERSIGHT HEARING ON THE

VETERANS HEALTH ADMINISTRATION'S MANAGEMENT OF

WOMEN VETERANS' HEALTH CARE

MARCH 9, 1994

Mr Chairman and Members of the Committee, I am pleased to be here today to discuss the Veterans Health Administration's (VHA) management of women veteran's health care. My comments are largely shaped by a recent inspection by my Office of Healthcare Inspections. The findings of this study were published on March 4, 1994, in a report entitled "Inspection of Women Veterans' Health Care Programs, Privacy Issues--Part II," Report Number 4HI-A19-042. This inspection is a follow up to our review of VA women's health issues of 1993, reported to this Committee on June 23, 1993.

Follow up on our 1993 recommendations has confirmed improvements in staffing both at Central Office and in the field. A National Training Program for Women Coordinators has been planned, although funding will allow attendance by only a minority of coordinators. In our last report we stressed that different Department of Veterans Affairs Medical Centers (VAMCs) might have different approaches to women veteran's care, of which the development of a Women's Health Clinic might be one. We recommended the development of guidelines on how to establish and operate a Women's Health Care Clinic. In fact, individual VAMCs, for example Salem, VA had already developed such guidelines. However, declining to promulgate guidelines, a VA working group recommended that because of limited resources, the use of a primary care system would be the most generally applicable approach to

meeting the needs of women veterans. The group recognized the establishment of women's clinics as an option.

In the current inspection, my Office addressed the issue of how effectively VA medical centers have met the needs of women veterans by visiting and evaluating aspects of women's health services in a stratified sample of VA medical centers around the country. Fifteen units at 10 VAMCs were visited between November 1993 and February 1994. Thirteen of these units were inpatient facilities and two were satellite ambulatory facilities associated with the VAMC. In this inspection we reviewed the current activities of women veteran coordinators and inspected issues relating to veteran privacy and the cleanliness of facilities. In all cases, the facility was given approximately 2 weeks advance notice of the inspection.

We found that progress has been made in the assignment of women veteran coordinators. Coordinators were present in all facilities. All coordinators have suitable professional backgrounds for their role.

Some coordinators did not seem to be fully briefed on the responsibilities of their function and some still did not have an adequate allotment of time to the function to be fully effective. On the other hand, evidence of attention to women's issues existed. For example, Brooklyn VAMC had appointed a full-time coordinator, although no additional funds for the purpose had been made available from Central Office.

Coordinators still need to have greater visibility in VAMCs and there is continuing need for training of coordinators in their tasks.

Full-time women veteran coordinators have been appointed in all four VA regions. VHA has established and appointed a Special Assistant to the ACMD for Environmental Medicine and Public Health for women veteran programs. The Office of the Assistant Secretary for Policy and Planning has created a full-time staff position responsible for women's issues throughout the Department. The relationships among these senior staff seems to be still evolving.

Although not mandatory, Women Veterans Advisory Committees were functioning in all but one of the medical centers visited.

Conditions for female veterans at VAMCs vary widely. Some VAMCs have made great efforts to ensure privacy for women veterans, while others still need to make progress.

Impediments to adequate privacy for women veterans include the structural conditions at VAMCs. No VAMC, including those built or remodelled in recent years, comprises exclusively private or semi-private rooms. All have some 4-bed rooms or larger. We found no examples, however, where women veterans were not housed either in individual rooms or in female only rooms. Sometimes, however, women veterans had to share bathrooms with male veterans. Correcting these deficiencies in VAMCs would require the investment of large sums of money.

Other impediments to privacy relate to issues correctable with little expense. For example, bathrooms more convenient to women's rooms could be reserved for women veterans. In some cases, improvements as simple as providing warning notices on bathroom doors requiring veterans to knock before entry would help.

Standards of cleanliness in bathroom facilities varied. The majority of hospitals were very clean, outstanding being Brooklyn, NY; Salem, VA; Grand Junction, CO; and Portland, OR. In a minority of hospitals, bathrooms were dirty, to the extent that in three centers, women veterans personally cleaned bathrooms on arrival and sometimes after the bath rooms had been used by male veterans.

Generally, hospital shops carried a better supply of female personal items than that found in our last inspection, but deficiencies in the availability of some feminine hygiene dispensers exist in some medical centers.

My staff were well received by VAMC Directors, and sensed VAMC administrators to be more focussed on women's issues and more responsive to the inspection than in the visits in 1993. The success in the provision of better services at the majority of facilities provides optimism that the improvements necessary elsewhere can be achieved. Formidable challenges remain. To bring VA hospitals to the standards of accommodation common in the private sector will involve major reconstruction, with its attending expense. Short of this, however, much

can be done to improve conditions for women veterans by continued sensitivity to the issues involved.

We recommended that the Acting Under Secretary for Health should:

1. Congratulate hospitals which have improved their attitude toward women;

2. Continue to insist on high standards of cleanliness in all VAMCs; and

3. Require all Directors to ensure maximum privacy for all veterans including women, within the limits of the intrinsic constraints posed by their facilities.

At the time of preparing this testimony, we did not have an official response from VHA to this report and its recommendations.

STATEMENT OF
SUSAN H. MATHER, M.D., MPH
ASSISTANT CHIEF MEDICAL DIRECTOR FOR
ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH

VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE COMMITTEE ON VETERANS' AFFAIRS

MARCH 9, 1994

Mr. Chairman and Members the Subcommittee,

Thank you for the opportunity to report on how the Department of Veterans Affairs (VA) is addressing the health care needs of women veterans.

According to the 1990 census, women veterans comprise 4 percent (1.1 million) of the total veteran population (27.2 million). Today, women veterans represent 11 percent of the active duty force and 13 percent of the reserve force. Among women veterans, the largest group served in peacetime (45 percent), followed by women who served in World War II (26 percent) and during the Vietnam Era (21 percent).

VA is responding to the health concerns of women veterans by expanding existing services and instituting new programs. In FY 1993, VA health care facilities provided care to 292,977 women - an increase of 18,479 (7 percent) over FY 1992. Of that number, there were 16,157 women hospitalized, representing an 8 percent increase over FY 1992. The distribution of workload is not uniform throughout VA. VA medical centers show a significant range in women veterans served, from the fewest -- Miles City, Montana, where 281 women veterans were treated, to the most -- Albuquerque, New Mexico, where 10,153 women veterans were treated in FY 1993. Twenty-one facilities treated more than 3,000 women veterans in 1993. While we still need intensive outreach concerning veterans benefits for some women veterans of earlier eras, the word that VA is here for them is certainly getting out to the newest women veterans. Among Persian Gulf veterans, where women accounted for approximately 7 percent of the forces in country, 8.9 percent of the outpatients and 7.6 percent of the inpatients seen in VA facilities are women. The proportion is even higher among Persian Gulf era patients, where 14 percent of the outpatients and 14.4 percent of the inpatients are women.

Secretary Brown has committed VA to assuring equal access to health care for women veterans and making needed improvements in women veterans' health care services.

These efforts include progress in (1) providing gender-specific health care services for women veterans, addressing privacy concerns, complete physical examinations and appropriate cancer screening, gynecological and reproductive health care; (2) priority access to comprehensive sexual trauma counseling and the coordination of related health care; (3) improving VA reporting of health care services to women veterans; (4) developing methods to monitor the quality of the services provided to women veterans; and (5) planning for new research initiatives related to women veterans health needs.

In 1992, when VA began receiving increasing numbers of women veterans seeking treatment for the effects of sexual trauma, a task force was established to address the most immediate needs: diagnosis and treatment. In September 1992, a major training conference was held and at least one person from each VA medical center received training there on the needs of women veterans who suffered sexual assault and other sexual trauma.

Caring for victims of sexual trauma is a major area of emphasis in the multi-year National Training Program (NTP) on women veterans' health. We have developed a series of five Women Veterans Health National Training Program modules designed for VA mental health and readjustment counseling clinicians, including psychiatrists, psychologists, social workers, nurse clinicians, vet center counselors, women veterans coordinators and other clinical staff. Three nationwide satellite broadcast conferences on treatment of sexual trauma have been conducted. The first, on May 12, 1993, was designed to provide VA mental health clinicians with an understanding of the factors influencing the assessment, diagnosis, and treatment of women veterans who have been victims of sexual assault while on active duty. The second satellite broadcast in this series was held on September 23, 1993, addressed character disorders and transference/counter-transference phenomenon. The third satellite broadcast in this series was held on February 24, 1993. It presented some of the legal and ethical dilemmas commonly encountered in the treatment of sexually traumatized women veterans and to discuss approaches to the successful resolution of these dilemmas.

While war-zone related experiences originally served as the primary backdrop for framing a PTSD diagnosis, later discoveries have shown that sexual abuse or sexual harassment of female veterans while they were in the military can be the precipitating factor in later stress disorder symptomatology.

To respond to these findings and to the increasing numbers of women veterans seeking care for stress symptomatology, in 1992 the National Center for PTSD created and funded a Women's Health Science Division (WHSD) headed by Dr. Jessica Wolfe. The WHSD is devoted exclusively to research and education on the psychological impact of military service including traumatic stress on women veterans. These efforts

will permit collaboration with the Menlo Park Division of the National Center for PTSD in offering a broad range of educational and training programs for clinicians.

In addition to existing programs and treatment resources, VA has established four women veterans stress disorder treatment teams. These teams provide evaluation, diagnosis and direct patient care and treatment. Also, provisions are made to obtain consultation and liaison to other inpatient and outpatient medical/surgical services when needed. These teams are located at VA medical centers Boston, New Orleans, Cleveland, and Loma Linda.

VA's Readjustment Counseling Service (RCS) staff began reporting an increased number of cases of women veterans coming to vet centers with psychological difficulties related to sexual trauma in late 1991. In early 1992, we initiated specialized in-service training on sexual trauma counseling. As part of VA's extension of services to women veterans, the RCS is being provided an additional $1.5 million on a recurring basis for 34 FTEE. The hiring of part time staff at 69 vet centers in 65 cities was done to broaden the geographic scope of some level of service availability. Staff provide outreach and counseling services to women veterans experiencing the psychological aftermath of sexual trauma incurred while on active duty in the military. Each one has had specialized training and supervision, specifically in the treatment of sexual trauma and has a minimum of a masters degree in a mental health discipline.

Each of the RCS Regional Offices and each vet center has a designated women veterans coordinator. There is also a Women Veterans Program Transition Committee of 30 RCS members nationwide to assist with the implementation of all phases of the program.

In addition to the specific initiatives to address the health effects of sexual trauma, a number of other initiatives have been developed specifically to address health care needs of women veterans. These include the opening of four Women Veterans Comprehensive Health Centers in FY 1993 and an additional four in FY 1994; full-time women veterans coordinators at selected VA medical centers; full-time regional women veterans coordinators; and a full-time women veterans national education coordinator and staff at the Birmingham Regional Medical Education Center to implement a multi-year national training program fully supporting the women veterans health programs. All of these initiatives have been supported by an allocation of $7.5 million from the VA's FY 1993 and FY 1994 budgets.

Each Women Veterans Comprehensive Health Care Center will serve as a resource, providing comprehensive services for women veterans in a primary service area. Each center represents a "pilot" program for duplication throughout VA. Sites were selected competitively from a nationwide request for proposals. The eight proposals chosen for funding are the VA medical centers in Minneapolis, Tampa, San Francisco, Boston, Durham, and the Southeast Pennsylvania Network, comprised of Coatesville, Lebanon, Philadelphia and Wilmington; the Chicago Area Network, comprised of Hines, West

Side, Lakeside and North Chicago; and the West Los Angeles and Sepulveda consortium.

The V A's Advisory Committee on Women Veterans has consistently recommended funding of full-time Women Veterans Coordinator positions. VHA has designated a full-time Women Veterans Coordinator position at each of the four VHA Regional field offices. Full-time regional coordinators provide, among other activities, regional program coordination and evaluation, innovative local programs to meet specific needs, liaison with VA Central Office, and consultation to the Regional Directors on matters relating to health care for women veterans. In addition, VA funded a full-time Women Veterans Coordinator position at the following 22 facilities: Bronx, Boston, East Orange, Philadelphia, Allen Park, Cleveland, Chicago West Side, Minneapolis, Bay Pines, Dallas, Houston, Miami, San Antonio, San Francisco, Tampa, Albuquerque, Long Beach, Palo Alto, Phoenix, San Diego, Portland and West Los Angeles. In addition, several VA medical centers have used local resources to fund full-time coordinator positions. We have recommended that the WVC be either a social worker or a nurse involved in the provision of clinical services to women. To assist VA medical centers in implementing these guidelines, we have developed a prototype position description for a full-time WVC social worker, a prototype functional statement for a full-time WVC nurse, and a prototype collateral assignment addendum for VA medical centers without full time positions. For medical centers without full-time positions, we have published guidelines that specify the WVC be allowed at least 5 hours per week for the administration of the local women veterans program and that the WVC report to the medical center director or chief of staff .

A Women Veterans Health Program National Steering Committee was established in 1992 and strategic plans have been developed to implement a variety of educational and informational methodologies relating to women veterans health. Three issues of a national newsletter devoted to the women veterans health program and a brochure concerning women veterans health programs, including sexual trauma counseling services, were published and distributed during 1993 and 1994.

In August 1992, the offices of Research and Development and the Health Services Research and Development sponsored a national conference for researchers, clinicians, and policy makers to discuss VA's research agenda related to women. Research involving women veterans is a long-term commitment with anticipated long-term pay-offs. Since May 1991, it has been VA policy that all applicants for VA research must consider (and document) the inclusion of women in their proposed study. This policy should contribute significantly to the achievement of the intent of section 109(a) of P.L. 102-585.

In FY 1993, VA investigators conducted a total of 273 research projects related to women's health. Of these, 113 were supported by special research funding and 160 were funded by non-VA sources. Research funding provided by VA was $2,448,823,and extra-VA source ($2,687,061), for a total of $5,135,884.

In FY 1994, John Feussner, M.D. and associates began an HSR&D Service directed research project entitled "Breast Cancer Among Women Veterans: A Pilot/Feasibility Study". This study will serve as a pilot phase for subsequent efforts to evaluate current primary and secondary prevention practice and rehabilitation therapy for breast cancer among women veterans.

In FY 1994, five VA medical centers plan to form a consortium to pool their intellectual, financial, and other resources to implement health service studies on women's health. These studies will examine organization of service, quality of, and access to, care, and the economic impact of providing care for women veterans. Each center will implement collaborative projects as part of the consortium as well as individual projects.

In FY 1994, the VA Environmental Epidemiology Service began a three-year study of reproductive health outcomes among women Vietnam veterans, an epidemiological study of any long-term adverse health effects experienced by women who served in Vietnam. This study is one of three research projects being conducted by the Department in fulfillment of the legislative mandate in P.L. 99-272. A mortality study of women Vietnam veterans has been completed and a study of psychological outcomes among women Vietnam veterans is underway.

The VA Inspector General completed an audit of the Women Veterans Program in 1993. The Inspector General's audit identified areas for improvement and we developed action plans to respond to the recommendations. At that time, it was obvious that while many creative and innovative programs existed at the local level, there needed to be greater standardization of information and services. This was one of our major programmatic thrusts in 1993.

In January, 1992, the General Accounting Office published a report entitled " VA Health Care for Women." In following up on the 1992 GAO Report, significant progress has been made in providing additional privacy for female veterans in VA health care facilities. Correction of existing privacy deficiencies is an ongoing process and current VA directives require quarterly reporting of the status of all planned and funded projects to make these corrections. Special considerations have been incorporated into the methodologies used in scoring and prioritizing projects that correct privacy deficiencies. In addition, space and planning criteria for new construction have been carefully reviewed to assure that these criteria fully support the need for patient privacy. During the last four fiscal years over 280 projects have included correction of privacy deficiencies.

VA has continued to stress preventive medicine. In FY 1992, 20,247 women veterans received Pap smears through VA and 24,652 Pap smears were done in 1993. Policy on mammography was established in 1991. In 1992, 15,964 women veterans received mammograms through the VA. In 1993, this number was 29,612. The number of Pap

smears and mammograms reported probably represents under-reporting because of the methodology used to extract the data. Steps are being taken to improve the reporting situation. The information was obtained by surveys done in January of the following year.

The number of directives issued in 1993 related to women veterans health testify to the high degree of activity in the program. In December 1993, VHA Directive 10-93-151 was published establishing the policy that women will be provided reproductive health care under the Veterans Health Care Act of 1992, Title 1, Section 106 of Public Law 102-585. In September 1993, VHA issued Women Veterans Health Care Guidelines, IL 10-93-027, to address the need for improved services to women veterans. The guidelines address Medical Care, Environment, Culture and Outreach.

Secretary Brown's commitment to improving the services to women veterans was recently underscored when he announced the appointment of Joan A. Furey as Director of the newly formed Women Veterans Program Office (WVPO) in the Department'sOffice of Policy and Planning.

Mr. Chairman, although VA has always opened its door to the nation's women veterans, the enactment of Public Law 102-585 and the special funding provided by the Congress in 1992 for improving Women Veterans Health Programs provided a tremendous stimulus for improving VA services to women veterans. Increasing numbers of women veterans are coming to the VA for services and thousands of dedicated VA staff are prepared to provide health and counseling services to them. During this coming year, we plan to further expand services for women veterans and intend to make the program improvements with special emphasis on improving quality of care. I am delighted to be able to bring you this update on what VA is doing to provide medical care for women veterans and to increase knowledge everywhere that "Women are Veterans Too".

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Statement of
Nurses Organization of Veterans Affairs
NOVA
Bette L. Davis, MSN, RN, CS
President
Before the Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
United States House of Representatives
On
Recent VA Actions to Improve the Provision of Health Care to Women Veterans
and Related Issues

March 9, 1994

Mr. Chairman, and members of the Subcommittee, I am Bette L. Davis, MSN, RN, CS, a clinical nurse specialist at the Washington, D.C. Veterans Affairs Medical Center. As president of the Nurses Organization of Veterans Affairs (NOVA), I am speaking on behalf of NOVA and for all VA nurses. Thank you for inviting NOVA to testify today on recent VA actions to improve the provision of health care to women veterans and related issues.

It is professionally rewarding to present an interim report following June 23, 1993's Congressional hearing on implementation of PL 102-585 (1992) and House passage of H.R. 3313, as amended (1993), legislation that addresses women veterans health care.

Women Veterans Health Care Services

NOVA is pleased to report substantial progress is being made in providing health care services to women veterans. Overall, more women veterans are being seen with more services offered. There is greater awareness, interaction and focus on women's health issues in the VA.

In each of the four VA medical regions, now in process for improving women veterans health care are:

- a comprehensive women's health center
- a stress-disorder treatment team that will also train local VA clinicians
- a full-time coordinator of women's services to facilitate training and communication of VAMC coordinators

Extended services now include:

- more counselors at 69 of VA's 201 community-based vet centers
- counseling for sexual trauma on an outpatient-priority basis at VAMCs
- preventive gynecological services

Women's Health Clinics

NOVA does not know the number of established Women's Health Clinics, but gynecology services are provided by all VAMCs, many of which include specific clinics for women emphasizing preventive care and counseling. Several VAMCs contacted by NOVA reveal improved efforts.

Attempts are being made at each facility to define and evaluate standards and procedures for screening, diagnosing and treating breast cancer. There are support groups (ex-Mammography Action Groups), gender specific drugs and pharmaceutical products (oral contraceptives, diaphragms, hormones) and new GYN equipment for a growing number of GYN clinics in facilities. Many clinics now have their own rooms. A few examples of improvement follow.

A women's health clinic is now operational with gender-specific appointments usually made within two weeks (emergencies excepted) as compared to a backlog of appointments of nine - twelve months in June, 1993.

A full-time female nurse practitioner is now assigned to a GYN and breast clinic compared to two-half days twice a week last fall. GYN appointments used to take four-five months, now it's one week. On average, 40 - 50 patients per month were seen, now six to eight a day are seen, with an increasing demand for pelvic exams, pap smears and breast exams as more women being discharged from a downsizing military may require rating exams. Presently, larger numbers could be cared for if the rating process and paper work were not so slow.

A new mammography machine, and new GYN equipment and supplies are in storage. There is no radiologist in house who can read mammograms. A larger GYN clinic room is indicated for the new examining table and equipment. The current room is very small with minimal walking space around the examining table, two chairs, desk and small cabinets. There is no space for teaching or counseling patients about sexually transmitted diseases, contraceptives, menopausal management, breast exams, etc. Most of the women patients seen have a primary psychiatric diagnosis and require additional time and space.

A non-staff gynecologist is available to the clinic twice a week and for GYN surgery which usually is done in-house. The nurse practitioner works closely and collaboratively with the gynecologist who reviews every record and sees any patient as indicated. A half-time (0.5 FTE) position is being requested for a staff-salaried gynecologist.

In regards to pelvic examinations, one female veteran said that the nurse practitioner did the best pelvic exam she'd ever had, was gentle and patient. She also commented that in her previous experience with rotating staff, they lacked awareness and sensitivity to females veterans; sometimes being asked why she was in a VA hospital or if she was the wife of a VIP or dependent.

in a general medical clinic at another facility where both men and women are seen, the current backlog of appointments is one year, worse than before. In response, Ambulatory Care Service is moving toward a primary care model and preparing primary care teams consisting of a staff mix of health care providers to increase access to care, decrease walk-in-visits and backlog of appointments.

Educational Efforts

Local education and training for staff and veteran consumers has been enhanced. Education of staff to increase awareness about special needs of female veterans regarding recognition, response and resources are underway.

A recently published "Women Veterans Health Care Guidelines" was distributed to all VA facilities, along with a packet of information for use in outreach activities relating to National Women Veterans Recognition Week.

Local facilities have provided a Women's Health Fair, a Women Veterans Health Awareness Day or a series of programs or lectures. Included in the educational programs are a variety of issues pertinent to women's health and well-being, such as topics on osteoporosis, the caregiver role, stress management, breast health awareness, estrogen replacement therapy, depression, etc.

Compared to NOVA's testimony less than a year ago regarding staff's awareness at one facility of women with PTSD and sexual trauma, it is reported there's been increased recognition of and sensitivity in treatment of women with PTSD or who have been sexually assaulted. Women are now being recognized as needing treatment which is handled differently compared to treatment of other acute or chronic mental disorders.

The case example of a women veteran presented before this committee in June, 1993, illustrated a hospitalization and treatment (for PTSD resulting from a repressed sexual assault) so negative that she wrote it up for her treatment team. For follow-up, she reports much improvement through talking it out with staff members and by writing about her experience. She was pleased that the case information was used in NOVA's testimony. She wishes that changes had been made before her hospitalization rather than afterward. Currently, she is active and functioning normally.

Sexual Counseling

A multidisciplinary sexual trauma team is now available in VAMCs. Mental health staff is more receptive and better informed about veterans with sexual trauma issues. There's less trouble admitting women to psychiatry service. Although some difficulty still exists with medical administration service (MAS) relating to eligibility, it is less problematic.

Other mental health activities include adding out-patient group counseling for sexual trauma survivors and initiating gender-specific groups for sexual trauma victims, PTSD or substance abuse.

Vet centers are used frequently be female veterans seeking help for multiple reasons: homeless shelter, employment counseling or jobs income and general counseling. A veterans center in a downtown area of a city recently added a Ph.D. psychologist as a sexual counselor who interact with the local VAMC.

Women Veterans Coordinator (WVCs)

Improved national efforts toward education and communication for WVCs are noted in general by those contacted. With four full-time regional coordinators, initiation of a national newsletter, a directory, a national conference, and National Training Programs (NTP) on Women Veterans Health specifically addressing a variety of women issues, sexual trauma and counseling and program information for primary health care providers, there's an air of support and hope among WVCs and women veterans.

Despite significant improvement, lack of half-time and full-time positions remains a problem. At the local level, VAMCs now have around eighteen full-time coordinators, but for the most part duties are still on a collateral - duty basis. Based on a VHA Directive issued last year to appoint WVCs that were in the clinical area, such persons are being appointed to these positions. One facility happily states a nurse practitioner has been made a full-time coordinator. Another facility still has less tham a full-time position even though the VA female population is over 3000. However, several full-time WVCs were hired within this particular region. A full-time FTE position based on documentation of need will continued to be requested.

In another facility, even with escalating phone calls and personal contacts with in-patients and out-patients, the allotted time per week is two-four hours for responsibilities as a coordinator. This time has not changed for two and a half years. Any increase in time allotted is pending a

response from a proposal for a women's wellness clinic submitted in 1993, in which a full-time WVC position was also requested. In the meantime, these duties are in addition to head nurse responsibilities. She feels limited in setting goals with no time to carry them out and is under pressure to function reactively instead of proactively. Important to her, also, is that while in a collateral assignment, her activities are in a grey area in terms of affecting her proficiency rating. Since it is not required to be part of it, the only reason for any of these activities to be in a proficiency is to ask that they be incorporated. Most people like recognition for work affecting their full performance of responsibilities.

Privacy and Accommodation

A lack of female pajamas and a limited choice of robes remain a problem. A 72 year old woman veteran said she hadn't seen any female pajamas for the 22 years she has been coming to the VA hospital and complained that men's pajamas never will fit women's bodies. A wide range of personal hygiene products, toiletries, clothing, etc. are available in the canteen, however.

Accommodation for women in newly constructed or renovated buildings indicate single rooms with private bathrooms, such as a new short term admission unit with twelve such rooms. In older or unremodeled facilities, private rooms with bathrooms remain a problem on wards with frequent admissions of female as the bathroom might be used for isolation or other purposes. In old VA facilities, especially on inpatient psychiatric units where no structural changes have been made, privacy and security remain a big concern.

Research

Providing high quality health care services to women veterans is enabled if based on identification and assessment of health needs of this critical group of women veterans. In order to serve them, VA should not only authorize research as mandated in PL 102 - 585, but appropriate funding for expanded comprehensive research. The growing number of women veterans becoming eligible for VA health care will affect VA's planning for services, particularly as national efforts toward health care reform are added to the picture.

NOVA thinks it is unrealistic not to do a comprehensive women veteran study to define more clearly how VA can develop plans to meet health needs of this population. We must consider

neglected areas of women's research in areas of gynecology, early cancer and heart desease among women, conditions relating to aging women, and more recently to the large and growing number of female veterans exposed to multiple chemicals which now appear to be effecting spouses and children. Continuing debate instead of taking action, over women's research smells like gender bias and continues to be a serious health threat for women veterans.

Local action to do something about one of the leading causes of death in women was initiated at the Denver VAMC for a women's Carcinoma Research Study. American Lake VAMC now has a X-Ray Densitometer for diagnosing and evaluating treatment of osteoporosis - equipment sought for the past four - five years. It will open up additional research in osteoporosis. The Washington, D.C., VAMC is engaged in several AIDS studies, open to women, involving clinical trials of treatment. They recently renewed a five year NIH grant in conjunction with seventeen other sites (no other VAMC) to conduct treatment protocols for veterans and non-veterans. Unfortunaly, either no females or few females (veterans and non-veterans) are enrolled. Several other VAMCs are involved in AIDS research and VA investigators are publishing their results, receiving recognition for their work.

Commendable recent research and treatment efforts already in process include studying the impact of military trauma on women veterans though a Women's Health Science Division established with VA's National Center for Post-Traumatic Stress Disorder.

Comments and Suggestions

NOVA is concerned that budget cuts and FTE reductions will impact negatively on progress being made. Loss of funds and staff affect all services' budgets and delivery of care. More laboratory tests either in-house or contracted out, additional pharmaceutical products, or more X-Ray or mammographies, all will strain financial resources, just as VA is on the edge of something beneficial happening. Therefore, the following recommendations are carefully thought out and are made by VA nurses and women veterans coordinators contacted by NOVA. They are:

- development of guidelines for interaction of regional comprehensive health care centers with other VAMC within the region;
- provisions of clerical help and MAS support for new programs, clinics, centers, and registries;
- finer tuning of record keeping and monitoring of work as actual numbers don't always

match computer numbers;

- establishment of a clearinghouse for identifying female discharges from military services and processing service - connected rating; and
- more national dissemination of women's information to VAMCs, relying less on individual facilities to assume this task

Mr. Chairman and members, NOVA thanks you for the work represented in bill H.R. 3313, and is pleased to support all the provisions. It is helpful to VA nurses and all veterans to see changes being made and to know we can make a difference in VA health care.

Thank you for inviting NOVA to testify today.

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
March 9, 1994

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to provide its views on the delivery of women veterans health care within the Department of Veterans Affairs (VA). We appreciate the continuing efforts of this Subcommittee to ensure that the requirements of recent legislation concerning women veterans is being carried out by the Veterans Health Administration (VHA) in a timely and effective manner.

Mr. Chairman, The American Legion supported the establishment of Public Law 102-585, the "Veterans Health Care Act of 1992", Title I - Women Veterans Health Programs. This legislation included nine relevant sections dealing with women veterans health care. The "Veterans Health Improvements Act of 1993" (H.R. 3313), would further direct VA to undertake certain improvements to Title I of Public Law 102-585. Veterans demographic data suggests that a need exists for VA to develop high quality health care services for women veterans. Further, in anticipation of national health care reform, and a possible expanded role in the treatment of women veterans, VA must expedite these efforts.

Prior to enactment of Public Law 102-585, health care services in VA were not extensively gender-based. Since enactment, VA has inaugurated many new women veterans initiatives and has worked to strengthen existing services. Some of these actions include the establishment of a National Training Program for women veterans health programs; establishment of eight women veterans comprehensive health care centers; the establishment of four women veterans stress disorder treatment teams and twenty-two full-time women veterans coordinators, plus full-time coordinators in each VHA region; and the recruitment of Vet Center counselors in 65 centers with special expertise to treat women who have experienced sexual trauma. Mr. Chairman, The American Legion commends these actions. We also recognize that it takes time and resources to build an acceptable level of services for women veterans.

The "Veterans Health Improvements Act of 1993" would require VA to extend and expand health care services for women veterans. This legislation includes provisions relating to "in-house" or contractual health care and the cost-effectiveness

of that care; women's reproductive services; the establishment of mammography standards, clinical research activities, and a women veterans population study; psychological trauma counseling; establishment of a toll-free service for veterans seeking information about counseling; women veterans coordinator positions and duties; and requirements relating to medical center privacy deficiencies for the treatment of women veterans. The American Legion supports H.R. 3313.

Mr. Chairman, it is important to recognize that many provisions of the "Veterans Health Improvements Act of 1993" could be accomplished immediately. In fact, the legislation directs VA to accomplish all seventeen provisions of the Act over the next five years. That being so, it is equally important to monitor the progress being made toward improving women veterans health care services and identifying the problems encountered along the way.

For Fiscal Year (FY) 1994, VA has apportioned nearly $12 million of recurring funding for women veterans health care programs. This amount includes $7.5 million which was appropriated by the Congress for FY 1993, and another $4.2 million, approved in April, 1993. The continuation of earmarked funding for these programs is extremely important. As the requirements for expanded women's health care services increases, so too will funding requirements. An example of funding shortages affecting women veterans health programs is the current shortage of travel resources to conduct national education and training conferences. In order to keep the momentum moving forward with regard to developing all provisions of the Women Veterans Health Improvements as proposed in H.R. 3313, the annual resource requirements of a fully functional women veterans health care program must be met.

A number of VA medical facilities have established women veterans health care clinics. As a result of P.L. 102-585, eight VA medical centers were approved to expand or establish Women Veterans Comprehensive Health Care Centers and 22 full-time women veterans coordinator positions were funded. We think that primary health care teams, and/or specific health care clinics devoted to women veterans is a concept that should be applied throughout VA. We also believe there is a possibility that national health care reform will add to VA's growing women veterans workload, along with a possibility that female dependents of veterans will be permitted to seek VA care. In those instances where the women veterans workload is not sufficient to provide certain in-house services, VA will need to continue its current authority to provide contractual

care services. Also, as VA continues to assess the status of facility accommodations for women veterans, priority construction funding will be required to improve patient privacy.

Mr. Chairman, with regard to impending health care reform and its possible impact on VA, and in particular women veterans, The American Legion suggests that VA undertake an updated research study of women veterans health care delivery within VA and the attitudes of male and female veterans toward VA medical care. The last VA initiated market research study of women veterans was conducted in 1982, at a time when VA did not receive high marks in the delivery of women veterans health care. Over the past decade, VA has made much progress in improving its women veterans health care programs. While the quality, quantity and type of care provided to women veterans has improved, it is uncertain what subgroups of women veterans today choose to utilize VA. It is equally uncertain what the prevailing attitudes are toward VA medical care by those who are eligible but choose not to utilize VA care. In a time when the health care utilization choices of many Americans are likely to be affected by health care reform, it is important to obtain as much information as possible on the health care preferences of those who have access to the VA medical system. In this regard, VA needs more information on the specific characteristics of its users, male and female alike.

Prior to the adoption and implementation of a specific health care reform plan, we feel it makes sense to conduct an up-to-date market research study of all veterans, with an adjusted sampling of women veterans. If VA is to succeed in a reformed health care environment, now is the time to obtain such useful information, not after the implementation of health care reform. P.L. 102-585 authorized up to $2 million to be spent on a population study of women veterans, however, these funds were not appropriated by the Congress. In order to properly prepare for the eventual introduction of health care reform, The American Legion recommends that the Congress now provide a specific appropriation for VA to design and conduct a comprehensive market research study on both male and female veterans health care utilization patterns.

Mr. Chairman, The American Legion has reservations about the effect of the current two-year limitation on sexual trauma counseling from the date of military discharge, within VA (P.L. 102-585). We opposed this time limitation when originally proposed and continue to see no scientific evidence to support such a statute. The delayed nature of sexual trauma suggests that a victim may very well not seek treatment within a

specified time frame. We strongly recommend that an open ended time frame would best address this issue. The American Legion also has concerns regarding the time limitation for treatment by fee-for-service providers in those instances where VA facilities are not capable of furnishing counseling economically because of geographic inaccessibility. We recommend the removal of the December 31, 1994, time limitation on the provision of fee-for-service contract care, as provided for in P.L. 102-585.

As the Veterans Health Administration (VHA) moves to reconfigure its four regional offices to 16 Veterans Service Areas (VSAs), we recommend that VA's special committment to the Women Veterans Coordinator Program is preserved. We hope that the four regional women veterans coordinators will retain their current administrative and oversight functions within VHA.

An issue of concern to many individuals involved with women veterans programs in VA is that medical procedures unique to women veterans are not rountinely being captured in VA's automated data base, due to a lack of specific capabilities between VA's Information Management System (IMS) and link-ups with the Decentralized Hospital Computer Program (DHCP). Improving the IMS program with regard to the reporting of women veterans health care procedures will help to incorporate quality management principles and develop guidelines for facility Women Veterans Health Programs, through the development of clinical indicators, and improve documentation and reporting systems. A distinct women veterans DHCP package would greatly improve current data base reporting requirements and quality assurance activities.

Overall, The American Legion believes VHA's women veterans health care programs are evolving in a positive direction. There is evidence of strong leadership and commitment to these programs at the managerial level. A need for further improvements will always exist. As these programs continue to develop and grow, funding support must keep pace. The American Legion looks forward to working with this Subcommittee in its efforts to protect and to promote the further development of VA's Women Veterans Health Care Programs.

Mr. Chairman, that concludes our statement.

STATEMENT OF
DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 9, 1994

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.4 million members of the Disabled American Veterans, and its Women's Auxiliary, I want to thank you for the opportunity to appear before the Subcommittee and offer our views related to the Department of Veterans Affairs (VA) provision of health care to women veterans.

Mr. Chairman, your letter of invitation to testify made reference to a variety of issues affecting women veterans and set forth those of particular interest to the Subcommittee. They include VA provision of gender specific health care to women veterans and problems encountered by women veterans in obtaining VA provided health care; availability in VA facilities of personal hygiene products; toiletries; cosmetics; clothing and other gender specific items used by women veterans; VA provided counseling for women veterans who are victims of sexual trauma; the effectiveness of VA's Women Veterans Coordinator program; VA medical facility accommodation of women veteran patients; the inclusion of women in medical and health care research supported and/or conducted by VA; and, the incidence of cancer among women veterans and their nonveteran peers.

Mr. Chairman, in 1982 women veterans totalled some 740,000. By 1990 the 1.2 million women veterans accounted for 4.3 percent of the total veteran population. By the year 2000, women will represent 5.3 percent of all veterans and by 2040, they will make up about 11.0 percent of the total veteran population.

Women have always provided meaningful contributions to our armed services over the course of our nation's history. This century witnessed women in service in large numbers for the first time. World War II saw 380,000 women in uniform. Later, 110,000 women served during the Korean Conflict while 261,000 served proudly and gallantly during the Vietnam Era.

Mr. Chairman, more recently, the contributions made by women in the military took on somewhat new and varied roles. During the Persian Gulf War, approximately 33,000 women were deployed in Southwest Asia serving in vital combat and combat support positions.

Not only did women continue to serve in the role of care givers and lifesaving and nurturing nurses, but expanded that role by serving also as physicians in a combat theater. They served as pilots of combat aircraft, as well as crew members. As in civilian life, women in the military have, in many instances, assumed job parity with their male counterparts and have performed honorably. In short, women have evolved in the roles they perform in our nation's military service. This is as it should be.

Not only are the functions and responsibilities of women in the military growing, so are their numbers. The 233,000 women in uniform now constitute approximately 11.0 percent of our

active military force with a significantly large segment, some 144,000, of our reserves also comprised of women.

Mr. Chairman, it is clear that as the number of women in the military grows and the number of female veterans increases, so must the services and benefits provided by VA also increase. In tandem, the focus to women veterans being served and/or eligible for benefits by VA must also be an area VA remains focused on.

The 1992 GAO Report, "VA Health Care for Women: Despite Progress, Improvements Needed," provides perhaps the most recent overview of what VA has been able to accomplish over the years.

Clearly, Mr. Chairman, more needs to be done. The area in greatest neglect and requiring immediate attention and improvement continues to be in the health care arena. Despite many acknowledged tangible gains, VA continues to be faced with persistent problems when attempting to ensure women veterans access to VA health care is satisfactory and, at a minimum, equal to that experienced by male veterans.

Mr. Chairman, it is our sincere belief that VA has, since the enactment of Public Law 102-585, during November 1992, made significant strides in their policies affecting women veterans who have been the victims of sexual trauma/abuse. Some accomplishments include:

* the augmenting by trained staff at VA Vet Centers who have specialized skills in providing counseling to women for the after effects of sexual trauma;

* the establishment, in January 1993, of a new division within the National Center for Post Traumatic Stress Disorder (PTSD) devoted to studying the impact of military trauma on women veterans;

* the creation of an eight week inpatient PTSD Program exclusively for women veterans at the Menlo Park division of the Palo Alto, California VA Medical Center which provides treatment approaches in recognition of the specific needs of women exposed to stressful events during military service;

* the establishment of four Women Veteran Stress Disorder Teams in each of the VA medical regions; and

* the creation of a VA Task Force on Sexual Trauma in Women Veterans to provide input and advice on responding aggressively to women's health care needs.

Mr. Chairman, medical services available and provided to women veterans have also continued to expand in quantity and quality. Accomplishments in the area of the provision of medical services include:

* the creation of eight Women Veterans Comprehensive Health Centers developed to focus on the unique health care needs of women and which will provide a full range of services to include serving as a resource to other VA facilities in specific geographic areas;

* the hiring of 22 full-time Women Veterans Coordinators at selected VA medical centers and the evaluation of the need of converting other part-time positions to full-time Women Veterans Coordinators;

* the dictate that once in the system, women patients receive complete physical examinations to include breast and pelvic exams and the provision of a yearly pap smear; and

* a large and varied number of different type training and education programs addressed at meeting the needs of women veterans seeking VA health care services.

Mr. Chairman, during September 1993, VA published and disseminated to the field the publication, "Women Veterans Health Programs: Women Veterans Health Care Guidelines." This publication is, in our view, long overdue. Importantly, it provides valuable and much needed information for not only VA health care providers and managers, but more importantly, for women veterans who are either using or considering using the VA health care system to meet their health care needs.

Mr. Chairman, this publication covers areas dealing with medical care for women encompassing both gender specific and general medical care issues such as primary care, gender specific care, medical equipment and supplies, quality assurance, education and training, and a checklist for women veterans' program guidelines for physical examinations.

Additionally, there is information concerning accommodations, privacy issues, clothing, personal hygiene products, canteen services, recreation, exercise and social activity that women patients are interested in. Finally, there is discussion regarding the issue of attitudes and sensitivity to women veterans' special needs as well as discussion on the imperatives of conducting outreach to women veterans.

Mr. Chairman, on the last point of outreach, we are concerned with the apparent prevailing perception that some women apparently hold they are not, in the true sense of the word, veterans. In our view, every effort must be made to dissuade such feelings and, to the contrary, instill the belief in all women veterans they certainly are and deserve to consider themselves veterans and most assuredly are on an equal plane with their male veteran counterparts. In this respect, we are hopeful that an aggressive outreach effort will not only be recognized but made to reach those women veterans entitled or potentially entitled to the many benefits and services offered by VA and who are not now availing themselves of such services or have left the system for various reasons.

At this point, Mr. Chairman, DAV would commend Secretary of Veterans Affairs, Jesse Brown, for his recent action in establishing the position of Women Veterans Program Coordinator at VA Central Office. This action is long overdue.

Ms. Joan Furey, recently appointed to that position, is a nationally recognized expert in the area of women's health care and, specifically the area of counseling and treatment of women veterans experiencing PTSD and/or sexual trauma.

Mr. Chairman, another vitally important attribute Ms. Furey brings to this position is her nationally recognized and acclaimed posture as an outspoken and effective advocate for veterans. Ms. Furey is an old friend of the DAV and it gives us great pleasure to welcome her to her new position, wish her the best of luck and, pledge to her and Secretary Brown, DAV's assistance, in any way possible, to make their goal of providing quality, timely and compassionate medical care services to women veterans a reality.

Mr. Chairman, as a continuation of the DAV's deep concern about the unique problems facing women veterans, the DAV will be

hosting a women veterans' health care forum at our National Service and Legislative Headquarters scheduled for May 25, 1994. The main purpose of this forum, which is being designed by a special DAV Women Veterans' Advisory Committee, is to bring top executives and legislative branch officials face to face with women veterans to develop short and long-term solutions to a variety of problems affecting VA's delivery of health care services to this growing segment of the veteran population. The DAV Women Veterans' Advisory Committee has met to discuss the general issues of interest that need to be addressed and a tentative process to develop a consensus building process to proactively address these issues. I am appending to my statement a list of the Advisory Committee.

The Committee felt it desirable to confine the one-day forum to the broad issue of women's health care. Some of the concerns identified that need to be addressed include:

* sensitivity to gender-specific needs;
* uniformity of quality service delivery;
* standard common evaluation of services rendered;
* visibility campaign, outreach;
* validation of female veteran value; and
* systemic behavioral modification.

Mr. Chairman, the DAV Advisory Committee has identified specific issues impacting women veterans in their quest to receive timely, quality and compassionate healthcare from VA. Some of these include:

* access to care;
* quality of care;
* safety issues;
* privacy issues;
* sexual trauma intervention; and
* post-traumatic stress disorder.

Mr. Chairman, it is our every intention to conduct the forum in a very proactive, action-oriented manner. Said another way, this forum will be one of participation. All attendees will be requested to come to the forum prepared to discuss, in a work group setting, specific predetermined interests of concern.

The work groups will "brainstorm" the issue toward the goal of reaching consensual agreement as to the necessary and desired action steps required to proactively address the issue toward a goal-oriented outcome.

Mr. Chairman, we are excited about the opportunity the forum will present to bring together those individuals recognized as experts in the field of women's health care. We anticipate the participants to consist of individuals from the VA Central Office, the Department of Defense, the Department of Labor, VA Medical Centers, staff from the Veterans' Affairs Committees, and other interested Hill staff, the various veterans' service organizations, women advocacy groups, and, of course, women veterans.

It is our belief and desire that by bringing together such a divergent group of individuals committed to active participation and discussion of the issues that we will be able to develop a proactive agenda with desired solutions and outcomes that will, in the end, benefit the way health care services are provided to eligible women veterans.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you or members of the Subcommittee may have.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Linda S. Schwartz, RN, MSN
Chair, VVA Veterans Affairs Committee
& Special Committee on Women Veterans

Before The

House Veterans' Affairs Subcommittee On
Oversight and Investigations

On

VA Programs for Women Veterans

March 9, 1994

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Introduction

Good morning Mr. Chairman, my name is Linda Schwartz. I am medically retired from the U.S. Air Force. I use VA services and I am the Chair of the Vietnam Veterans of America's (VVA) Veterans Affairs Committee, as well as the Special Committee on Women Veterans. I am pleased to have the opportunity to speak to you about the status of VA services for women veterans.

There is no doubt that there have been many improvements on the part of the Department of Veterans Affairs in this arena. The most recent and most promising is the appointment of Joan Furey, RN, MSN, as the Director of the Office of Women Veteran Programs. We see that Secretary Brown has taken decisive action in creating this new office and we applaud his selection of Joan Furey as its first Director. We know Joan to be a tireless and committed advocate for women veterans. VVA looks forward to working with her as this new initiative to serve women evolves.

Pending Legislation -- H.R. 3313 & S. 1030

We also see that many of the provisions of the pending legislation H.R. 3313 & S. 1030, which would fund Women Veteran Coordinators, extend the period for treatment for veterans who are victims of sexual trauma and augment present VA health care services for women veterans, would be tangible benchmarks for the improvement and equalization of VA services for women. Because many of these changes have been a major part of VVA's legislative agenda for the past twelve years, we look forward to the enactment of these measures.

At the same time we understand that members of the Senate have intentions of using veterans health care legislation as a test for the question of federally funded abortions. We think it is important to state for the record that not one single woman veteran that we know of has made abortion an issue. It is sad to note that VA's authority to counsel veterans who are victims of sexual trauma was in danger of being discontinued because the Senate has failed to pass the aforementioned legislation.

Veterans health care is no place to decide the battle on abortion. When much needed authorization for adequate care of women veterans is held hostage because of concern for this question, we want to know where these Senators were when women veterans were not receiving adequate physical exams? Where were these advocates of women's rights when women veterans were dying of cancer at twice the rate of civilian women, in need of substance abuse programs and homeless with their children on the streets of America? Why must veterans take the point on this issue?

VVA strongly urges the House and Senate to pass these bills, which will greatly enhance VA's ability to provide much needed health care services to women veterans -- exclusive of the controversial abortion issue.

Homeless Women Veterans

As the numbers of homeless increase, the special needs of women veterans especially those with children are also on the rise. VA domiciliaries and traditional shelters and housing programs are often unable to accommodate the special needs these situations require. VVA supports the idea that the concept of mass housing and shelters needs to be reexamined. Not only do these forms of housing exclude a certain portion of the veteran population, they seem to create a cycle which perpetuates itself.

Not unlike male veterans, homeless women veterans often are in need of much more than a roof over their heads. Having participated in the recent VA Summit on Homeless Veterans, there are many creative new approaches aimed at alleviating the problems of the homeless by providing a holistic "continuum of care" which begins

with treatment for substance abuse and progresses to job placement or educational opportunities. Experience has shown that women veterans often become homeless because they flee abusive situations. Many are battered women with children which requires special considerations. Once again identification of women veterans in the homeless population is the first and most important step to providing assistance. It has been suggested that simply asking "Did you ever serve in the military?" on intake forms for homeless services and agencies would be invaluable in identifying veterans outside the VA service programs.

H.R. 3013

Although Secretary Brown has taken the initiative to create an Office of Women Veterans Programs, VVA believes that the provisions of H.R. 3013 are still warranted. We want to thank Congresswoman Waters and many members of this Committee including you, Mr. Chairman, for your thoughtful assessment of the need to legislate and solidify a permanent program within the VA. This legislation will ensure accountability for quality of care, adequate privacy and resources for the growing population of women veterans. This is an idea who's time has come and the need is now.

VVA sees this as crucial because of the past performance and neglect by the VA in implementing services authorized and funded by Congress. Years of failure to correct deficiencies noted by the General Accounting Office (GAO) in 1992, and the pervasive practice of the VA to ignore legitimate complaints voiced by women veterans must come to an end if VA is to be competitive in the new health care environment.

Because VVA has been at the forefront in seeking reforms of VA's accommodation of women veterans, we are well acquainted with the trail of broken promises and systematic efforts to overlook and minimize their needs. It is important to state that this history of neglect is no reflection on Secretary Brown. However the performance of previous Administrations have taught us the realities of politics and care for veterans. We would be derelict in our advocacy if we did not insist on legislative authority to ensure that never again will women veterans have to beg for complete physical examinations, adequate privacy or recognition of their service to this nation.

In particular, we call your attention to several congressional actions which were aimed at correcting problems encountered by women who sought help from the VA. Although these programs were authorized and funded by Congress, the bureaucracy of VA administrators stonewalled and stymied the implementation of these measures. For example in 1982, Congress directed the VA to include women veterans in all VA health research studies. While this was designed to equalize the VA research agenda, this protocol has yet to be implemented.

Another glowing disparity has been the poor support of the VA Advisory Committee on Women Veterans. When this body was created by Congress in 1983, many believed their activities and charge to report directly to Congress would be sufficient oversight of VA programs. However, this Committee created by Congress did not meet for an entire 18 month period because of "lack of funding". This was particularly dismal given the fact that at the same time, other non-statutory advisory committees were fully funded for quarterly meetings. If the Advisory Committee is to really accomplish the important work Congress intended, there needs to be adequate resources, "fenced funds", more support and more meetings.

In a recent meeting convened by Assistant Secretary for Policy and Planning Victor P. Raymond, women veterans agreed that the Women Veterans Advisory Committee needed to hold hearings in several key cities to see first-hand how programs and services are being delivered to women veterans. This would be a giant step and a realistic approach to assessing the effectiveness of the present system of care. It would also provide a pragmatic means of identifying substantive needs for

change or additional services. By taking the Committee to the women veterans in their own communities, there are many excellent opportunities to garner media interest and public understanding of VA's commitment to serve women veterans. Such interest and understanding would facilitate the much needed outreach and enhance VA's image.

Yet another instance of the need to codify a program is the 1986 legislation which called for and funded a study of the health effects of herbicides on women who served in Vietnam. The authorization of this study was for some time a flicker of hope to these women as they tried to make sense of their multiple miscarriages, infertility and deformed children. They had many questions about their own health status and the early deaths of women they served with, which they thought would be answered by such a study. It is now 1994 -- there are no answers, there is no study. We ask how can the VA fail to carry out a law enacted by Congress?

Even more outrageous is the failure of the VA to follow the mandates of Public Law 102-218, which created the position of the Chief Minority Affairs Officer. This Officer was directed to assess the needs, investigate policies and study the impact of the VA system with regard to minorities including women. For months this position was unfilled. Even people at the VA weren't sure who or what was supposed to be in charge of programs for women.

Troubling, too, is the fact that a "Survey of Vietnam-Era and Disabled Veterans" is to be conducted by the Department of Labor every two years in accordance with provisions of Title 38, of the United States Code. Presently, this survey does not include women. Given the fact that these veterans constitute the fastest growing subset of the population and there is evidence from other sources to suggest that unemployment is a problem for women veterans, such an omission needs to be corrected as soon as possible.

Thought should also be given to legislating the inclusion of post-Vietnam Era veterans in this survey. Without a doubt the growing numbers of unemployed and displaced workers and the downsizing of America's military force warrant close monitoring in these troubled times. Employment and job placement is becoming the most important concern for veterans. For example in my own state of Connecticut it is estimated that 40-50 percent of our unemployed are veterans. In a time when Veterans Preference is only given "lip service" even in federal jobs, we need to adequately assess the needs of all veterans and allocate resources accordingly.

The discrepancies noted in these examples are not limited to a single structural unit of the VA or even a single Cabinet level agency. Services to women veterans which were authorized by Congress in the name of the American people have not been delivered. It is time that the years of neglect, bureaucratic inertia and excuses come to an end. Congress needs to ensure that laws are enforced at every level of the Department. In order to be serious about programs for women veterans now and in the future, the Director tasked with oversight, policy development and investigative powers must have the tools and the clout to adequately address these responsibilities.

It is important to stress that the provisions of H.R. 3013, to have the Director of the proposed Bureau report directly to the Secretary and progress of the program be reported to Congress is imperative. As we have noted in this testimony, the programs and problems of delivering services to women veterans are complex. In addition to empowering the Director, this access to the Secretary and reporting requirement would send a clear message that Congress will no longer tolerate indifference and disregard for the implementation of programs legislated to improve care of women veterans.

Congresswoman Waters' legislation would strengthen the existing Office. We are all aware that future Administrations may not place the same priority on this issue as the present Secretary. VVA believes that the report by the Congressional Budget Office indicating that there are no budget implications for this legislation is

even more evidence that the provisions of H.R. 3013 are a cost-effective means of ensuring the accountability, visibility and efficiency needed to improve and maintain quality services to women veterans.

Women Veterans Health Study

As the nation prepares for major reforms of our heath care delivery systems the importance of pragmatic and systematic assessment and planning for the future becomes self evident. As we look to the role of the VA in the 21st century, the need to conduct a major study on the health of women veterans is unquestionable, given the estimated cost and benefits of such a venture.

We suggest that a cost-effective approach for the future must include collaborative efforts with other agencies like the National Institutes of Health. In the years we have debated the pros and cons of a health study of women veterans, other studies on women have been conducted or concluded. Once again, VVA supports the concept of developing a schedule of questions about military service which could be part of any further studies by major agencies. This approach could provide information on significant differences in health problems of women veterans when compared with women who did not serve. This information could assist in future planning and development of programs within VA, which would better guide the allocation of resources within the Department.

Summary

Throughout its history the Department of Veterans Affairs has struggled with the question of care for women veterans. As the number of women serving on active duty continues to increase, the need to provide adequate care for these future veterans is no longer an issue of knee-jerk response to complaints. There are those within the veterans community who have publicly voiced opposition to any legislated programs for women veterans. The notion that the services in the aforementioned pending legislation are discriminatory to male veterans betrays the discrimination women veterans have suffered for years.

We are heartened by the actions Secretary Brown has taken to help women veterans and homeless veterans. But at the same time we cannot forget the lessons of the past. There is a need to strengthen the present Office of Women Veteran Programs to ensure there will be enough power to do the job. Because federal programs to assist women veterans are not limited to VA, the concept of creating a Bureau is pragmatic and much needed. Programs designed to help women veterans are all underused. Much like the men, there is a critical need that providers of services to veterans work together to maximize the utilization of resources presently allocated for veterans on local, state and national levels.

As the Department of Veterans Affairs prepares for major changes in the nation's health care system, the need to upgrade and standardize care for women is no longer a luxury. If VA is to be competitive in this new environment, it must be able to provide privacy and care for the gender-specific needs of women. Equally important is the concept that planning and development of VA programs will have to be determined by hard numbers and real facts if it is to survive. The days of rhetoric are coming to an end.

VVA has long been the champion for women veterans. As we move into a new era of health care in America, the problems of a new generation of women veterans will present even more challenges to the system. Regardless of period of service, VVA intends to remain true to our founding principle that "Never again will one generation of veterans abandon another." VVA will always be a voice and a reminder that women who serve the nation are entitled to honor, equality and recognition.

Mr. Chairman, this concludes my statement.

STATEMENT OF

TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE DEPARTMENT OF VETERANS AFFAIRS

RECENT ACTIONS TO IMPROVE THE PROVISION OF HEALTH CARE TO

WOMEN VETERANS AND RELATED ISSUES

MARCH 9, 1994

Mr. Chairman and Members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), it is an honor to participate in today's hearing. PVA appreciates this opportunity to present our views and concerns regarding the Department of Veterans Affairs (VA) recent actions to improve the provision of health care to women veterans and related issues. PVA represents more than 300 women veterans, all of whom have spinal cord injury or disease. We consider the fulfillment of their health care needs for gender-specific services, spinal cord medicine and other services of paramount importance.

There has been a significant increase in the number of women serving in the United States Armed Forces; correspondingly there has been a substantial increase in the number of women veterans. The 1990 census identified 1.2 million women veterans, comprising 4.5% of the veteran population. The dramatic increase in women veterans presents the VA with an unparalleled challenge to meet the specialized health care needs of women veterans in what has historically been a male-oriented health care system. In addition, the VA faces the imminent challenge of national health-care reform which could have a profound effect on the structure of and services within the VA system. If the VA is to compete

successfully in a reformed health care system, VA health care facilities must be equipped and prepared to afford women veterans, as well as the dependents of veterans who may soon be eligible for VA medical care beneficiaries, comprehensive health care services; otherwise the VA stands the real risk of losing a substantial portion of its market share to other health care providers. It is incumbent upon the VA to provide eligible women veterans and dependents timely, appropriate gender-specific health care services.

Women Veteran's Health Care Initiatives

The VA's track record for providing women veterans gender-specific health care is not impressive. The health care services afforded to women veterans are sporadic and inconsistent, with few exceptions, throughout the VA system. According to a recent investigation of the Inspector General (IG) of the VA, many VA facilities were found to be deficient in providing certain gender-specific services. For example, of the 166 facilities surveyed 75 offered no on-site women's health care clinics. In addition, the IG visited eight facilities and found the following: two opened their women's health clinics every other week for merely four hours; five facilities offered gynecological care on a contract basis; and only two facilities had rape kits and obstetrical kits. Moreover, the U.S. General Accounting Office (GAO) has found that physical examinations, including cancer screening for women veterans, continue to be sporadic.

Even with these problems, VA is taking some positive steps in improving women's health care. More hospitals are designating women veterans' coordinators. VA has established four additional sites for Women's Comprehensive Health Care, bringing its total number to eight. Compliance with privacy standards is improving. All medical center pharmacies carry contraceptives and hormone replacement therapies even though limited access to providers who can prescribe them may still make them difficult to obtain. All VA

medical centers should now have in place sexual trauma teams to offer counselling to any veteran who is sexually harassed or attacked while on active duty.

The passage of H.R. 3313 (Veterans Health Improvements Act of 1993) would amend title 38 and begin to eliminate the inequitable distribution of VA health care services to women veterans. Although women represent 4.5% of the veterans population they make up only 2.4% of all VA discharges. The portion of women veterans seeking health care that are service-connected is higher for women than men, suggesting that women are more likely to seek care in VA if they have a high priority status for care. Why aren't women veterans seeking health care at the same rate as their male counterparts? The reasons are multiple: first, women are unaware of the VA services available to them; second, eligibility status is even more confounded for female than for male veterans; third, women perceive the system as one oriented solely towards the needs of men; and, finally, VA has not done enough outreach to women veterans to inform them of their eligibility and of the services they now provide.

The above reasons have seriously curtailed the growth and demand for women health care services within the VA. Women who were previously only able to get a Pap smear at VA and had to get contraceptives elsewhere were alienated from the system. This problem and some others have been solved. Women need to be informed that these services are now available to them. Should H.R. 3313 be enacted, women veterans will finally have an opportunity to seek the fuller continuum of care through VA-care that they can typically receive through most private insurers, DoD, or Medicaid today. Unlike these other payers, however, VA will still not offer prenatal, obstetrical care or fertility services.

Despite having served in the military, women were not given "veteran" status until 1948. This belated recognition of women as veterans has ramifications for women's awareness of eligibility for health care services even today. Many women do not recognize themselves as veterans, as the 1985 Survey of Female Veterans demonstrated. This type of unawareness suggests that far more outreach needs to be done to inform eligible women veterans of their benefits. For example, the women veterans program at the Minneapolis VA medical center, one of the eight Women's Comprehensive Care Centers around the nation, found that its database of women patients tripled when it began a serious outreach effort to inform and demonstrate to the state's women veterans that the outstanding Minneapolis program was dedicated to providing high-quality in-house women's health care services. Other VA medical centers have had similar experiences. Jumps in workloads, such as Minneapolis', are indicative that there is a great deal of suppressed demand for services within the women veterans' community.

A designated women veterans' coordinator for each VA medical center (especially those designated as medical/surgical facilities) would undoubtedly help VA develop its women's patient base and help to guide service delivery and enhancement to best meet the needs of women veterans. Outreach is an essential part of developing effective women's health care services.

Outreach efforts will help VA medical centers identify women's need for services—information that is critical to VA managers in deciding how best to provide women's services. Need at most VA medical centers is greatly suppressed. Basing an assessment on women's current utilization of VA services is likely to result in a grave underestimate of actual need. VA must first make the effort to educate women veterans about their benefits before deciding that women simply do not use VA services enough to warrant the purchase of equipment or the enhanced availability of women's clinics. This argument of lack of demand, which VA continues to

use, is circular. Women will not come to a service that is not accessible and cannot fulfill their needs. Women will not come to a service they believe they lack eligibility for or that they are not aware exists. VA medical centers must make concerted efforts to examine actual need among women veterans in their service areas before they justify not providing in-house services.

If outreach efforts are not fruitful, VA can justify providing services through sharing or fee-based arrangements. PVA is not in favor of having services open which do not have the capacity to justify them. Underutilized facilities often render lower quality care because staff lose the skills busier providers are able to retain. It is quite possible, however, that outreach efforts will bring enough women veterans into the system to justify increasing in-house service delivery. Outreach and interim "information and referral" services would warrant the designation of a full-time women veterans coordinator at medical centers with or without a women's clinic.

Identification of potential users and outreach are essential to VA's strategic planning for the future anyway. Health care reform may change VA's benefits package as well as its beneficiary population. Veterans' dependents may be eligible for care in the system which has the potential of increasing the need for women's health care delivered or paid for by the VA. The effects of health care reform will also have to be considered before VA medical centers can accurately project how many eligible women beneficiaries it will serve.

Effective women veterans' coordinators can make the system a more welcoming place for women. Women veterans are often alienated by what they perceive as a male-oriented organization. An accessible advocate that can channel women to the appropriate care providers—whether inside or outside of VA—can do wonders to improve the image of a health care organization for any patient. PVA

conducted a series of focus groups which included women veterans who had never used the VA medical care system and women that had used the system in the past as well as a variety of men's groups. The idea of a case-manager—whether a physician, a mid-level health professional or another individual—had universal appeal for veterans in all of the groups examined. A recognizable ally would help many women veterans get over the fear of entering a system they associate as being exclusively for men.

Women veterans' coordinators can implement and monitor privacy standards. Many VA facilities are still having problems accommodating women on wards. Through past Congressional testimony we heard of a sexually abused woman veteran who was put on an all-male psychiatric ward where she was clothed in just a hospital gown. Another woman veteran we've spoken to claimed that her nurses had to make a painstaking search each morning to locate a small man's gown for her. Private bathrooms remain a problem for many VA facilities. Many wards have a shared bathroom. When a woman is placed on the ward, she is likely to have her use of the bathroom facilities limited to certain hours. This inconveniences male veterans as well. Creating private clinic space in outpatient clinics presents yet another challenge for VA. Most VA medical care centers' space available for women's clinics is severely curtailed.

For all of the above reasons, women veterans' coordinators are, in short, essential to the success of VA's provision of health care. There are presently eighteen full-time women veterans coordinators around the nation. VA plans on adding four more. Other VA medical centers have designated women veterans coordinators, but often they share this responsibility with the responsibilities of another full-time position. This is the case at least one major city's VA medical center where the women veterans' coordinator is also the head nurse on a busy hospital ward! PVA staff reached this industrious lady after no less than six phone calls. VA

telephone operators were not aware of how or where to route the call. Most women veterans who may already have poor perceptions of VA medical care (as the Survey of Female Veterans indicates one-third do) would not be so persistent. PVA and other veterans service organizations co-authoring the *Independent Budget* recommended 50 additional full-time women veterans coordinators for the VA medical system.

The success of a women veterans' coordinator is highly dependent on the support that individual is given by the leadership of the organization. Women veterans' coordinators should be demonstrably involved in the establishment of policy for each individual medical center. The position should be given high-visibility in the organization, such as appointments to organization-wide committees and task forces. The position's functions should be well understood by even the lowest level clerk so that the coordinator is as accessible as possible. Signs should also be placed in high-traffic areas of all medical facilities to ensure that women know that a coordinator is available to them, either in that facility or in the facility nearest to them with a coordinator. Facilities with successful womens' programs, such as Minneapolis VA medical center's program, also make an effort to see each woman admitted into the facility to ensure that she is receiving the appropriate treatment and her needs are being met.

We are concerned about other aspects of health care delivery and research on women's health as well. The last three *Independent Budgets* have documented our concern for VA's research into lifetime cancer prevalence in women veterans, which the Survey of Female Veterans showed to be twice as high as that of the general population. Research into women veterans' gender-specific issues has not been a high priority. The *Independent Budget* has recommended research into women's issues receive $4 million in FY 1995.

The climate seems ripe to make significant improvements in health care delivery to all veterans. Meaningful debate about health care reform has spurred both women and veterans' health advocates to action. VA has an important and continuing role to play in the provision of health care, research and education in the nation's health care system. Women are a growing part of VA's patient base. To ignore them would be to spurn a meaningful strategic plan for VA's future. Women, a long neglected group even among veterans, should be among the first share in the benefits from our new resolve to create a better health care system for all veterans.

Mr. Chairman that concludes my testimony. I will be happy to answer any questions that I can.

STATEMENT OF

DENNIS CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

PROVISION OF HEALTH CARE TO WOMEN BY VA

WASHINGTON, D.C. MARCH 9, 1994

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars of the United States, I wish to thank you for inviting our participation in today's important hearing addressing the issue of the provision of health care to women veterans by the Department of Veterans Affairs. I would also take this opportunity to thank and congratulate you on behalf of the VFW's entire membership for your continuing efforts and concern on behalf of all of America's veterans through the diligent functioning of this subcommittee.

Mr. Chairman, the testimony today centers around examining the benefits and services provided to women veterans by VA. We are also looking at how successful efforts have been to increase the level of women veteran's program participation. The VFW appreciates the increased responsiveness exhibited by the VA and the resultant increase in female veteran utilization of VA services.

The Women Veterans Advisory Committee was originally established in 1983 to advise VA on meeting the special needs of women veterans. It was then apparent that many inadequacies existed in providing medical care for women veterans in VA clinics and hospitals. As a combined result of the male oriented VA hospital system and a general lack of benefit awareness, many women veterans were not utilizing VA benefits and services. The Women Veterans Advisory Committee moved swiftly to address the inequal-

ities that existed in the VA system. It also served to heighten public awareness of women veterans and that they are entitled to the same rights and privileges enjoyed by male veterans.

It is unnecessary to cite the many issues addressed, nor is it necessary to list the numerous recommendations made by this committee; the overall accomplishments speak for themselves. As a result of their concerted efforts, the Women Veterans Advisory Committee working together with VA, women veterans are no longer a totally forgotten group within VA even though much remains to be done. This continued and combined effort can only serve to further improve and upgrade the care and treatment provided all veterans.

The VFW is pleased to note that the Department of Veterans Affairs is now providing health care clinics for women and that mammography services are available in most major VA medical centers. VA has also continued to compile data on women veterans which should prove useful in providing enhanced services to this deserving and long neglected segment of the veteran population. Additionally, it would seem that the privacy issue is at last being addressed within VA. While there has not been a large increase in women veterans utilizing VA, the numbers are nonetheless still on the rise. Continued efforts to assure women that they will receive not only proper medical care, but appropriate consideration with respect to their particular needs will certainly assist in truly opening up the VA health care system to these veterans. Mr. Chairman, the term "veteran" applies to all former members of the Armed Forces regardless of gender. Now that VA is acting upon this fact through both word and deed, the VA health care system is becoming steadily more available to women veterans. Fair and equal treatment is not just a good idea--it is a mandate.

Mr. Chairman, this concludes my statement. Once again, thank you for including the VFW in today's important hearing. I would be happy to respond to any questions you may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

MARCH 9, 1994

QUESTIONS FOR THE HONORABLE STEPHEN A. TRODDEN
INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

1. **What additional resources are needed to provide effective oversight of VA facility compliance with VA directives on the provision of health care services to women veterans?**

The Veterans Health Administration (VHA) has a full-time National Women Veterans Coordinator (WVC) who reports to the Assistant Chief Medical Director for Environmental Medicine and Public Health. VHA also has established four full-time WVC positions in its Region offices. The Office of the Assistant Secretary for Policy and Planning has also created a full-time position of Executive Director for Women Veterans Programs. This person reports directly to the Assistant Secretary. Additionally, two full-time employees have been added to the Southeastern Regional Medical Education Center in Birmingham, Alabama to develop and coordinate a Women Veterans National Training Program. This staff commitment is greater than it has ever been before. We believe these centrally-directed positions, in conjunction with the eight recently established centers of excellence in women's health care, are adequate to initiate and oversee the development of Women Veterans Treatment Programs throughout the country. However, we are concerned that as the VHA organization evolves from 4 regions to 16 veterans service areas, the four Region-based WVCs might be lost.

2. **Last year the Office of Inspector General called on the highest levels of VHA management to provide better leadership for improved women veterans health care.**

   Describe the actions taken by the highest levels of VHA management to demonstrate stronger leadership for the provision of adequate treatment for women veteran patients since the OIG recommendation and describe the impact(s) of these actions.

   What further actions can be taken by the highest levels of VHA management to improve women veterans health care?

Since last year the Under Secretary for Health through the Office of the Assistant Chief Medical Director for Environmental Medicine and Public Health has established the WVC positions discussed above. The Under Secretary has also established eight centers for excellence for women's health care around the country. These centers are regional referral resources which smaller medical centers can use for consultation and specialized treatment of patients with gender-related illnesses. Our Inspection report entitled "Inspection of Women Veterans Health Care Programs, Privacy Issues--Part II," dated March 4, 1994 (Report Number: 4HI-A19-042) showed that while VA managers have

considerable work yet to do to make VA medical centers hospitable places for women patients to receive comprehensive treatment services, they have made some progress in attempting to ensure the availability of adequate services for women. My Office of Healthcare Inspections plans to conduct further inspections of women veterans health care issues over the next 2 to 3 years. These inspections will evaluate VHA's management of mammography and PAP smear examinations, and the effectiveness of the women's centers of excellence. We will continue to keep you apprised of the findings in these inspections.

MS. KAY DENNIS ♦ 1800 ATRIUM PKWY ♦ APT. #341 ♦ NAPA, CA 94559

ANSWERS TO QUESTIONS ON VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

ANSWERS TO
QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERAN'S AFFAIRS

VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

MARCH 9, 1994

BY MS. KAY DENNIS
NAPA, CALIFORNIA

I. What past efforts to make women more aware of their veterans benefits have been successful and should be repeated?

The most successful program in California for identifying women veterans and making them aware of their veteran status and their eligibility for veterans benefits was the appointment of the seven member State Commission on Women Veterans. This committee was funded for only three years because of state budget deficits, but in that time it accomplished the following:

A. Held ten public hearings in all parts of the state which were well attended and full of good information.

B. The individual commission members met with many smaller women veterans groups in order to develop a network of informed women veterans of all wars which could continue to identify women veterans and make them aware of the benefits they have earned.

C. Developed a questionnaire, thousands of copies of which were distributed throughout the state by every means possible including all veterans groups, VA mailing lists, County Veterans Service Offices, Women Veteran Coordinators in VA Hospitals and Medical clinics, and the California State Employment Development Department which was particularly helpful in this project.

A total of 2,130 forms were completed, returned and tallied. It was most surprising to find that a significant number of the respondents did not consider themselves veterans because they had not been wounded, had not been overseas, did not serve in time of war, etc. Also we found that some had applied for one or more of their benefits but had been told they were not eligible in such a rude manner that they left and never returned.

NOTE: In many cases a significant problem seems to be the word "VETERAN". This is a problem nationwide, according to Admiral Francis Shea-Buckley, U.S.N. (Ret.), a member of the V.A. Advisory Committee on Women Veterans. If the woman is asked "Are you a veteran?" She will very often answer "No". If the question however is: "Have you ever been in the military service?" She will say "yes".

It should also be pointed out that women who are not aware of their other veterans benefits almost all know they are entitled to educational benefits and a G.I. home loan.

MS. KAY DENNIS ♦ 1800 ATRIUM PKWY ♦ APT. #341 ♦ NAPA, CA 94559

ANSWERS TO QUESTIONS ON VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

II. What new efforts to make women more aware of their veterans benefits should be tried?

A. Before service personnel are discharged each branch of the service should be certain that every discharged veteran in its jurisdiction is thoroughly briefed on his or her rights and benefits and a brochure summarizing this information should be provided each veteran.

B. A permanent commission on Women Veterans should be appointed in every state. Its purpose should be to make sure that all women veterans are identified, that they are informed about the veterans benefits they have earned, and that the benefits are actually being provided.

C. The work that the California State Commission on Women Veterans did was a wonderful beginning but it was just that, only a beginning. There are so many problems that are just now being recognized as applying to women veterans as well as men: I.E. PTSD (post traumatic stress disorder), homelessness, substance abuse, agent orange, etc.

D. The Women Veteran Coordinators in the VA hospitals and the State Commission on Women Veterans together can be powerful sources of help in identifying women Veterans and creating and maintaining programs that will effectively help them.

III. Do you believe that the responsibilities of a Women Veterans Coordinator can be accomplished in five hours a week? What is the minimum number of hours per week a Women Veterans Coordinator should have to accomplish these responsibilities?

A. In order to answer this question fairly and accurately, I called the Women Veterans Coordinator that I talked to in preparation for my appearance before the committee on March 9th. I asked her to send me her thoughts on this question and if possible to consult with other WVCs for their input. I intended to use this information as a source for my answer to this question.

Her reply <u>IS</u> my answer. I will not change or delete one word because the dedication of these women to their jobs, to their hospitals and clinics, and most of all to the women veterans they want to serve, as well as their frustration at not having the time and support to do what they want to do, and should do, is so self-evident that any comments by me are superfluous.

Here is <u>their</u> answer: Letter dated 4/19/94

Kay,

Sorry for the informality of this, but I do not have access to a typewriter or word processor.

I. To answer your question re. responsibilities of WVC (Women Veterans Coordinator): can the job be accomplished in 5 hrs per week?

The opinion of all WVC's I communicate with , as well as any staff associated with the Women's Programs, is a

MS. KAY DENNIS ♦ 1800 ATRIUM PKWY ♦ APT. #341 ♦ NAPA, CA 94559

definite NO. 5 hours/wk doesn't even scratch the surface.

If you read the VA's own Program Guide for Women Veterans Coordinator, you can easily see that the duties and responsibilities, and reporting requirements, cannot be carried out in only a few hours a week. These duties and responsibilities don't even begin to cover the intangible and often informal things that require the time of the WVC, for example, phone calls from patients, from other staff, from outside facilities, patients dropping in, etc.

The need to communicate with the WVC, or for intervention in certain situations, occurs at all times; thereby necessitating access to the WVC during all administrative hours, not just those few hours allotted. This makes it very difficult for both the patient and the WVC when the WVC's input is needed when she is performing her other job duties. Using myself as an example, when I have a heavy clinic day scheduled, I have no time to return phone calls from patients, or problem-solve issues of the facility at that time, Often, I must wait until my allocated administrative time (which is on Wednesdays) to return calls or do other things. Perfect example is this input you very appropriately asked me to provide. Try as I may, I could not squeeze any time in until today.

"Official duties of the WVC include:

- maintaining community networks to facilitate needs of women vets.
- assists with planning activities, therapies, and building modifications which reflect the needs of women vets.
- serves on hospital-wide committee to support women's programs.
- serves as liaison for women vets with the administration of the facility, region, and veterans organizations.
- Promotes public relations and outreach within the community.
- Provides education for staff members including students, interns, and volunteers, regarding the care of women vet patients.
- acts as patient advocate for women patients, both inpatients and outpatients.
- acts as consultant and ombudsman on issues pertaining to women veterans health care.

"OTHER SUGGESTED DUTIES INCLUDE"

- Case Coordination
  - Interviewing women patients.
  - Orienting patients to the facility, services available, and benefits.
  - Consultant to health care team.
  - Identify concerns and unmet needs of women patients and bring to attention of facility director.

- Program Coordination
  - Assures compliance of Women Vets Program with all VA policies and regulations.
  - Assists with planning activities, therapies, and building modification which reflect the needs of women patients
  - Develops a file of resources for women in the facilities and the community.
  - Coordinates women veterans activities in the facility.

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ANSWERS TO QUESTIONS ON VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

Develop and maintain working relationships with women veterans organizations and auxiliaries.
Collaborates with community agencies.
Serves on appropriate boards and committees

- Program Evaluation
  Monitors adequacy of rooms, privacy issues, clothing and personal needs.
  Canteen products.
  Evaluates satisfaction with care women receive.
  Quality assurance activities related to the level of care women patients receive.
  Keeps statistics on women patients

"OTHER RESPONSIBILITIES"

- In providing medical care to women, the WVC is involved in setting up Women Veteran Clinics - she often is a direct care provider for women, as well as having the duties of the WVC.

- She also is charged with setting up the Womens Veterans Primary Health Care Teams - she serves as chairman of the team. The team is supposed to meet regularly to manage the care of the female patients and to identify special concerns of female patients.

- The WVC's are also frequently sought as speakers, and to give inservices and employee orientation and training in the care of female patients. She also is supposed to have quarterly meetings with the facility director.

- Outreach needs - getting the word to patients as to the services available at the facility. Identifying groups of patients not currently receiving services that are available.

II. The minimum hours per week needed to accomplish all of the duties - MUST BE 40 HOURS PER WEEK! THIS IS A FULL TIME JOB!

A. Time Issues:
- A major problem: When the WVC is a "Collateral Duty Assignment" (meaning, she has WVC duties as only part of her job) she can not do full justice to the role of the WVC. The allotted administration time is often taken up - ie, she is given other duties to do during that time; for example, staffing shortages will necessitate her being assigned other duties by her supervisor during her administrative time.

B. Paper work and reports:
- Va Central Office requires the WVC to keep numerous statistics and do numerous reports on Women's Program Issues.
- Clinical data tracking, such as PAP smear results and follow-up is ongoing.
- Minutes of the various meetings

C. Direct Clinical Issues:
- Scheduling and notifying patients of abnormal results and tests.
- Referrals to other VA's for services needed
- fee basis for services not available.
- helping patients sort out eligibility issues.

MS. KAY DENNIS ♦ 1800 ATRIUM PKWY ♦ APT. #341 ♦ NAPA, CA 94559

D. equipment:
- Keeping track of equipment needs
- requesting and submitting paperwork for equipment
- obtaining, pricing, and vendor information for needed items.

E. Education:
- Obtaining educational materials for patients
- Setting up educational programs for patients
- setting up training and educational programs for staff and providers.

F. Communication:
- Communicating to the facility administration the needs of the program.
- Communicating and networking with other VA's

The 5 hours allotted time for WVC's is eaten up immediately by just one or 2 of the activities mentioned in the previous pages. This is a labor intensive, complex, and comprehensive job. It cannot be accomplished, and the duties it was intended to serve cannot be effectively done, in anything less than a full time 40/hr week capacity.

Hope this helps.

April 19, 1994

U.S. House Of Representatives
Committee On Veterans' Affairs
335 Cannon House Building
Washington, DC 20515

Dear Congressman Lane:

This is in response to your request dated March 17, 1994. The State Of Ohio Governor's Advisory Committee on Women Veterans is pleased to provide these additional comments and recommendations to the Subcommittee on Oversight and Investigations as a follow-up to committee member Mary Jean Reed's testimony of March 9, 1994.

1.(a) What past efforts to make women more aware of their veterans benefits have been successful and should be repeated?

The VA Advisory Committee on Women Veterans has been very influential in providing an independent and objective review of Department Of Veterans Affairs programs and services and how they impact on women veterans. This committee was established by P.L. 98-160 in November 1983. The VA Advisory Committee on Women Veterans should continue and must receive adequate funding to carry out its mission. This committee has been the driving force behind improving the treatment of women veterans at Department Of Veterans Affairs Medical Facilities. It has also been instrumental in advocating outreach efforts to make women veterans aware of the benefits they have earned.

(b) What new efforts to make women more aware of their veterans benefits should be tried?

Problem: Identifying and locating women veterans.

Recommendations:

1. Department Of Veterans Affairs be required to maintain a computer registry of ALL veterans.

2. The Department Of Defense be required to provide this information to the Department Of Veterans Affairs upon discharge of service member via whatever mechanism these Departments deem to be most expedient.

3. State Offices Of Veterans Affairs and State Advisory Committees on Women Veterans be granted access to this information.

Problem: Employment Issues of Women Veterans are not adequately addressed by the Department Of Labor.

Recommendations:

1. Require the Department Of Labor to increase the number of women veterans in Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representative (LVER) positions. Give priority to BOTH disabled and women veterans for the LVER positions.

2. Require DVOPS and LVERS be sensitized to employment issues which affect women veterans through state and local training programs. Require all National Veterans Training Institute programs include a track on women veterans.

2.(a) Do you believe that the responsibilities of a Women Veterans Coordinator can be accomplished in five hours a week?

No.

(b) What is the minimum number of hours per week a Women Veterans Coordinator should have to accomplish these responsibilities?

Minimally, the position of Women Veterans Coordinator should be FULL-TIME and a coordinator should be assigned to each VA Medical Center. The coordinator should be a woman veteran. Ideally, each VA Medical Center and VA Outpatient Clinic would have a FULL-TIME Women Veterans Coordinator. A FULL-TIME Director for each region should be appointed to oversee coordinators. This Director should also be a woman veteran. Quarterly regional meetings should be held to assist coordinators in networking activities with the goal of improving services for women veterans.

The State Of Ohio Governor's Advisory Committee On Women Veterans commends your efforts on behalf of our nation's women veterans.

Sincerely,

Mary Jean Reed

Mary Jean Reed, for the
Governor's Advisory Committee Women Veterans
State Of Ohio

Department of VAMC
3495 Bailey Ave.
Buffalo, NY 14215
May 17, 1994

The Honorable Lane Evans
Chairman, Subcommittee on
Oversight and Investigations
U.S. House of Representatives
Committee on Veterans Affairs
325 Cannon House Office Building
Washington, D. C. 20515

Dear Mr. Evans:

In response to the questions asked in your March 17, 1994 letter, I offer the attached.

Thank you for providing me the opportunity to contribute to the information on VA Health Care for Women Veterans.

Sincerely yours,

Joanne Sulewski

Joanne Sulewski, MD
Chief, Gynecology Section
Department of Surgery

1. **Please elaborate on your statement that patients in need of care have been turned away by VA.**

There are two ways by which patients in need of health care are turned away by the VA.

First, there are limitations imposed by eligibility requirements. Separation physical examinations were not performed on some women in the military. It is impossible to determine if they are entitled to service related benefits.

Those who seek non-service related care are in a discretionary category. They undergo a means test in which the threshold income level is $23,000 and comprises both income and total assets. Particularly among the elderly, a small income or pension and a lifetime of basic assets may cause them to exceed that threshold and may result in denial of health care. Some turn to medicare which is less costly than the minimal cost for discretionary care available through the VA. Medicare has some limitations in contrast to services available through the VA (eg. low cost medications, densitometry for evaluation of osteoporosis and yearly PAP smears).

Some with mental disorders may exceed the $23,000 threshold but may be unable to be productive or manage their personal affairs. Their illness limits their ability to meet minimal financial, nutritional and social responsibilities. The VA is a leader among health care providers in counseling and psychiatric services but veterans cannot gain access to these benefits because of their income threshold.

Another means of limitation is through staff shortages. Access to outpatient clinics such as podiatry, dermatology, ophthalmology, gastrointestinal can exceed 3 months. When a physician leaves, dies or retires, patients have been referred to private physician care because the available staff cannot meet the demand. Replacements are not readily available and physicians frequently are replaced by non-physician health care providers.

An earlier (February 18, 1994) response by the Buffalo VAMC to the House Veterans Affairs Committee anticipated that the impact of FTEE controls would severely restrict operations. A reduction of 36.2 and 41.0 FTEE in FY-94 and FY-95, respectively was anticipated to reduce the number of inpatients by 500 and 400, and the number of outpatients by 5000 and 2000 in the respective years.

2. (a). **What past efforts to make women more aware of their veteran's benefits have been successful and should be repeated.**

Outreach efforts are necessary to make women aware of their veteran's benefits. A health fair is an example of an outreach effort. A total of 286 women veterans attended the health fairs of 1988 and 1989 at the Buffalo VAMC. At the second health fair, 74% were new attendees. Of the 286 women, 28% never received previous health care at a VAMC and 70% were found to have one or more abnormal laboratory results at the fair. Elevations of cholesterol (greater than 240 mg/dl), blood pressure (greater than 140 systolic or 90 diastolic) and glucose (greater than 120 mg/dl) were found respectively in 47%, 30% and 19% of the women. Anemia as determined by hematocrit (less than 37%) or ferritin levels (less than 20 mg/ml) was found respectively in 21% and 9% of the women.

Health fairs provide opportunities for almost all departments in the VA to become aware of the needs of women veterans and to reach out to them. While health fairs were successful, they have been discontinued at our VA because those in a discretionary category that attend, are billed for services for that day.
In contrast, other health care institutions within the community sponsor free health fairs for the public.

Receptions, usually event related, are another type of outreach. For example, the Buffalo VAMC held a reception in August 1991 for Women Veterans of the Persian Gulf War. Of the 35,000 women who served, approximately 500 are from western New York. The purpose of the reception was to honor the women and to inform them of the benefits, facilities and services available through the VAMC. Those who attended encouraged outreach efforts including securing invitations to reserve units.

During subsequent visits to three reserve units, servicewomen were made aware of Public Law 102-25, establishing the Persian Gulf War Period. Benefits and services available through the VA were explained to the women. At least seven other reserve units declined participation in the outreach visiting program.

Within one year at the Buffalo VAMC, the utilization rate by these women veterans approached 1:8, the utilization rate of all women veterans in Western New York; the number of servicewomen in the Persian Gulf Registry was 67 (14% of the total). The ultimate result of this series of outreach activities was successful and has been adapted or modified for other event related activities, including the annual women veterans week reception.

The importance of media in outreach efforts cannot be overstated. Within two years, televised programs, radio announcements, featured articles in the newspapers and magazines and flyers for specific events attracted 521 additional women veterans, an increase of 63%, to seek services at the VAMC in Buffalo. The number of clinic stops increased 210% from the number 5 years earlier.

Networking within the community facilitates outreach efforts. Servicewomen may learn of their veterans benefits through service organizations. Leaders of the veteran community attend the annual commanders forum, an informational session at the VAMC, and are invited to participate in events for women veterans.

Community involvement by the VA with women's organizations are another resource. During Women's History Week Celebration in 1994 in Buffalo, the Buffalo VAMC was a major participant. The series of week-long events was promoted widely in newspapers, on television and through mailings. The women developed a community resources book which lists the Buffalo VAMC and which was distributed to more than 120 women's organizations in the community.

There are agencies within the community that need to be informed about benefits and services available at the VAMC. In a joint educational project on homeless women veterans with the School of Nursing at Daemen College and the Department of Nursing at the VAMC in Buffalo, preliminary information substantiates there is need to exchange information with community agencies about resources available through the VA.

2. (b) **What new efforts to make women more aware of their veteran's benefits should be tried?**

Advertising is an effective way of communicating with and informing the target audience, but essentially has never been used by the VA because of regulatory prohibitions. This is needed particularly for women veterans. The VA has had the identity of a male oriented institution. The utilization rate (11/1000) of the VA by women veterans is one-third that of male veterans in the mid Atlantic Region. (Female veterans' usage of VA hospitalization, Biometrics monograph No. 2, 1987). Unless there is a special event to be highlighted, media seldom feature the VA or women veterans.

Advertising will reach those servicewomen who are not easily identified in the community. Many don't recognize themselves as veterans. They merge into civilian life after their military experience, change their name with marriage, tend not to join service organization or have not been encouraged to join.

Exchange of information with other community agencies has been done to a limited extent but may need to be more inclusive and regularly scheduled. Key individuals at those agencies need to be identified and made aware of the services and benefits available to women veterans at the VA. Examples of agencies include colleges, shelters and other health care providers.

3. **Do you believe that the responsibilities of a Women Veterans Coordinator can be accomplished in five hours a week? What is the minimum number of hours per week a Women Veterans Coordinator should have to accomplish these responsibilities?**

In 1984, the women veterans coordinator was first appointed at the Buffalo VAMC and five hours per week were sufficient. The number of women veterans at the Buffalo VA has increased since that time. Women veterans comprise approximately 4% of all veterans and 11% of active military personnel. Services available to women veterans have increased in the past decade and the women veterans coordinators program has grown together with the responsibilities of the coordinator. Public Law 102-585 provides for new programs including treatment for a history of sexual trauma and improved delivery of health care to women veterans.

Servicewomen need to be informed of benefits and new health care programs at VAMC. In a VA poll, 18% of women did not seek health care because they could not afford the cost or lacked coverage; 24% used medicaid (income less than $10,000) and of this number less than 20% used a VA facility. (A Report on the New York State Assembly 1986 Hearings on Women Veterans, Honorable Barbara Patton). An analysis on "Socioeconomic and Demographic Characteristics of the Veteran Population by Sex, Race and Hispanic Origin; What Data from the 1990 Census Show" by SH Schwartz and RE Klein found that 84% of women veterans were white and their median income ($12,600) was half the median income ($25,600) of white male veterans.

The women veterans coordinator needs to reach out to those in need, but uninformed, and to facilitate health care services for them at the VA. This position should be full time at a large tertiary care facility because of the number of patients, services and programs available; referrals from smaller VAs; and the outreach required in generally a large metropolitan area. In a smaller, less comprehensive center the coordinator minimally should be halftime because less overall staff with which to coordinate efforts is available.

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
One Veterans Drive
Minneapolis MN 55417

In Reply Refer To:

618/111M

April 21, 1994

The Honorable Lane Evans
Chairman
House Veterans Affairs Subcommittee on
Oversight & Investigations
US. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Congressman Evans:

Enclosed please find copies of my responses to the additional questions the subcommittee had regarding my testimony on Women's Health Care in the Veterans Affairs Medical Center.

I thank you for the opportunity to testify before the committee and answer the follow-up questions.

If you need additional information, please do not hesitate to contact me at (612) 725-2000 Extension 1788.

Sincerely,

Val Ulstad MD

VAL ULSTAD, MD
Clinic Director, Women Veterans Comprehensive Health Care Center

QUESTIONS SUBMITTED BY HONORABLE LANE EVANS, CHAIRMAN OF OVERSIGHT & INVESTIGATIONS COMMITTEE ON VETERANS' AFFAIRS

1. Please elaborate on your statement regarding the prevalence of serious mental health concerns.

Survey Description:

The purpose of the survey was to assess (1) utilization of mental health services by women veteran patients, (2) their satisfaction with these services, and (3) their potential need for specific services such as treatment for sexual trauma/harassment, alcohol abuse, and eating disorders.

The survey was conducted over a one month period. WVCHC patients were given the questionnaire prior to their appointment at the WVCHC.

The questionnaire consisted of items concerning demographics, mental health care utilization , and perception of and satisfaction with mental health services. In addition, 7 trauma questions developed by Dr. Jessica Wolfe from the National PTSD center, 4 items concerning alcohol use and substance abuse problems, and t items concerning eating disorders were included. The Brief Symptom Inventory (Derogatus & Spencer, 1982) which is a shortened from of the SCL-90-R was also utilized. The Brief Symptom Inventory data has not been analyzed yet.

Description of Sample:

The questionnaire was completed by 107 patients. Of the 107 respondents, 28.1% are less than 35 years old, 39.2% are between the ages of 36 and 65, and 32.7% are greater than 66 years old. Over half of the sample (56.1) reported living within 60 miles of the VA. Reported VA benefits were as follows: 29.9% service connected, 11.2% category A, 3.7% category C and 47.7% did not know their level of benefits. Concerning reported insurance coverage 26.0% have Medicare, 17.3% have private insurance or an HMO, 1.9% have Medicaid, and 41.3% have no health insurance.

Mental Health Care Utilization and Satisfaction:

52.4% of the subjects reported that at some point in their life they felt a need for mental health services. Mental health services were reportedly utilized in the past by 23.8% at the Minneapolis VA and 35.4% at a facility or agency other than the Minneapolis VA. Perceived need for mental health services varied as a function of age with 51.7% of women under age 35, 71.9% of women between the ages of 36 and 55 and 27.3% of the women over age 56 reporting a past need of such services. Utilization of services was not significantly different across age groups.

Of those utilizing services at the VA, 91.7% received individual counseling. Concerning satisfaction with the individual counseling received 57.2% reported they were somewhat or very satisfied 14.3% reported they were neither satisfied or dissatisfied, and 28.5% reported they were somewhat or very dissatisfied. Overall quality of mental health services at the VA was rated as good or excellent by 59.1%, fair by 18.1%, and poor or very poor by 22.8%. Concerning the statement "If a women veteran needs counseling or has an emotional problem, the VA is good place to get help", 50% agree, 13% disagreed and 37% has no opinion. Concerning that statement "Women veterans receive the same kind and quality of mental health services as do male veterans at the VA", 25% agreed, 19% disagreed, and 56 % had no opinion. About a quarter (26%) of the women who received mental health care at a non-VA facility gave "concern about how women are treated at the VA" as the reason why.

Prevalence of Trauma Histories and Treatment:

Past trauma was assessed utilizing the following questions with a Yes/No format: (1) Physical assault/violent crime; "Have you ever been physically assaulted or been a victim of violent crime" (2) Partner assault; "At any time, have a partner ever threatened to or actually hit you, kick you or physically hurt you in other ways" (3) Sexual assault; "Have you ever had an experience where someone used force or the threat of force to have sexual relations with you against your will" and (4) Sexual harassment; "Have you ever received uninvited and unwanted sexual attention from someone with whom you worked (e.g., touching, or cornering, pressure for sexual favors, verbal remarks)".

Trauma histories were prevalent with 34.9% reporting physical assault and/or being a victim of violent crime, 38.8% reporting partner assault or threatened assault, 39.0% reporting sexual assault and 38.6% reporting sexual harassment. Of the trauma victims, the vast majority of incidents occurred while in the military (45.9% for violent crime, 55.0% for partner assault, 51.2% for sexual assault, and 79.5% for sexual harassment).

When prevalence of trauma is assessed as a function of age, there is clearly increased prevalence rates in younger and middle-aged women. For women veterans under the age of 35, 50.0% report partner assault, 60% report sexual assault, 41.4% report sexual harassment. For women between 36 and 55, 58.1% report partner assault, 51.6% report sexual assault, 15. 9% report sexual assault, and 12.5% sexual harassment. Results of chi square analyses indicate that these age differences in reported prevalence are statistically significant.

Prevalence of Substance Abuse and Eating Disorders:

Current substance abuse and eating disorders were assessed with the following questions: "Do you currently have a problem with alcohol or substance abuse (e.g., marijuana, cocaine, amphetamines, valium, etc.)' and "Do you believe you have a problem with an eating disorder (e.g., bulimia or anorexia)". In addition, questions were asked about bingeing (defined as eating large amounts of food in short period of time where you feel out of control) and purging

(defined as causing yourself to vomit, use of laxatives or diuretics [water pills] to control your weight).

Current substance abuse is reported by 5.8% of the sample and a perceived current eating disorder is reported by 12.3%. Bingeing is reported by 25.2% of the sample and purging is reported by 6.7% of the sample. No woman over the age of 56 reported purging as a problem.

Conclusions:

Older women report less mental health problems and less perceived need for mental health services than do younger and middle aged women. This may be due to differences in prevalence rates and/or reporting behaviors. The prevalence of trauma is very high in younger and middle aged women in this sample. This is clearly an area to target future mental health services. Further assessment is needed to determine the prevalence of eating disorders, but these results suggest that this may be a significant problem in our population.

2. What past efforts to make women more aware of their veterans benefits have been successful and should be repeated?

Of course, all of this is predicated on the idea that there is a service that each VAMC has to offer that women veterans will find desirable. We have to keep working to make our system user-friendly to women veterans, or we will only make the situation worse if we entice them to come to us and then disappoint them once again with the services offered.

Past outreach efforts that have been most successful are mass mailings, presentations to Veterans Service Organizations about our program, networking with the County Veteran Service Officers organization to spread the word locally about our program throughout the state, publishing articles in Veterans Service Organizations' newsletters that go out to all of their memberships about the services offered.

What new efforts to make women more aware of their veterans benefits should be tried?

Provide information to local Reserve units about services. We have difficulty getting the names of women veterans from computer data banks that should have some of these names and addresses (Veterans Benefits Administration, our own data base in the medical center, at times). We need to keep working with these organizations to access their information. More mass media campaigns to get the word out.

3. Do you believe that the responsibilities of a Women Veterans Coordinator can be accomplished in five hours a week? What is the minimum number of hours per week a Women Veterans Coordinator should have to accomplish these responsibilities?

In the larger medical centers who have a fairly large number of women veterans to serve, I think there should be full-time coordinators. Our Women Veterans Coordinator, Nancy O'Brien spends 10-15 hours per week in outreach alone, and this in only one of her responsibilities. In addition, she tries to see all women veterans admitted to the medical center (we average 15-20 women in the hospital at any one time, with 2-5 admissions per day on the average). She sits on a variety of hospital committees and taskforces to represent the needs of women veterans and serves as an advocate or representative for women veterans who are in need of such advocacy. Ms. O'Brien helps to case manage women veterans with complicated needs. She also provides education to other areas of the medical center on the needs of women veterans and the services offered by the WVCHC and keeps management of the medical center informed about policy decisions regarding women veterans. Nancy is often the contact person for both veterans and hospital staff who are seeking information regarding services for women veterans she chairs the Women Veterans Advisory Committee (which organizes Wellness Day and is expanding into TQI activities to look at services for women vets). I believe this role can not be accomplished in less than a full-time position in the larger medical centers, and the smaller ones (like St. Cloud, MN VAMC) probable need at least half-time coordinators. At. St. Cloud, MN VAMC, the coordinator is currently only five hours per week - she van barely accomplish knowing who all of the women veterans are much less have any time for outreach activities, sitting on committees, keeping up on the policies, etc.

Since the current situation is still that women veterans do not feel comfortable with most VAMC's, do not even know what they are eligible for, and are very hard to identify who to give this information to – and also that many staff in the VA system are still not sensitive to the needs of women veterans, or knowledgeable in how to serve the, -- we need coordinators to do all of the functions that I have mentioned above.

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
Salem VA 24153

In Reply Refer To: 658/(11A-DH)

The Honorable Lane Evans, Chairman
Subcommittee on Oversight & Investigations
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Congressman Evans:

Enclosed are the additional questions with responses requested by your committee on "VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES". Thank you for your interest in VA health care for women veterans. If I can be of any further assistance to you or your committee, please feel free to contact me.

1. **The last page of your statement reports a significant increase in the number of women who are coming to the Salem Women's Health Clinic. In your opinion, does this increase suggest that women will come to the VA if the services they need are provided? What else does this increase indicate to you?**

I feel the increase in numbers of women utilizing services at the Salem VAMC indicates that women most definitely will take advantage of services available if they are provided in a sensitive, gender specific manner. One important aspect of womens' services, if such services are going to be marketable, is that available programs be viewed and presented as an essential part of normal hospital environment and not as an "extra". Women who participate in VA health care must be made to feel as important as men in the system - a part of the "norm". If (as with any service, whether it be male or female) the demand is low for a specific service, i.e. mammogram, then the system needs to be in place to provide it through contract with community agencies. Any service which a female may need should be a normal extension of all services available through the VA, should not be considered "fluff", and should not be difficult for the female to access. At Salem, we have tried to make women feel a part of the entire system, thus accounting in part for the increase in numbers. The increase in the number of females seeking care at the VA may also be attributed to greater recognition at the national level of the need to provide care to all veterans, male and female alike, and the emphasis to increase services for females nationwide.

2.
The Honorable Lane Evans

2. What past efforts to make women more aware of their veterans benefits have been successful and should be repeated?

We have utilized several communication strategies at the Salem VAMC to increase women veterans' awareness of available benefits, including a reception, a brochure, a television and radio spot informing women of the clinic, and a reception for female veteran employees. We had a year follow-up reception/program for our female veterans and plan future radio spots. Local outreach through service organizations has also been initiated.

What new efforts to make women more aware of their veterans benefits should be tried?

There are several efforts which could help make women more aware of their benefits. These include, but would not be limited to, nationally produced leaflets or brochures on women's benefits, posters explaining benefits by 1992/93 guidelines, videos which could be shared with service organizations (DAV, VFW), a national roster of female veterans with their addresses which could be accessed for marketing purposes, and the ability of the VA to advertise services available at the local level.

3. Do you believe that the responsibilities of a Women Veterans Coordinator can be accomplished in five hours a week? What is the minimum number of hours per week a Women Veterans Coordinator should have to accomplish these responsibilities?

Being the Women Veterans Coordinator is a big responsibility, however the specific amount of time required to fulfill the obligations of the position, in my opinion, varies from VAMC to VAMC. The amount of time required can depend upon the size of the women veterans population in each catchment area, the number of women utilizing the VAMC facility, the types of programs available/utilized, satisfaction of care provided, and plans for expansion of women services. At present, with our current female population, five hours per week minimum is adequate to accomplish these responsibilities. However, if our program continues to grow, more time may be required in order to fulfill the responsibilities of the job. What is important is to be realistc about the position and balance needs and responsibilities with what the institution can afford.

Thank you for the opportunity to participate in this hearing and to respond to your questions. If you have any questions or require further information, feel free to contact me at (703) 982-2463, extension 2030.

Sincerely,
Barbara Zicafoose MSN RNCS ANP
Barbara Zicafoose, MSN RNCS ANP

HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
HEARINGS

VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

MARCH 9, 1994

QUESTION SUBMITTED FOR THE RECORD
MS. LYNN SMITH, RN, MSC, ANP
REGIONAL WOMENS VETERANS COORDINATOR, SOUTHERN REGION
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

Question 1A: How many separate VA facilities (medical centers, separate outpatient clinics, etc.) are in VHA's Southern Region?

Answer: There are 43 medical centers, 1 independent outpatient clinic, 23 satellite outpatient clinics, 7 community-based clinics, and 7 outreach program clinics in VHA's Southern Region.

Question 1B: During fiscal year 1994, how many of these facilities will you monitor to assess compliance with VA directives on the provision of health care services to women veterans?

Answer: All facilities will be monitored for provision of gender-specific care and provision of sexual trauma counseling for women veterans primarily through the women veterans coordinator assigned at the medical centers. Medical centers and the independent outpatient clinic have either a full-time or a part-time women veterans coordinator. However, women veterans coordinators are not designated for all separate clinics.

Question 1C: How frequently will you monitor each facility and how will you assess compliance with VA directives on the provision of health care services to women veterans?

Answer: Compliance of VA facilities on the provision of health care services for women veterans is monitored in a variety of ways. These include the annual survey of women veterans health programs, quarterly privacy deficiencies for women veterans' report, monthly and/or quarterly evaluation of quality monitors at the facility level, annual equipment requests, and conference calls with women veterans coordinators. Site visits are made on a consultation basis to offer assistance for enhancing the women veterans program, problem solving, and education for women veterans coordinators.

Question 1D: What action(s) can you take to improve facility compliance with VA directives on the provision of health care services to women veterans?

Answer: Providing education for women veterans coordinators, identifying centers of excellence, liaison between coordinator and medical center directors to ensure that the coordinators have the time and resources to do their job, promoting awareness of the program for medical centers' top management, establishing effective network groups,

establishing and updating a clinical inventory of women's health services, coordinating construction projects to support women veterans with regional construction managers, assisting with program and patient care issues, problem solving, assisting with unique marketing strategies to meet needs of all female veterans in Southern Region catchment areas, and promoting centralized quality improvement monitors and data base.

Question 1E: What additional resources are needed to be able to effectively monitor and assess the compliance of all VA facilities in VHA's Southern Region with VA directives on the provision of health care services to women veterans?

Answer: Women veterans coordinators have been effective in promoting health care services for women veterans and monitoring the program. Medical Center directors will need to monitor the women veterans coordinator's workload and shift resources to assure the women veterans coordinator's workload is covered. In VA facilities that do not have a full-time women veterans coordinator, the hours (designated minimum of 5 hours in the program guide for women veterans health care program) of the collateral assignment should be based on the actual workload of women veterans and the potential for workload in the service areas. Actual and potential workload would include satellite outpatient clinics, community-based clinics and outreach program/clinics within the medical center's service area. Potential workload's criteria would identify the VA facilities that have need for extensive outreach activities. There are seven full-time women veterans coordinators funded by Central Office and four full-time coordinators funded by medical centers within the Southern Region.

Correcting privacy deficiencies for women veterans are essential to enhance and promote health care services for women veterans. These construction needs are identified in the quarterly report to Congress which addresses the VA Directive 10-92-038 (copy attached).

HONORABLE JACK QUINN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
HEARINGS
VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

MARCH 9, 1994

QUESTIONS SUBMITTED FOR THE RECORD
DR. SUSAN H. MATHER, M.D., MPH
ASSISTANT CHIEF MEDICAL DIRECTOR FOR ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

Question 1: How many employees at VA Central Office are assigned full-time to the administration and coordination of women's health programs?

Answer: In addition to Dr. Susan Mather, Assistant Chief Medical Director for Environmental Medicine and Public Health, the VA women veterans health programs office now has 1.0 FTEE, whose efforts are supplemented by full-time women veterans' coordinators in each of the four VHA Regions and the 2.0 FTEE which were allocated to the Women Veterans Health National Training Program in the Birmingham Regional Medical Education Center. In addition, VA has assigned 1.0 FTEE in the newly formed Women Veterans Program Office of Policy and Planning.

Question 2: GAO has suggested that under VA's health care reform proposal, the most critical deficiency in the women's program--failure of facilities to provide appropriate cancer screening examinations --may be overcome through primary care, and that VA does not need to wait for health care reform to implement a primary care system. What plans does VA have to move toward a primary care system?

Answer: The VA has begun implementing a women veterans primary care health care system. On September 27, 1993, the Under Secretary for Health issued Women Veterans Health Care Guidelines (IL 10-93-027) (copy attached) utilizing the primary care model. A survey of VA facilities in January 1994 showed that 166 facilities had begun to implement the primary care guidelines and 86 actually had primary care teams for women in place, only four months after the publication of the guidelines.

HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
HEARINGS
VA HEALTH CARE FOR WOMEN VETERANS AND RELATED ISSUES

MARCH 9, 1994

QUESTIONS SUBMITTED FOR THE RECORD
DR. SUSAN H. MATHER, M.D., MPH
ASSISTANT CHIEF MEDICAL DIRECTOR FOR ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS

Question 1: Describe the additional resources which are needed to be able to effectively monitor and assess the compliance of all VA facilities with VA directives on the provision of health care services to women veterans?

Answer: This question must be considered within the context of the overall mission and structure of the Veterans Health Administration (VHA) and the ability to monitor and assess compliance with VA directives related to all veterans. Program and policy offices, such as the Women Veterans Health Office, are not set up to enforce compliance, which is essentially a local function. However, experience in carrying out the 1992 recommendations of the GAO made it obvious that 0.5 FTEEs for that office at that time was inadequate to meet program needs. The office now has 1.0 FTEE, whose efforts are supplemented by full-time women veterans coordinators in each of the four VHA Regions. In addition, 2.0 FTEE are allocated to the Women Veterans Health National Training Program in the Birmingham Regional Medical Education Center. Additional resources, in terms of staff and other support for training, have been made available from the Salt Lake City Learning Resource Center. This represents a considerable increase in available resources. As VHA moves toward greater decentralization, the structure and resources needed will be re-evaluated.

Question 2: Are VA medical center directors now required to annually certify compliance with VA directives on the provision of health care services to women veterans? If yes, how many have and how many have not certified compliance? If no, why not implement this certification requirement?

Answer: VA medical center directors are not required to annually certify compliance with VA directives on the provision of health care services to women veterans, nor are they required to do so for male veterans. Some individual directives may require annual or one time reporting. Compliance is a local responsibility. VA medical center directors implement VA programs consistent with VA guidelines within the context of decentralization

of certain functions allowing the medical center maximum flexibility in meeting the unique needs of women veteran patients. Resources are better spent providing for a culture which stresses continuous improvement in the delivery of health care services to women veterans.

Question 3: Why is it important for VA to develop and use quality indicators to monitor women veterans health care?

How many VA facilities have not established appropriate and sufficient quality monitors for women veterans health care?

How many VA facilities have established appropriate and sufficient quality monitors for women veterans health care, but do not consistently apply these monitors?

When will VA develop "methods to monitor the quality of services provided to women veterans" and how will these monitors be used?

Answer: Clinical (or quality) indicators are quantitative measures of important aspects of patient care and are useful for those responsible for assessing and improving care of patients. They recognize existing standards of care and enable an institution to assess how well it is meeting standards of care. The development and implementation of clinical indicators are an early step in the continuous quality improvement process. Accreditation organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are interested in seeing the entire process of indicator development (i.e., the emphasis is on the process as well as the product).

Our initial surveys (later documented by GAO) showed that many local facilities were having difficulty with the process and so a number of efforts are underway to improve it. Using the JCAHO standards as a model for indicator development and with input from clinical and quality experts, VA has developed a workbook for clinical indicator development, including an indicator for preventive health care for females. This workbook is available on diskette and in hard copy. In addition to the copy already sent to individual medical centers, each women veterans coordinator will receive a copy.

It is unclear exactly where each VA facility is in the process of developing appropriate and sufficient quality monitors for women veterans health care. The regional women veterans coordinators are continuously working with the facilities in their region to assess this.

A three-hour training module, focusing on improving organizational performance with specific detail on how clinical indicators are used to measure performance, has been developed for the national meeting and the National Training Program in FY 1995. Two other resources are planned for distribution at the meeting - a resource manual that will include a section on quality assurance (terminology, outline of process, core concepts and resources on station, e.g., QA staff) and handouts to accompany the QA (quality assurance)

presentation. The regional women veterans coordinators will review indicators for each medical center using pre-established criteria. The program office will continue to collect information using volume indicators for mammography, pap smears and sexual trauma counseling.

Question 4: Why are women veterans health care policies not being implemented at all VA facilities?

If a facility doesn't implement VA policy on women veterans health care, what can VA do to bring about compliance? At which facilities has VA taken action to foster implementation of VA policy on women veterans health care?

Answer: There is no evidence that overall women veterans health care policies are not being implemented. The one area that continues to need improvement is preventive health care services, primarily cancer screening. The GAO was highly critical of the documentation of the Central Office review of the revised plans from each facility for the care of women veterans and of the fact that critiques of these revised plans were not provided back to the facilities. However, all of the facilities did provide plans and these plans were reviewed by a physician and a program assistant. During the course of the review, it became apparent that the existing eclectic approach to women's care was probably not the best one and that more guidance needed to be provided. In the course of developing the guidance, a working group recommended that the primary care model was a better approach to providing coordinated care that incorporated preventive health strategies than the more usual fragmentation that occurs with the use of multiple specialty clinics. A survey of VA facilities in January 1994 showed that 166 facilities had begun to implement the primary care guidelines and 86 actually had primary care teams for women in place, only four months after the publication of the guidelines. The provision of high quality, comprehensive health care should be approached in the spirit of continuous quality improvement. Documentation is important and VHA will be working on improving the documentation of compliance with VA directives through the efforts of the regional women veterans coordinators.

Question 5: On page five, your statement reads, "While many creative and innovative programs existed at the local level, there needed to be greater standardization of information and services. This was one of our major programmatic thrusts in 1993."

Describe the results of this thrust.

Why have some VA facilities greatly improved women veterans health care while others haven't?

What has been done to replicate these good programs nationwide and more importantly, what has been accomplished and what remains to be accomplished?

Answer: The major emphasis in 1993 involved providing appropriate training for the provision of sexual trauma counseling and necessary medical care services. Over 2,000 women veterans received

sexual trauma counseling at VA medical centers and over 1,700 received related medical services. Guidelines utilizing a primary care model were issued and greater emphasis on quality assurance was begun. Vet Center staff project they will see over 1300 women veterans for sexual assault counseling, by the end of FY 1994.

The single most important factor in improving care is a critical mass of women veteran patients. Some small VA medical centers with limited missions and small populations of women veterans have been able to make less progress than those who see large numbers of female patients every week. The ability to recruit staff interested in women's health also impacts on the quality of health care.

VA medical centers with significant programs were recognized in the competitive process which led to the funding of eight Comprehensive Women Veterans Health Care Centers. This has created a great deal of interest in other medical centers who have sought consultations with the "successful" staff. National Health Care Reform has also focused the attention of medical centers on the need to meet the needs of both males and females in VA facilities. The National Center for Post-Traumatic Stress Disorder (PTSD) has expanded its services to include a Women's Health Science Division which is having significant influence on clinical care and education in PTSD and the Women's PTSD Inpatient Unit at Menlo Park has expanded its mission to include sexual trauma in addition to combat related stress. Improving the coverage of women veterans with preventive health services, particularly cancer screening, still remains the biggest area for improvement.

Question 6: At the bottom of page five, you report on the number of women who received PAP smears through VA. What is of concern, of course, is the number of women who should have, but did not, receive a PAP smear. Are you confident that every woman veteran who comes to VA and should receive a PAP smear is receiving this level of care?

Answer: At this point, we cannot say for certain that every women veteran who comes to VA and should receive a PAP smear is receiving one. However, the situation is improving and we will continue to stress this in both the Women Veterans Health Program and the VA Preventive Medicine Program.

Question 7: By what date will every Women Veterans Coordinator be provided written information describing the responsibilities and duties of this position?

Answer: The position descriptions for women veterans coordinators (WVCs) (nurse, social worker and collateral prototype position descriptions) have been provided to each medical center and to each women veterans coordinator prior to the planned official dissemination by the Human Resources Management Office. In addition, Women Veterans Health Care Guidelines, distributed to the field as an attachment to the Under Secretary for Health's Information Letter (IL 10-93-027) (copy attached) included a discussion of the clinical role of the WVC. Every WVC received a copy of the guidelines.

Question 8: How can the women veterans national education coordinator support facility Women Veterans Coordinators and improve women veterans health care in VA?

Answer: The national education coordinator (NEC) does already support the facility women veterans coordinators (WVCs) by organizing necessary training. For example, the NEC is actively involved in meeting the need for specific training in quality assurance (QA) which was identified as a result of the review of the plans for women veterans care submitted by all facilities. The NEC organized a workshop in August 1993, in Washington, D.C., to begin a coordinated approach. It worked with a subgroup to develop a training package, and included this into the training for full-time women veteran coordinators which took place in June of this year. The NEC is committed to team building and is very involved in efforts both to include WVCs in all teams addressing women veterans health care and to provide the necessary training to allow them to be effective members. Recent examples of the training of teams which will ultimately improve care to women veterans are the sexual trauma and primary care teams.

Question 9: Heart disease is the leading killer of women; one woman in nine will develop breast cancer in her lifetime; lung cancer is the leading cause of cancer deaths in women; the reported cases of women with AIDS nearly doubled between 1984 and 1991; and because of age, race, and/or socioeconomic status some women are known to be disproportionately affected by stroke, substance abuse, violence and sexually transmitted disease.

Describe the actions VA is taking to address each of these health issues in terms of (a) information and education, (b) preventive health care services, (c) comprehensive treatment and (d) scientific research.

Answer: There are now specific education, prevention, treatment and research programs to address eight medical and psychosocial problems which are of great concern to women. They can and are being addressed within the framework of primary care. As stated in the Women Veterans Health Care Guidelines, primary care consists of:

a. Intake and Initial Assessment
b. Preventive Health Care Service
   (1) Breast screening, including mammograms
   (2) Pap smears
   (3) Other services as indicated
c. Acute and chronic biopsychosocial care
d. Referral Coordination
e. Accessing other appropriate levels of care

In addition to having the framework in place to deal with these concerns, there are other activities addressing them. For example, heart disease in women is the subject of two recent VA satellite video conferences. The first was sponsored by the Birmingham Regional Medical Education Center on March 4, 1994, and was titled "Cardiac Issues in Women." The second was held in April 1994, and was entitled, "Women's Health Issues and the Physician Assistant: Heart Disease and Cancer Detection."

In FY 1994, John Feussner, M.D. and Associates began an HSR&D Service directed research project entitled "Breast Cancer Among Women Veterans: A Pilot/Feasibility Study". This study will serve as a pilot phase for subsequent efforts to evaluate current primary and secondary prevention practice and rehabilitation therapy for breast cancer among women veterans.

Smoking cessation has been a part of VA's Preventive Medicine program, and education programs dealing with the special problems of women in smoking cessation, particularly those related to weight gain. Lung cancer in women, as in men, is almost totally related to smoking but smoking also contributes to the high incidence of heart disease in both populations.

AIDS is increasing among women in the veteran population as well. By the end FY 1993, VA had provided care to 104 women veterans with AIDS since the beginning of the epidemic. Between October 1993 and March 1994, VA treated 67 women with HIV infection and 69 with AIDS. To highlight the concerns about women and AIDS and HIV infection, the most recent quarterly VA AIDS/HIV Conference Call (April 20, 1994) was devoted to this issue.

Question 10: VA's Women Veterans Advisory Committee recognized that some women veterans might need child care facilities, including overnight accommodations, in order to use VA facilities. How has VA responded to this issue?

Answer: Current legislation does not allow VA to pay for care for children of veterans. Despite the recognition of this need, we have been unable to recommend a plan even utilizing collaborative efforts with community-based service providers without adding significant resources and expertise.

Question 11: What additional steps can VA take to improve the visibility and availability of Women Veterans Coordinators?

Answer: VHA has made the women veterans coordinator (WVC) an essential member of the primary care team, which should give her more clinical visibility. A number of full-time positions have been established in VAMCs having sufficient workload to justify it and in those where the WVC has this function as a collateral duty, the designation of at least five hours per week for her WVC duties will increase her availability.

Question 12: How can VA improve awareness among women of their veterans benefits?

Answer: Much has already been accomplished to assure that women veterans are aware of their VA benefits. During recent years, VA and other veterans affairs groups have had the increasing awareness that many women left active duty without a personal sense of their veteran standing, much less an understanding of their benefits.

As a result, both the Veterans Health Administration and the Veterans Benefits Administration have stressed service and outreach to women veterans as among their most important public service

responsibilities. Each has designated women veterans coordinators at every VA medical center and regional office. Organizations primarily for women or with women veterans among their members have been targeted for information and outreach services. Activities like health awareness programs, women Veterans Day celebrations, special mailings to women veterans, symposiums and seminars, etc., are among national and local initiatives.

Over the last few years, VA's aggressive outreach services to military service members pending separation or retirement have helped close any gap in benefits understanding among newer women veterans. Women have actively participated in transition assistance programs and other related efforts to assure that men and women leaving active duty are fully aware of and prepared to use their benefits.

Much, however, remains to be done. A continued emphasis on women veteran issues is a clear responsibility as is continued attention to issues of sexual harassment and sexual trauma experienced on active duty. Each outreach initiative designed and each public information campaign undertaken needs to consider the needs, concerns, and problems of women veterans in its design.

Question 13: How can VA improve awareness among women of VA health care services?

Answer: VA can improve awareness among women of their eligibility for VA health care services through continuous outreach efforts designed to identify, educate and attract eligible women veterans into its programs. VA has improved efforts to include women in its publications, including training and health programs. The VA Pamphlet 10-114, "Women Veterans Health Programs including Sexual Trauma Counseling Services" was developed, printed and distributed to all medical facilities during 1993 (copy attached). It is available in the publications depot and is being used by health care providers for outreach to the women veterans community. The 1994 edition of VA Pamphlet 80-94-1, "Federal Benefits for Veterans and Dependents" includes a separate section devoted to women veterans, emphasizing not only their eligibility for the same VA benefits as male veterans, but also appropriate and timely medical care to women veterans for gender-specific disabilities. It advises women veterans of the availability of women veterans coordinators in VA medical centers and regional offices to counsel them regarding treatment and benefits. The pamphlet also describes the privacy accommodations for women being made in VA medical centers, the opportunity for complete physical examinations including breast and pelvic examinations, inpatient and outpatient gynecology services, referrals for necessary services that many not be available at each facility, including the provision of counseling to overcome psychological trauma resulting from physical assault, battery of a sexual nature or sexual harassment during active duty. This 1994 edition of VA Pamphlet 80-94-1 is also available in the publications depot and is being used by counselors for outreach and education to women veterans. VA has issued

News Releases concerning VA programs for women veterans, VA research on women veterans' health, and the establishment of the newly formed Women Veterans Program Office, to encourage women veterans to utilize available services. VA continues to work with the State Directors of Veterans Affairs to disseminate information and raise awareness that "Women are Veterans, too!", to sensitize employment counselors to ask women about their veteran status and service experience, and to identify disadvantaged women veterans and distribute information brochures.

Question 14A: How has VA responded to the Advisory Committee finding that state employment counselors often don't provide counseling on veterans' benefits to women because they fail to identify their veteran status?

Answer: Joan Furey, the Director of the VA's newly created Women Veterans Program Office has met with the DAS for Veterans Employment and Training at the Department of Labor to discuss initiatives addressing this issue. The Veterans Employment and Training Service and the Women's Bureau of the DOL have:

1) Published circular No. 92-3, September 1992 entitled "Benefits to Employers Who Hire Women Veterans."

2) Supported the Women's Research and Education Institute in sponsoring a conference in December 1993 entitled "Hire a Vet She's a Gopd Investment."

3) Developed a 1993 Handbook entitled "Hire a Vet She's a Good Investment" for distribution to state employment agencies.

Question 14B: Has VA mailed information and publicity regarding women veterans to all state employment offices as recommended by VA's Women Veterans Advisory Committee in 1992? When did this occur?

Answer: Ms. Furey is in the process of developing outreach activities that will facilitate the distribution of these materials to the individual state veterans affairs departments, VA women veterans coordinators and other individuals that can assist in the large scale dissemination of this information.

Question 15: Has VA developed and implemented nursing care standards and plans which address the special physical, psychosocial and educational needs of women veterans as recommended by VA's Women Veterans Advisory Committee? Describe these standards and their application today.

Answer: VA has not developed nursing care standards and plans which address special physical, psychosocial and educational needs of women veterans.

Normally standards and nursing care plans are developed on the local level, with the plan individualized to meet each patient's needs. Women Health Care Guidelines were developed and distributed to all VAMC facilities September 1993 by the Acting Under Secretary for Health. Nursing Service concurs with the guidelines and is working

to facilitate these guidelines and other initiatives to improve the quality of care to women veterans.

Question 16: What types of information will VA's study of reproductive health outcomes among women Vietnam veterans provide and when will this information be available?

Answer: The VA's reproductive health study among women Vietnam-era veterans is a retrospective (historical) cohort study which will compare the reproductive health outcomes of all eligible women Vietnam veterans to those of an equal number of women veterans who did not serve in Vietnam. The adverse reproductive health outcomes of interest are infertility, spontaneous abortions, still births, live births with congenital malformations, low birth weight, pre-term delivery, and infant deaths. The risk of cancer, particularly of the reproductive organs, will also be determined for the Vietnam and non-Vietnam cohorts. Information on exposure variables will be collected from telephone interviews and will be supplemented with and validated by military personnel records. Data on the outcome variables will be also collected by telephone interviews and validated by reviews of medical and hospital records. Information on effect modifiers and confounders will be collected to the extent feasible from military and medical records and from the study participants through telephone interviews and will be considered in the analyses.

Data collection efforts are currently underway in the pilot study of 250 Vietnam and 250 non-Vietnam women veterans. The pilot study is scheduled to be completed in December 1994. Following the review of the pilot study results, a decision will be made whether to proceed with the main study which would require an additional twenty months to complete.

Question 17: Compare the post-service mortality of women Vietnam veterans and women Vietnam-era veterans.

Answer: The initial morality study of women Vietnam veterans and a subsequent update of that study have been completed by the VHA Environmental Epidemiology Service.

The original study was titled "Mortality Among Women Vietnam Veterans, 1973-1987," and was published in the American Journal of Epidemiology (Am J Epidomiol 1991;134:973-80). After adjusting for rank, military occupation, duration of military service, age, and race, morality rates for all causes of death combined and for all cancers among women Vietnam veterans were similar to those among the cohort of women non-Vietnam veterans. Among women Vietnam veterans, crude mortality rates for cancers of the pancreas and uterine corpus were twice those among non-Vietnam women veterans; however, the numbers were too small for an adjusted comparison. Women Vietnam veterans had a slightly higher risk of death from external causes compared to the non-Vietnam cohort because of a statistically significant risk of dying from injuries sustained in motor vehicle accidents (Relative Risk=3.19, 95% Confidence Interval=1.03-9.86).

The update to the mortality study was titled "Cancer Mortality Patterns Among Women Who Served in the Military: The Vietnam Experience" and included vital status determinations for the same two cohorts through 1991. The results were presented in November 1993 at the NIH sponsored meeting: "Women's Health: Occupation and Cancer," and are in the official proceedings printed in the Summer issue of the Journal of Occupational Medicine. With an average follow-up period of over 20 years, the updated study results confirmed earlier findings of no excess of mortality from all causes combined or from all cancers among women Vietnam veterans compared to the non-Vietnam comparison cohort. An elevated risk of mortality from pancreatic cancer was observed among women Vietnam veterans compared to the non-Vietnam cohort (Relative Risk=2.78). The risk of pancreatic cancer deaths among Vietnam nurses was statistically significant when the analysis was restricted to women nurse veterans (Relative Risk=5.74, 95% Confidence Interval=1.22-27.04). Nurses who served in Vietnam also had an elevated risk of death from uterine cancer (Crude Rate Ratio = 1.86) compared to nurses who served elsewhere.

Question 18: Do women veterans experience a higher incidence of cancer than their non-veteran peers? What actions has VA taken to determine women veterans experience a higher incidence of cancer than their non-veteran peers? What actions has VA taken to investigate this and what has been learned?

Answer: It is unclear whether women veterans experience a higher incidence of cancer. The oft quoted "statistic" that women veterans do experience a higher incidence of cancer than non-veteran peers is based on the Survey of Female Veterans done by Louis Harris and Associates under contract to the VA, published in 1985. Over 3,000 women veterans were identified out of a total of 526,367 households from a national probability sample of the adult population. Nearly one in ten of the women surveyed reported a diagnosed case of cancer. Cancer of the uterus, ovaries, and cervix (43 percent) was the leading form. Breast cancer accounted for 26 percent of the cancer seen and affected approximately 2 percent of the women. Population surveys are expensive and not done very often in the general public so relatively little comparative data exists. Another population survey of American women conducted by the Louis Harris organization in 1985 (National Survey of Antecedents, Mediators and Consequences of Stress) showed a lifetime prevalence of just over 5 percent in American women in general. There has been at least one other survey of veterans which shows a lower lifetime prevalence of cancer in male veterans, but the numbers of women were too small to be statistically significant. This was the survey of aging veterans which showed that 9 percent of males over 55 reported having been diagnosed with cancer compared to 14 percent of females over 55. The difference is more dramatic than those figures indicate because 43 percent of the cancer in male veterans was skin cancer, which represents only 16 percent of the cancers in females. It must be pointed out; however, that other studies have cast doubt on the dependability of patient reporting of health status when compared to physical exam and medical record

review. One study which was not a survey, the "Vietnam Women Veterans Mortality Study," also showed a somewhat higher incidence of cancer among women veterans than predicted in the population. This was based on the review of death certificates but the total numbers were small.

There are several possible explanations for the apparent higher prevalence of cancer in women veterans: First, the demographic composition differs, most notably in age. However, the difference persists for all ages, but is most marked for younger women. Income information and education as a marker for socioeconomic status was examined and showed that the differences in rates persisted across income and educational categories but were greatest for those with incomes above $20,000 and with some college education. Second, behavioral characteristics may differ. Unfortunately, the Survey of Women Veterans did not explore most behavioral correlates of cancer, such as diet, tobacco and alcohol use. Third, occupational differences between women veterans and other women may provide a residual explanation for differences in cancer. Occupational differences may be producing differences in rates of diagnosis as well as risk. Women veterans who were exposed to combat situations -- almost exclusively Army nurses who served during World War II -- show higher rates of breast, bone, stomach and colon cancer than other women veterans. The reasons for this are certainly not clear. Plans are being made for examination of the behavioral correlates with cancer and other possible explanations of this in the next survey of women veterans.

Question 19: How has VA worked with other federal agencies to ensure systematic data collection on the status, problems, and trends of women veterans as recommended by the VA's Women Veterans Advisory Committee and what are the results of this effort? Identify the agencies VA has worked with in this regard and describe the results of these efforts.

Answer: To date the VA has not developed collaborative relationships with other federal agencies involved with women's issues. It is anticipated that with the development of the Women Veterans Program Office, such relationships will develop. The VA's involvement with HHS on the National Action Plan Against Breast Cancer is a beginning step toward the development of such collaborative activities.

Question 20: Have closer research ties between VA and NIH been established to better facilitate health studies of women veterans as recommended by VA's Women Veterans Advisory Committee? Describe these closer ties and their impact.

Answer: VA's Associate Chief Medical Director for Research and Development is a member of the White House Committee on Science and Technology Policy and Planning. This provides an excellent linkage with National Institutes of Health (NIH) and other agencies sharing interests in women veterans' issues. In addition to such formal linkages, VA investigators and administrators have a variety of other linkages with NIH. For example, VA scientists frequently serve as reviewers for NIH study sections for extramural investigator

initiated research. Also, a representative from the VA Health Services Research and Development Service attended the December 14, 1993, HHS Secretary's Conference on Breast Cancer at NIH. This representative attended the workgroup on Policy and Regulation and urged increased attention to health services research and the importance of considering the needs of women veterans. Additionally, a researcher from the National Cancer Institute served as a reviewer for a VA study of breast cancer in VA. This study, at the Durham, North Carolina, VA Medical Center, was funded effective October 1, 1993.

Question 21: Has VA requested NIH appoint women veterans to serve on the Advisory Committee on Research on Women's Health as recommended by VA's Women Veterans Advisory Committee?

Answer: While VA concurred with the recommendation of the VA's Women Veterans Advisory Committee as stated in their July 1992 report, at that time NIH did not have an Advisory Committee on Research on Women's Health. At the present time, NIH has advised VA that they have decided to establish an Advisory Committee on Research on Women's Health this year and we intend to recommend that they consider the appointment of women veterans to serve on it.

Question 22: How has VA cooperated with other agencies to ensure women veterans are included in scientific research and studies as recommended by VA's Women Veterans Advisory Committee? What are the results?

Answer: In September 1992, the VA Office of Research and Development sponsored a one-day conference to address an agenda for research on women's health care issues. Participants included staff, researchers, policymakers, and clinicians from the Veterans Affairs Central Office and Veterans Affairs HSR&D field programs, and representatives from the Offices of the Secretaries of Veterans Affairs and the Department of Defense. A specific outcome of this meeting has been the work within the VA Health Services Research and Development Service, through its service-directed research program, to establish a consortium specifically for research on women's health issues. Five VA medical centers have joined to develop a proposal for this consortium. Additionally, under the umbrella of the consortium, seven separate project proposals addressing issues such as access to care, appropriateness of care, cancer screening, post-traumatic stress disorder and variation in use of VA health care services for women veterans have been developed. These proposals will undergo scientific review in May 1994. For purposes of coordination, a representative from the Agency for Health Care Policy and Research will serve on the review panel.

Since May 1991, it has been VA policy that all applicants for VA research must consider and document the inclusion of women in their proposed studies. This is in line with similar policy at the National Institutes of Health.

Collaborative efforts and studies are described further in the attached VA Fact Sheet on VA Research on Women Veterans' Health.

Question 23A: Are current VA special programs for women veterans with post-traumatic stress disorder or other service-related psychological conditions fully meeting the needs of this population of women veterans?

Answer: Yes. As of January 1994 in VA medical centers 2,157 women have received counseling for sexual trauma and 1,714 have received related medical care services. This suggests that not only are women veterans coming to VA for sexual trauma services, but they are receiving comprehensive care for a range of medical and psychological concerns. An additional 67 women received counseling contract services.

Question 23B: How many women veterans could benefit from these services and how many have actually received these services? How can VA provide these services to more women veterans?

Answer: No one knows how many women veterans could benefit from counseling for sexual traumas incurred while on military duty. A 1988/89 survey by the Department of Defense (DoD) reported that completed or attempted rape occurred in only 5 percent of their sample, while pressure for sexual favors and touching had higher frequencies (15 percent and 38 percent, respectively). Some VA data suggest that the incidence of sexual traumatization may be higher. Preliminary studies from the Women's Health Sciences Division of the National Center for PTSD suggest that as many as 30 percent of women veterans may have suffered assaults at some point in their military career. This is consistent with data from a 1992 Readjustment Counseling Service survey reporting 26 percent of all women veterans being counseled at that time had reported sexual assault in the military. A February 1994 report from the inpatient Women's Trauma Recovery Program at the Menlo Park Division of the Palo Alto VA Medical Center indicated that of the 29 women veterans who had completed the treatment program since its inception in 1992, 10 (34 percent) reported active duty sexual trauma. According to the 1990 census, there are 1.1 million women veterans. The number of women veterans who have received services is noted in the response to the first part of this question. VA can provide these services to more women veterans by increasing the number of VA clinicians who understand how to diagnose and manage psychological and physical problems related to sexual trauma, and by increasing the awareness of women veterans that treatment services are available through VA. Caring for victims of sexual trauma is a major area of emphasis in the multi-year National Training Program on women veterans' health. A series of five Women Veterans Health National Training Program modules have been designed for VA mental health and readjustment counseling clinicians, women veterans coordinators and other clinical staff. Three of these modules have already been presented to system-wide audiences of over 1,000 participants per module. The topics covered included: diagnosis and treatment of sexual trauma; problems in

psychotherapy, and ethical/legal issues. In addition, there was a face-to-face training on Women Veterans Health and Other Issues of Sexual Trauma for over 400 VA clinicians from mental health services, primary care services and vet centers from the Eastern half of the nation in Baltimore in July 1993. This successful program will be repeated for Western U.S. staff in September 1994 in San Diego. Local VA facilities should advertise the availability of these clinical services for women veterans in their local communities, as the Boston Women Veterans Stress Disorder Treatment Team has begun to do.

Question 23C: What is needed to fully meet the needs of this women veterans population?

Answer: All VA medical facilities should have the capability of providing at least initial diagnostic screening and basic treatment or referral for psychiatric and physical disorders for women veterans who have experienced sexual trauma. Skills in the treatment of PTSD and substance use disorders in women are needed.

Question 24: Where and how has VA expanded its efforts to assist homeless women veterans who have child-rearing responsibilities by providing facilities for these veterans and their family members as recommended by the VA's Women Veterans Advisory Committee? How does VA plan to respond to this recommendation?

Answer: At the VA's recent summit on homeless veterans a special workshop was held to discuss the issues of homeless female veterans. We are exploring ways to enhance our services to this population by working with community agencies that provide housing and other interventions to homeless women with dependent children. Facilities in Memphis and Waco have accessed community resources. We are reviewing these initiatives with the involved staff to assess the process they undertook in developing these programs in anticipation of providing guidance to the field that will promote additional initiatives. The Women Veterans Program Office has begun to assess the needs of this population and is working with representatives of the VA's homeless program to address this issue more effectively in the future.

Question 25: Describe VA's programs for aging women veterans, including domiciliary and nursing home care.

Answer: VA domiciliaries and nursing homes provide a comprehensive array of rehabilitative and health maintenance support services to eligible women veterans of all ages. Current construction criteria clearly address the needs of aging veterans of both sexes. Each program provides gender-specific health screening programs, gender-specific health education programs and gender-specific resocialization activity programs. Geriatric, Research, Education and Clinical Care Centers (GRECCs) are engaged in ongoing research efforts that may bear directly or indirectly on the future care of aging women veterans. GRECCs at Miami and West Los Angeles are currently conducting clinical research in osteoporosis and other bone disorders.

Question 26: Has VA increased the employment of women veterans as recommended by VA's Women Veterans Advisory Committee? What are the results?

Answer: From March 31, 1993 to March 31, 1994, VA employment of women veterans increased from 6,926 (2.6 percent of the total workforce) to 7,191 (2.7 percent of the total workforce), a gain of 265 (3.8 percent).

Question 27: How could VA encourage more women veterans to seek health care from VA?

Answer: VA can encourage more women veterans to seek health care from VA by expanding VA outreach programs including medical research and the identification of the health care needs of women veterans in order to enhance and improve VA programs, in conjunction with the Women Veterans' Advisory Committee, veterans' service organizations and women veterans consumers. VA can encourage more women as the "word-of-mouth" positive experiences of satisfied consumers spreads.

ATTACHMENTS TO QUESTION #13
(HONORABLE LANE EVANS)

Federal Benefits for Veterans and Dependents

1994 Edition

Department of Veterans Affairs

Office of Public Affairs (80D)
810 Vermont Ave., N.W.
Washington D.C. 20420

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Introduction

The surest way to obtain current information on VA benefits and claims procedures is to call the nearest VA regional office. A call to 1-800-827-1000 from any location in the United States will connect you to a VA regional office. Counselors can answer questions about benefits eligibility and application procedures. They make referrals, when necessary, to other VA facilities, such as medical centers and national cemeteries. To assure that accurate information and courteous responses are given to the public, VA supervisory personnel occasionally monitor telephone calls. No record is kept of the caller's name, address, claim or telephone number. Local phone numbers of VA regional offices in 50 states, the District of Columbia, Manila and Puerto Rico are listed in the back of this book, along with the commercial phone numbers of all VA facilities. VA facilities also are listed in the federal government section of telephone directories under Department of Veterans Affairs.

Many state governments and some municipalities operate agencies or offices devoted to administering state and local veterans programs and assisting veterans in filing claims for VA and other federal benefits. Many veterans service organizations also provide information and assistance.

VA regional offices process claims for VA benefits and administer those benefits, which include: disability compensation, pension, home loan guaranty, life insurance, education, vocational training, burial allowance, and survivor's compensation, pension and education.

VA medical center admissions offices are the immediate source for information regarding medical care eligibility, admissions procedure and scheduling. They can provide information on all types of medical care, including nursing home, dental, drug and alcohol dependency, prosthetics, readjustment counseling, and Agent Orange, radiation exposure or Persian Gulf War examinations.

VA national cemeteries or regional offices can answer questions about eligibility of veterans and dependents for burial benefits. Documentation of military service must be shown to the director of the cemetery when burial is requested. The cemetery will schedule an interment service, and provide burial and an inscribed government marker.

Who's Eligible

Eligibility for most VA benefits is based on discharge from active military service under other than dishonorable conditions for a minimum period specified by law. Active service generally means full-time service as a member of the Army, Navy, Air Force, Marines, Coast Guard, or as a commissioned officer of the Public Health Service, the Environmental Services Administration or the National Oceanic and Atmospheric Administration. Completion of at least six years of honorable service in the Selected Reserves also provides for home-loan benefits for those not otherwise eligible. Men and women veterans with similar service are entitled to the same VA benefits.

The Defense Department issues each veteran a military discharge form, DD 214, identifying the veteran's condition of discharge — honorable, general, other than

honorable, dishonorable or bad conduct. Honorable and general discharges qualify a veteran for most VA benefits.

Dishonorable and some bad-conduct discharges issued by general courts-martial bar VA benefits. VA determines benefit eligibility for veterans with other bad conduct discharges and discharges described by military branches as "other than honorable." After reviewing the facts of each specific case, VA decides whether separation from service was under dishonorable or other than dishonorable conditions. Veterans in prison and parolees may be eligible for certain VA benefits. VA regional offices can clarify eligibility of prisoners and parolees.

Service in 26 organizations (see p. 29 & 30) during periods that include World Wars I and II has been certified as active military service by the Defense Department. Members of these groups may be eligible for VA benefits if Defense certifies their service and issues a discharge under honorable conditions.

Wartime Service

Certain VA benefits and medical care require wartime service. As specified in law, VA recognizes these war periods:

Mexican Border Period — May 9, 1916, through April 5, 1917, for veterans who served in Mexico, on its borders or in adjacent waters.

World War I — April 6, 1917, through Nov. 11, 1918; for veterans who served in Russia, April 6, 1917, through April 1, 1920, extended through July 1, 1921, for veterans who had at least one day of service between April 6, 1917, and Nov. 11, 1918.

World War II — Dec. 7, 1941, through Dec. 31, 1946.

Korean Conflict — June 27, 1950, through Jan. 31, 1955.

Vietnam Era — Aug. 5, 1964, through May 7, 1975.

Persian Gulf War — Aug. 2, 1990, through a date to be set by law or Presidential Proclamation.

Filing a Claim

Those filing a claim with VA for the first time must submit a copy of their service discharge form (DD 214), which documents service dates and type of discharge, or give their full name, military service number, branch of service and dates of service. Once a claim is filed, the veteran's VA file number ("C" number) or Social Security number serves as the veteran's identifier.

Keep Important Documents

The veteran's DD 214 form should be kept in a safe, convenient location accessible to the veteran and next of kin or designated representative. The veteran's preference regarding burial in a national cemetery and use of a headstone provided by VA should be documented and kept with this information. The following documents, if not included in VA files, will be needed for claims processing related to a veteran's death:

- marriage certificate for a surviving spouse or children.
- death certificate if the veteran did not die in a VA medical facility.
- children's birth certificates for children's benefits.
- veteran's birth certificate for parents establishing eligibility.

Información Para Los Veteranos De Habla Hispana y Sus Dependientes

Si necesita información o ayuda en la solicitud de los beneficios dispuestos por ley para veteranos y/o dependientes, escriba, llame o visite cualquiera de las oficinas del Departamento de Asuntos de Veteranos que aparecen al final de este folleto, o si desea, puede ponerse en contacto con el representante de una de las organizaciones de veteranos de su localidad. Cualquier solicitud para servicios médicos puede hacerse en uno de los hospitales o clínicas externas del Departamento de Asuntos de Veteranos.

En aqullos estados donde hay una gran concentración de veteranos y dependientes de habla Hispana, las oficinas del Departamento de Asuntos de Veteranos tienen consejeros bilingües que le ayudaran en la solicitud de cualquier beneficio de veterano. Ademas se encuentra disponible en las oficinas regionales del Departamento de Asuntos de Veteranos o en la Oficina Central (27), localizada en 810 Vermont Avenue, NW, Washington, D.C. 20420, un breve folleto titulado "Sus Beneficios," el cual puede obtenerse gratis.

Veterans Benefits Timetable

Time	*Benefits*	*Where to apply*
90 Days	REEMPLOYMENT	Former employer
Limited time	UNEMPLOYMENT COMPENSATION: The amount of benefit and payment period varies among states. Apply soon after separation.	State employment service
120 days or up to one year if totally disabled	INSURANCE: Servicemen's Group Life Insurance may be converted to Veterans Group Life Insurance.	Office of SGLI, 213 Washington St., Newark, NJ 07102-9990
Two years (from date of notice of VA disability rating)	DISABILITY INSURANCE: Life Insurance (up to $10,000) is available for veterans with service-connected disabilities. Veterans who are totally disabled may apply for a waiver of premiums on these policies.	Any VA office
10 years from release	EDUCATION: Educational assistance depends upon period of service.	Any VA office
12 years (generally from date of discharge)	VOCATIONAL REHABILITATION: For disabled vets, VA will pay tuition and fees, and the cost of books, tools and other program expenses as well as provide a monthly living allowance. Upon completion of the vocational rehabilitation program, VA will assist in finding employment.	Any VA office
No time limit	GI HOME LOANS: VA will guarantee a loan for the purchase of a home, farm with a residence, manufactured home or condominium.	Any VA office

Benefit Programs for Veterans

Disability Compensation

Eligibility

Monetary benefits, called disability compensation, are paid to veterans who are disabled by injury or disease incurred or aggravated during active military service in the line of duty. The service of the veteran must have been terminated through separation or discharge under conditions that were other than dishonorable. Monetary benefits are related to the residual effects of the injury or disease. The amounts of the benefits, which are not subject to federal or state income tax, are set by Congress. Disability compensation is paid in monthly payments. Rates effective December 1, 1993:

1994 Compensation Rates

Disability	Monthly Rate
10 percent	$ 87
20 percent	166
30 percent	253
40 percent	361
50 percent	515
60 percent	648
70 percent	819
80 percent	948
90 percent	1,067
100 percent	1,774

In addition, amounts up to $5,071 per month are paid when the eligible veteran is adjudged to have suffered certain specific, severe disabilities. These are all decided on an individual basis. Federal law prohibits the award of VA disability compensation concurrently with military retirement pay, except to the extent the retirement pay is waived.

Allowances for Dependents

Veterans whose service-connected disabilities are rated at 30 percent or more are entitled to additional allowances for dependents. The additional amount, from $16 to $164 a month, is determined according to the number of dependents and the degree of disability. A disabled veteran evaluated 30 percent or more also is entitled to receive a special allowance for a spouse who is in need of the aid and attendance of another person.

Prisoners of War

Former prisoners of war who were incarcerated for at least 30 days are entitled to a presumption of service connection for disabilities resulting from certain diseases or ailments if manifested to a degree of 10 percent at any time after active service. These presumptions may be rebutted by proof of other intervening causes.

Other Disability Benefits

Specially Adapted Homes

Disabled veterans may be entitled to a grant from VA for a home specially adapted to their needs or for adaptations.

For $38,000 Grant. VA may approve a grant of not more than 50 percent of the cost of building, buying or remodeling adapted homes or paying indebtedness on those homes already acquired, up to a maximum of $38,000. Veterans must be entitled to compensation for permanent and total service-connected disability due to:

(a) loss or loss of use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes or a wheelchair, or

(b) disability which includes (1) blindness in both eyes, having only light perception, plus (2) loss or loss of use of one lower extremity, or

(c) loss or loss of use of one lower extremity together with (1) residuals of organic disease or injury, or (2) the loss or loss of use of one upper extremity, which so affects the functions of balance or propulsion as to preclude locomotion without using braces, canes, crutches or a wheelchair.

For $6,500 Grant. VA may approve a grant for the actual cost, up to a maximum of $6,500, for adaptations to a veteran's residence which are determined by VA to be reasonably necessary. The grant also may be used to assist eligible veterans in acquiring a residence which has already been adapted with special features for the veteran's disability. In the latter situation, the amount of the grant is based on the fair market value of the existing special features, and not their cost. Veterans must be entitled to compensation for permanent and total service-connected disability due to:

(a) Blindness in both eyes with 5/200 visual acuity or less, or

(b) Anatomical loss or loss of use of both hands.

Supplemental Financing. Veterans with available loan guaranty entitlement may also obtain a guaranteed loan or a direct loan from VA to supplement the grant to acquire a specially adapted home.

Housing Insurance. Veterans with a specially adapted housing grant may be eligible for Veterans Mortgage Life Insurance.

Automobiles or Other Conveyances

Veterans and current service personnel qualify for this benefit if they have service-connected loss of one or both hands or feet, or permanent loss of use, or permanent impairment of vision of both eyes. Veterans entitled to compensation for ankylosis (abnormal immobility) of one or both knees, or one or both hips, also qualify for adaptive equipment for an automobile. There is a one-time payment by VA of not more than $5,500 toward the purchase of an automobile or other conveyance. VA will pay for adaptive equipment, and for repair, replacement, or reinstallation required because of disability, and for the safe operation of a vehicle purchased with VA assistance or a previously or subsequently acquired vehicle. To apply, contact a VA regional office or the prosthetic office at a VA medical center.

Clothing Allowance

Any veteran who is entitled to receive compensation for a service-connected disability for which he or she uses prosthetic or orthopedic appliances, including a wheelchair that tends to wear out or tear clothing, may receive an annual clothing allowance of $478. Any veteran whose service-connected skin condition requires prescribed medication that irreparably damages the veteran's outer garments also may receive the allowance.

Pension

Eligibility

Veterans may be eligible for support if they have limited income when they have 90 days or more of active military service, at least one day of which was during a period of war. Their discharge from active duty must have been under conditions other than dishonorable. They must be permanently and totally disabled for reasons neither traceable to military service nor to willful misconduct. Payments are made to qualified veterans to bring their total income, including other retirement or Social Security income, to an established support level. Countable income may be reduced by unreimbursed medical expenses. Pension is not payable to those who have assets that can be used to provide adequate maintenance.

Improved Pension

Effective Dec. 1, 1994, the Improved Pension program provides for the following maximum annual rates, generally payable monthly. The annual payment is reduced by the amount of the annual countable income of the veteran and the income of any spouse or dependent children.

• Veteran without dependent spouse or child	$ 7,818
• Veteran with one dependent spouse or child	$10,240
• Veteran in need of regular aid and attendance with no dependents	$12,504
• Veteran in need of regular aid and attendance with one dependent	$14,927
• Veteran permanently housebound with no dependents	$ 9,556
• Veteran permanently housebound with one dependent	$11,977
• Two veterans married to one another	$10,240
• Veterans of World War I and Mexican Border Period, add to the applicable annual rate	$1,769
•Increase for each additional dependent child	$1,330

Reduction While in Nursing Home or Domiciliary

When a veteran without a spouse or a child is being furnished nursing-home or domiciliary care by VA, the pension is reduced to an amount not in excess of $90 per month after three full-calendar months of care. The reduction may be delayed if nursing-home care is being continued for the primary purpose of providing the veteran with a prescribed program of rehabilitation services.

Protected Pension Programs

Pensioners entitled to benefits as of Dec. 31, 1978, who do not elect to receive a pension under the Improved Pension program, will continue to receive pension benefits at the rate they were entitled to receive on Dec. 31, 1978, as long as they remain permanently and totally disabled, do not lose a dependent, or their incomes do not exceed the adjusted income limitation. The income limitation is increased annually based on changes in the Consumer Price Index.

Vocational Training

Veterans in receipt of pensions between Feb. 1, 1985, and Dec. 31, 1995, may elect to participate in a vocational training program. Under this pilot program a veteran

may receive 24 months or more of vocational training and related services as well as up to 18 months of placement and post-placement services. Work income will affect the continuing receipt of pension.

Aid and Attendance or Housebound

A veteran who is a patient in a nursing home or otherwise determined by VA to be in need of the regular aid and attendance of another person or who is permanently housebound may be entitled to higher income limitations or additional benefits, depending on the type of pension received.

Education and Training

VA administers a number of education and training programs for veterans, For the Montgomery GI Bill program, the discharge must be honorable. Discharges

Montgomery GI Bill (Active Duty)

Eligibility

The Montgomery GI Bill (Active Duty), also known as Chapter 30, is a program of education benefits generally for individuals who enter active duty for the first time after June 30, 1985. Active duty for benefit purposes includes full-time National Guard duty performed after Nov. 29, 1989. The participant generally must serve continuously on active duty for three years of a three-year or greater initial enlistment or, for a lesser benefit, two years of an initial active-duty obligation of less than three years. An individual also may qualify for the full benefit by initially serving two continuous years on active duty, followed by four years of Selected Reserve service. In the latter case, the participant must enter the Selected Reserve within one year of release from active duty. The participant must meet the requirements for a high school diploma or an equivalency certificate before the first period of active duty ends. Completing 12 credit-hours toward a college degree meets this requirement. Individuals who initially serve a continuous period of at least three years of active duty, even though they were initially obligated to serve less, will be paid at the higher basic rate.

Participation Requirements

Participation in the Montgomery GI Bill requires that servicepersons have their military pay reduced by $100 a month for the first 12 months of active duty. This money is not refundable. If an individual decides not to participate in this program, this decision cannot be changed at a later date. An exception is made under specific conditions for servicepersons who are involuntarily separated from active duty with an honorable discharge after Feb. 2, 1991. Those who previously decided not to participate in this program and who voluntarily separate from active duty after Dec. 4, 1991, under the Special Separation Benefit or the Voluntary Separation Incentive Program also may elect to participate. If the serviceperson decides to participate before separation, military pay will be reduced before separation, and education or training may take place following separation.

Vietnam Era GI Bill Conversion

Also eligible for Montgomery GI Bill benefits are those individuals who had remaining entitlement under the Vietnam Era GI Bill on Dec. 31, 1989, and served on active duty without a break sometime between Oct. 19, 1984, and July 1, 1985, and continued to serve on active duty to July 1, 1988, or to July 1, 1987, followed by four years in the Selected Reserve after release from active duty. The individual must have entered the Selected Reserve within one year of release from active duty. The Completion of 12 credit hours toward a college degree meets the requirement. individual who converts from the Vietnam Era GI Bill must have met the requirements for a high school diploma or an equivalency certificate before Dec. 31, 1989. Completion of 12 credit hours toward a college degree meets the requirement.

Discharges and Separations

For the Montgomery GI Bill program, the discharge must be honorable. Discharges designated "under honorable conditions" and "general" do not establish eligibility for education benefits. A discharge for one of the following reasons could result in a reduction of the required length of active duty:

(a) Convenience of the government.
(b) Disability.
(c) Hardship.
(d) A medical condition existing before service.
(e) Force reductions.
(f) A medical condition which prevents satisfactory performance of duty.

Education and Training Available

The following education and training opportunities are available under the Montgomery GI Bill:

(a) Courses at colleges and universities leading to associate, bachelor or graduate degrees, and accredited independent study. Cooperative training programs are available to individuals not on active duty.

(b) Courses leading to a certificate or diploma from business, technical or vocational schools.

(c) Apprenticeship or on-job training programs for individuals not on active duty.

(d) Correspondence courses.

(e) Flight training from Sept. 30, 1990, to Sept. 30, 1994. Before beginning training, the veteran must have a private pilot license and meet the physical requirements for a commercial license. Benefits also may be received for solo flying hours up to the minimum required by the FAA for the rating or certification being pursued.

The individual may receive tutorial assistance benefits if enrolled in school half-time or more. Remedial, deficiency and refresher training also may be available.

Payments

Veterans who served on active duty for three years, or two years active duty plus four years in the Selected Reserve or National Guard, will receive $400 a month in basic benefits for 36 months. Those who enlist for less than three years will receive $325 a month. VA pays an additional amount, commonly called a "kicker," if directed by the Defense Department. Rate increases are tied to the Consumer Price Index. By law, there will be no rate change for the 1994 federal fiscal year, and the 1995 fiscal year increase will be reduced by one-half.

Work-Study

To be eligible for work-study benefits, participants must train at the three-quarter or full-time rate. Payments may be at the federal minimum wage or, if greater, the hourly minimum wage of the applicable state. Under this program, participants may perform outreach services under the supervision of a VA employee, prepare and process VA paperwork, work at a VA medical facility, or perform other approved activities.

Period of Eligibility

For the most part, benefits under Chapter 30 end 10 years from the date of the veteran's last discharge or release from active duty. VA can extend this 10-year period if the veteran was prevented from training during this period because of a disability or because he or she was held by a foreign government or power. The 10-year period can also be extended if an individual reenters active duty for 90 days or

more after becoming eligible. Veterans serving periods of active duty of less than 90 days can qualify for extensions under certain circumstances. If the veteran's discharge is upgraded by the military, the 10-year period begins on the date of the upgrade. If eligibility is based on both the Vietnam Era GI Bill and the Montgomery GI Bill, and discharge from active duty was before Dec. 31, 1989, the veteran will have until Jan. 1, 2000. In most cases, VA will subtract from the 10-year period those periods the veteran was not on active duty between Jan. 1, 1977, and June 30, 1985.

If eligibility is based on two years of active duty and four years in the Selected Reserve, the veteran's eligibility will end the later of: (a) 10 years from release from active duty; or (b) 10 years from completion of the four-year Selected Reserve obligation. This four-year obligation, however, does not apply to certain individuals discharged because of downsizing the military between Oct. 1, 1991, and Sept. 30, 1995.

Montgomery GI Bill (Selected Reserve)

Eligibility

The Montgomery GI Bill (Selected Reserve) is a program of education benefits for members of the reserve elements of the Army, Navy, Air Force, Marine Corps and Coast Guard, as well as the Army National Guard and the Air National Guard. This program also is referred to as Chapter 106. To be eligible for the program, a reservist must:

(a) have a six-year obligation to serve in the Selected Reserve signed after June 30, 1985, or, if an officer, agree to serve six years in addition to the original obligation;

(b) complete Initial Active Duty for Training (IADT);

(c) meet the requirements for a high school diploma or equivalency certificate before completing IADT; and

(d) remain in good standing in a Selected Reserve unit.

Education and Training Available

Reservists may seek an undergraduate degree or take technical courses at colleges and universities. Those who have a six-year commitment beginning after Sept. 30, 1990, may take courses leading to a certificate or diploma from business, technical, or vocational schools; cooperative training; apprenticeship or on-job training; correspondence courses; independent study programs; and flight training from Sept. 30, 1990, to Sept. 30, 1994.

Payments

The full-time rate is $190 a month for 36 months. Rate increases are tied to the Consumer Price Index. By law, there will be no change for the 1994 federal fiscal year, and the fiscal 1995 increase will be reduced by one-half.

Work-Study

Reservists training at the three-quarter or full-time rate are eligible for the work-study program. Terms of participation are the same as under the Montgomery GI Bill (Active Duty) program, except that reservists can also work at a military facility if the work is related to the Chapter 106 program.

Period of Eligibility

If a reservist stays in the Selected Reserve, benefits end 10 years from the date the reservist became eligible for the program. VA may extend the 10-year period if the individual could not train due to a disability caused by Selected Reserve service. If a reservist leaves the Selected Reserve because of a disability, the individual may use the full 10 years. In other cases, benefits end on the day the reservist leaves the

Selected Reserve, except that certain individuals separated from the Selected Reserve due to downsizing of the military between Oct. 1, 1991, and Sept. 30, 1995, will have the full 10 years to use their benefits. If the 10-year period ends, however, while the participant is attending school, VA will pay benefits until the end of the term. If the training is not on a term basis, payments may continue for 12 weeks.

Veterans' Educational Assistance Program (VEAP)

Eligibility

Under VEAP, active duty personnel voluntarily participated in a plan for education or training in which their savings are administered and added to by the federal government. Servicepersons were eligible to enroll in VEAP if they entered active duty for the first time after Dec. 31, 1976, and before July 1, 1985. Some contribution to VEAP must have been made prior to April 1, 1987. The maximum participant contribution is $2,700. While on active duty, participants may make a lump-sum contribution to the training fund.

A serviceperson who participated in VEAP is eligible to receive benefits while on active duty if: (a) at least three months of contributions are available, except for high school or elementary school, in which case only one month of contributions is needed; and (b) the first active-duty commitment is completed.

If the individual's first term is for more than six years, benefits may be available after six years. To attend an elementary or high school program, the individual must be in the last six months of the first enlistment.

A veteran who participated in VEAP is eligible to receive benefits if the discharge was under conditions other than dishonorable and:

(a) the first enlistment was prior to Sept. 8, 1980, or the participant entered active duty as an officer before Oct. 17, 1981, and served for a continuous period of 181 days or more or was discharged for a service-connected disability; or

(b) the participant enlisted for the first time on or after Sept. 8, 1980, or entered active duty as an officer on or after Oct. 17, 1981, and completed 24 continuous months of active duty.

Education eligibility may be established even though the required active duty is not completed if the veteran:

(a) receives VA disability compensation or military disability retirement;

(b) served a previous period of at least 24 continuous months of active duty before Oct. 17, 1981; or

(c) was discharged or released for early out, hardship or service-connected disability.

An individual who contributed or who could have contributed to VEAP before being involuntarily separated from active duty with an honorable discharge after Feb. 2, 1991, may elect before separation to receive Montgomery GI Bill (Active Duty) benefits. VEAP participants who voluntarily separate from active duty after Dec. 4, 1991, under the Special Separation Benefit or the Voluntary Separation Incentive Program also may elect to participate in the Montgomery GI Bill (Active Duty).

Education and Training Available

VEAP participants may pursue associate, bachelor or graduate degrees at colleges or universities. Courses leading to a certificate or diploma from business, technical or vocational schools may also be taken. Other opportunities include apprenticeship or on-job training programs, cooperative courses and correspondence-school courses. Flight training may be pursued from April 1, 1991, through Sept. 30, 1994. Benefits

also may be received for solo flying-hours up to the minimum required by the FAA for the rating or certification being pursued. Before beginning training, the veteran must have a private pilot license and meet the physical requirements for a commercial license.

A participant may study abroad, but only in programs leading to a college degree. A participant with a deficiency in a subject may receive tutorial assistance benefits if enrolled half-time or more. Remedial, deficiency and refresher training is available.

Payments

When the participant elects to use VEAP benefits to pursue an approved course of education or training, the Defense Department will match the participant's contribution at the rate of $2 for every $1 the individual put into the fund. Defense also may make additional contributions to the fund in exchange for special duties performed by the participant.

A typical VEAP payment: A participant contributes $1,800 over a 36-month period and the government adds $3,600 (2 for 1 match); there is no additional benefit from the Defense Department. This results in a total entitlement amount of $5,400. This amount would be divided by 36 months, yielding a monthly benefit of $150 for full-time schooling for the veteran.

A veteran will receive monthly payments for the number of months contributed, or for 36 months, whichever is less. The amount of the payment is determined by dividing the number of months that contributions were made into the participant's training-fund total.

Period of Eligibility

A veteran has 10 years from the date of last discharge or release from active duty to use VEAP benefits. This 10-year period can be extended by the amount of time the veteran could not train because of a disability or because of being held by a foreign government or power. The 10-year period may also be extended if the veteran re-enters active duty for 90 continuous days or more after becoming eligible. The extension ends 10 years from the date of discharge or release from the later active duty period. For periods of less than 90 continuous days, the veteran may qualify for extensions under certain circumstances. A veteran with a discharge upgraded by the military will have 10 years from the date of the upgrade.

Work-Study

To be eligible for work-study benefits, a person must train at the three-quarter or full-time rate. Payments may be at the federal minimum wage or, if greater, the hourly minimum wage of the applicable state.

Vocational and Educational Counseling

Servicemembers, veterans and dependents of deceased and totally disabled veterans may receive a wide range of vocational and educational counseling services throughout the period they are eligible for an educational assistance program administered by VA. Counseling services include educational and vocational counseling and guidance, and testing. In addition, the following individuals may receive these services regardless of eligibility for any other VA educational benefits: (a) servicemembers within 180 days of their planned discharges or releases from active duty, and (b) veterans within one year after discharge. VA does not pay for travel expenses for servicemembers or veterans receiving counseling services.

Counseling Required for Individuals Rated Incompetent

A veteran rated incompetent by VA must be counseled prior to entering a VA educational or training program. VA will pay the cost of travel for this counseling.

Vocational Rehabilitation

Eligibility

Veterans and servicemembers who served in the Armed Forces on or after Sept. 16, 1940, are eligible for vocational rehabilitation if three conditions are met:

(1) They suffered a service-connected disability or disabilities in active service which entitle them to at least 20 percent compensation or would do so but for receipt of military retirement pay. Veterans with a 10 percent disability also may be found eligible if they have a serious employment handicap.

(2) They were discharged or released under other than dishonorable conditions or are hospitalized awaiting separation for disability.

(3) VA determines that they need vocational rehabilitation consistent with their abilities, aptitudes and interests to overcome an employment impairment. Their service-connected disabilities must materially contribute to this handicap.

Period and Length of Rehabilitation Program

Generally, the veteran must complete a rehabilitation program 12 years from the date VA notifies him or her of entitlement to compensation. This period may be deferred or extended if a medical condition prevented the veteran from training for a period or if the veteran has a serious employment handicap.

Disabled veterans may receive services until they have reached their rehabilitation goal, but the duration of a rehabilitation program generally may not exceed 48 months. VA may provide counseling, job placement and post-employment services for an additional period not to exceed 18 months.

Benefits

A disabled veteran will be given an evaluation to establish entitlement. A disabled veteran may receive employment assistance, self-employment assistance, training in a rehabilitation facility, and college and other training. Severely disabled veterans may receive assistance to improve their ability to live independently.

Rehabilitation Program Costs

While in training and for two months after completing training, eligible veterans may receive subsistence allowances in addition to their disability compensation or retirement pay. Servicemembers cannot receive subsistence allowances until they leave active duty. VA pays the costs of tuition and required fees, books, supplies and equipment. VA may also pay for special support, such as tutorial assistance, prosthetic devices, lip-reading training and signing for the deaf. VA will help the veteran to pay for at least part of the transportation expenses unique to disabled persons during training or employment services. VA also may provide an advance against future benefit payments for veterans who run into financial difficulties during training.

Work-Study

For work-study benefits, a person must train at the three-quarter or full-time rate. Participants will be paid in advance 40 percent of the amount specified in the work-study agreement or an amount equal to 50 times the applicable minimum wage, whichever is less. They may provide outreach services under the supervision of a VA employee, prepare and process VA paperwork, work at a VA medical facility or perform other approved activities.

Rates for Vocational Rehabilitation Training

Type of training	No dependents	One dependent	Two dependents	Each add. dependent
Institutional				
Full-time	$366	$454	$535	$39
Three-quarter-time	275	341	400	30
Half-time	184	228	268	20
Farm cooperative/ apprenticeship/OJT				
Full-time	320	387	446	29
Extended evaluation/ Independent living				
Full-time	366	454	535	39
Three-quarter-time	275	341	400	30
Half-time	184	228	268	20
Quarter-time	92	114	134	10

Special Program for Veterans Rated Unemployable

Veterans awarded 100 percent disability compensation based upon unemployability may request an evaluation and, if found eligible, may participate in a rehabilitation program and receive special assistance in securing employment. A veteran with an unemployability rating who secures gainful employment under the special program will continue to receive disability compensation without reduction until the veteran has worked continuously for 12 months.

Special Program for Veterans Receiving Pension

Veterans who are awarded VA pension through Dec. 31, 1995, may be eligible for up to 24 months — or more under certain circumstances — of vocational training. Program participants may also receive up to 18 months of services in employment counseling.

Any veteran receiving a pension awarded prior to Dec. 31, 1995, may apply for an evaluation and for participation in vocational training. If an evaluation shows the veteran can achieve a vocational goal and the veteran wants vocational training, VA will help develop a plan of training and supportive services. Veterans are not required, however, to take part either in evaluation or training.

A veteran will continue to receive pension while receiving training or employment services. If a veteran in the training program loses entitlement to pension, training may be continued unless the pension is the result of fraud or administrative error. If a veteran's pension is terminated for excessive work or training income, the veteran may continue to receive VA health care and retain priority for treatment for three years after the date the pension is terminated.

Participants may work up to 12 months with no change in their evaluation as permanently and totally disabled. The employment must be within the scope of the vocational goal or a related field identified in the participant's VA rehabilitation plan and must be obtained within one year after eligibility for counseling expires. Earnings during this 12-month period count as income for pension purposes.

Home Loan Guaranties

Eligible veterans and unremarried surviving spouses may obtain VA-guaranteed loans for the purchase and refinancing of homes, condominiums and manufactured homes. The VA guarantees part of the total loan so a veteran may obtain a mortgage on a home or condominium with a competitive interest rate — without a downpayment if the lender agrees. VA requires a downpayment for the purchase of a manufactured home. VA also requires a downpayment for a home or condominium if the purchase price exceeds the reasonable value of the property or the loan has a graduated payment feature. With a VA guaranty, the lender is protected against loss up to the amount of the guaranty if the borrower fails to repay the loan. A VA loan guaranty can be used to:

(a) Buy a home.
(b) Buy a residential unit in new or proposed, existing or converted condominium projects.
(c) Build a home.
(d) Repair, alter or improve a home.
(e) Refinance an existing home loan.
(f) Buy a manufactured home with or without a lot.
(g) Buy and improve a manufactured home lot on which to place a unit owned and occupied by the veteran.
(h) Improve a home through installation of a solar heating or cooling system or other weatherization improvements.
(i) Purchase and improve simultaneously a home with energy-conserving measures.
(j) Refinance an existing VA loan to reduce the interest rate.
(k) Refinance a manufactured home loan to acquire a lot.
(l) Purchase and improve a home simultaneously.

Eligibility

To be eligible for a loan guaranty, applicants must have a good credit rating and have an income sufficient to support the new mortgage payments. The applicant also must agree to occupy the property as a home. To obtain a VA Certificate of Eligibility, complete a VA Form 26-1880, "Request for Determination of Eligibility and Available Loan Guaranty Entitlement," and submit it along with required supporting documents to the nearest VA regional office.

World War II Eligibility: (a) active duty on or after Sept. 16, 1940, and prior to July 26, 1947; (b) a discharge or separation under other than dishonorable conditions; and (c) at least 90 days total service, unless discharged earlier for service-connected disability.

Post-World War II Eligibility: (a) no other active-duty service except that which occurred after July 25, 1947, and prior to June 27, 1950; (b) a discharge or separation under other than dishonorable conditions; and (c) at least 181 days continuous active-duty service unless discharged earlier for a service-connected disability.

Korean Conflict Eligibility: (a) active duty at any time on or after June 27, 1950, and prior to Feb. 1, 1955; (b) discharge or separation under other than dishonorable conditions; and (c) at least 90 days total service, unless the veteran was discharged for a service-connected disability.

Post-Korean Conflict Eligibility: (a) active duty for 181 continuous days or more, any part of which occurred after Jan. 31, 1955, and prior to Aug. 5, 1964; and (b) discharge or release under conditions other than dishonorable; or (c) early discharge or release from active duty after such date for a service-connected disability.

Vietnam Eligibility: (a) active duty for a total of 90 days or more, any part of which occurred after Aug. 4, 1964, and prior to May 8, 1975; and (b) discharge or release from active duty under conditions other than dishonorable; or (c) earlier release from such active duty for a service-connected disability.

Post-Vietnam Eligibility: For veterans whose enlisted service began before Sept. 8, 1980, or whose service as an officer began before Oct. 17, 1981, the following is required: (a) active duty for 181 continuous days or more, all of which occurred after May 7, 1975, and discharge or release from active duty under conditions other than dishonorable; or (b) early release for service-connected disability; (c) early release from such active duty for service-connected disability. Eligibility requirements for veterans separated from enlisted service between Sept. 8, 1980, and Aug. 1, 1990, or service as an officer between Oct. 17, 1981, and Aug. 1, 1990, are: (a) completion of 24 months of continuous active duty or the full period — at least 181 days — for which the person was called or ordered to active duty, and discharge or release from active duty under conditions other than dishonorable; or (b) completion of at least 181 days of active duty with a hardship discharge or discharge for the convenience of the government; or (c) early discharge for service-connected disability.

Persian Gulf War Eligibility: Eligibility requirements for Persian Gulf War veterans are: (a) completion of 24 months of continuous active duty or the full period — at least 90 days — for which the person was called to active duty, and discharge or release from active duty under conditions other than dishonorable; or (b) earlier release after at least 90 days, with a hardship discharge, discharge at the convenience of the government, or discharge for a service-connected disability. Reservists and National Guard members are eligible if they were activated on or after Aug. 2, 1990, served at least 90 days active duty, and were discharged honorably.

Active Duty Personnel Eligibility: Until the Persian Gulf era is ended by law or Presidential Proclamation, persons on active duty are eligible after serving on continuous active duty for 90 days. Six-month enlistees who serve for six months on active duty for training only are not eligible since their service does not constitute "active duty" as defined by law, although they may be eligible for FHA Home Mortgage Insurance for veterans.

Eligibility for Members of the Selected Reserve: Individuals who have completed at least six years in the Reserves or National Guard are eligible if they: (1) have been discharged under honorable conditions, or (2) have been placed on the retired list, or (3) have been transferred to an element of the Ready Reserve other than the Selected Reserve, or (4) continue to serve in the Selected Reserve. Eligibility for reservists expires Oct. 28, 1999.

Eligibility for Others: Others eligible include unremarried spouses of veterans who died on active duty or as a result of service-connected causes; spouses of active-duty service members who have been missing in action or a prisoner of war for at least 90 days; U.S. citizens who served in the armed forces of a U.S. ally in World War II; and certain citizens who were part of organizations with recognized contributions to the U.S. World War II effort. Questions about eligibility may be answered at any VA regional office.

Expiration

Loan guaranty eligibility is not normally subject to an expiration date. Eligibility for reservists not activated by Presidential Order, however, expires Oct. 28, 1999.

Entitlement

The amount of the VA guaranty available to an eligible veteran is called the entitlement. The basic entitlement available to an eligible veteran is $36,000. Up to $46,000 of entitlement, however, may be available to veterans purchasing or constructing homes to be financed with a loan of more than $144,000 and to veterans who obtain an Interest Rate Reduction Refinancing Loan of more than $144,000. The amount of entitlement depends on the loan purpose and amount:

Loan Guaranty Entitlement

Loan Amount	Guaranty Percent	Dollar Amount
Up to $45,000	50%	$22,500
$45,001 to $56,250	40% - 50%	$22,500
$56,251 to $144,000	40%	$36,000
Over $144,000	25%	$46,000
Manufactured home and/or lot loan	40%	$20,000

The maximum home loan entitlement was raised from $4,000 to $7,500 in 1950, to $12,500 in 1968, to $17,500 in 1974, to $25,000 in 1978, to $27,500 in 1980, to $36,000 in 1988 and to $46,000 in 1989. A veteran who previously obtained a VA loan can use the remaining entitlement for any eligible purpose. Veterans who used their entitlement to purchase a manufactured home must first dispose of the manufactured home before purchasing a second manufactured home with a VA guaranteed loan. The amount of remaining entitlement is the difference between $36,000 — or $46,000 for special loans — and the amount of entitlement used on prior loans. Veterans refinancing an existing VA loan with a new VA loan at a lower interest rate need not have any entitlement available for use.

VA does not establish a maximum loan amount. No loan for the acquisition of a home, however, may exceed the reasonable value of the property. A loan for the purpose of refinancing existing mortgage loans or other liens secured of record on a dwelling owned and occupied by the veteran as the veteran's home is generally limited to 90 percent of the appraised value of the dwelling as determined by VA. A loan, however, to reduce the interest rate on an existing VA loan can be made for an amount equal to the outstanding balance on the old loan plus closing costs and reasonable discount points. A loan for the purchase of a manufactured home or lot is limited to 95 percent of the amount that would be subject to finance charges.

A veteran who previously obtained a VA loan can use the remaining entitlement for a second purchase. The amount of remaining entitlement is the difference between $36,000 — or $46,000 for special loans — and the amount of entitlement used on prior loans. Veterans refinancing an existing VA loan with a new VA loan at a lower

interest rate need not have any entitlement available for use.

Closing Costs

Payment in cash is required on all home loan closing costs, including title search and recording, hazard insurance premiums, prepaid taxes and the 1 percent origination fee which may be required by lenders in lieu of certain other costs. In the case of refinancing loans, all such costs may be included in the loan, as long as the total loan does not exceed 90 percent of the reasonable value established by VA for the property. Interest rate reduction refinancing loans can be made for an amount equal to the outstanding balance of the old loan plus closing costs and reasonable discount points. Loans, including refinancing loans, are charged a funding fee by VA, with the exception of loans made to certain disabled veterans and unremarried surviving spouses of veterans who died as a result of service or service-connected disabilities. The VA funding fee is based on the loan amount and, at the discretion of the veteran and the lender, may be included in the loan. A fee also is charged for assumption of a VA loan made after March 1988. Veterans who are using entitlement for a second or subsequent time who do not make a downpayment of at least 5 percent are charged a funding fee of 3 percent. This fee varies according to the loan:

Funding Fee

Loan Category	Veterans % of loan	Reservists % of loan
Purchase or construction loans with downpayments of less than 5 percent, refinancing loans and home improvement/repair loans	2.0	2.75
Purchase or construction loans with downpayments of at least 5 percent but less than 10 percent	1.5	2.25
Purchase or construction loans with downpayments of 10 percent or more	1.25	2.0
Manufactured home loans	1.0	1.0
Interest rate reduction loans	0.5	0.5
Assumption	0.5	0.5
Second or subsequent use	3.0	3.0

Restoration and Substitution of Entitlement

Veterans may have guaranty entitlement restored under the following conditions: (1) the veteran sells the home which was obtained with the VA loan, and (2) the VA is relieved of liability on the VA loan — normally accomplished by paying off the loan — or the loan is assumed by an eligible veteran who is able and willing to substitute entitlement for that used by the original veteran buyer.

Financing, Interest Rates and Terms

Veterans obtain VA-guaranteed loans through the usual lending institutions, such as banks, savings and loan associations, building and loan associations and mortgage loan companies. Real estate brokers usually assist the borrower in finding a lender.

Veterans may obtain a loan with a fixed or a variable interest rate, which may be negotiated with the lender. If the lender charges discount points on the loan, the veteran may negotiate with the seller as to who will pay points or if they will be split between buyer and seller. Points paid by the veteran may not be included in the loan. If the veteran chooses an adjustable rate mortgage, the interest rate may not be raised more than 1 percent annually and may not increase more than a total of 5 percent over the life of the loan. The term of the loan also is subject to negotiation with the lender and may be for as long as 30 years and 32 days.

VA normally does not require that a downpayment be made. VA does require a downpayment for a manufactured home or lot loan, for a loan with graduated payment features, and to prevent the amount of a loan from exceeding VA's determination of the property's reasonable value. If the sale price exceeds the reasonable value, the veteran must certify that the difference is being paid in cash without any supplementary borrowing.

The maximum maturity for manufactured home or lot loans varies. A VA office can provide specific information. A cash downpayment of 5 percent of the purchase price is required for such loans. The downpayment also must include an amount equal to the difference, if any, between the maximum loan allowable for the transaction and the cost to the veteran.

Safeguards for Veterans

VA protects veteran borrowers in the following ways:
(a) Homes completed less than a year before purchase with VA financing and inspected during construction by either VA or HUD must meet or exceed VA minimum property requirements for construction and general acceptability.
(b) VA may suspend from participation in the loan program those who take unfair advantage of veteran borrowers or decline to sell a new home or make a loan to an eligible veteran of good credit because of race, color, religion, sex, disability, familial status or national origin. All credit transactions involving VA financing also must meet the requirements of the Equal Credit Opportunity Act and the Federal Reserve Board's Regulation B.
(c) The builder of a new home inspected by VA or HUD during construction is required to give the purchasing veteran a one-year warranty that the home has been constructed in substantial conformity with VA-approved plans and specifications. A similar warranty must be given for new manufactured homes.
d) In cases of new construction completed under VA or HUD inspection, VA may pay or otherwise compensate the veteran borrower for correction of structural defects seriously affecting livability if assistance is requested within four years of the time a home loan is guaranteed or made.
(e) The borrower obtaining a GI loan may only be charged the fees and other charges prescribed by VA as allowable.
(f) The borrower has the right to prepay at any time, without premium or penalty,

the entire indebtedness or any part thereof not less than the amount of one installment or $100, whichever is less.
(g) It is the policy of VA to encourage holders to extend all reasonable forbearance and indulgence in the event a borrower becomes temporarily unable to meet the terms of the loan.

Occupancy Certification

Veterans must certify that they intend to live in the home they are buying or building with a VA guaranty. Also, when a veteran wishes to refinance or improve a home with a VA guaranty, the veteran must certify to being in occupancy at the time of application. If the veteran is on active duty, the spouse may certify occupancy. In refinancing outstanding VA-guaranteed loans solely to reduce the interest rate, veterans need only certify to prior occupancy. Veterans purchasing homes with GI loans also are required to certify they will not discriminate in the resale of their homes.

Release of Liability

When a veteran sells residential property financed through a VA guaranty, the veteran, upon request, may be released from liability to the federal government, provided the loan is current, the purchaser has been obligated by contract to purchase the property and assume all of the veteran's liabilities, and VA is satisfied that the purchaser is a good risk. A release of liability does not mean that a veteran could have the VA guaranty entitlement restored. VA usually restores entitlement only when it is no longer liable to the lender on the guaranty and the veteran is otherwise eligible for restoration. The release of a veteran from liability to the government does not change the fact that VA continues to remain liable on the guaranty. If a veteran-buyer, however, agrees to substitute entitlement for that of the original veteran-borrower and if all other requirements for substitution of entitlement are met, the veteran-seller may qualify for restoration.

For loans made on or after March 1, 1988, a release from liability determination must be made in every case involving the assumption of a VA-guaranteed loan. This will involve a determination of the good credit of the buyer assuming the loan by the holder of the loan or VA. A VA loan for which a commitment was made on or after March 1, 1988, is not assumable without approval of VA or its authorized agent. The person who assumes a VA loan for which a commitment was made on or after March 1, 1988, must pay a fee to VA equal to 1/2 of 1 percent of the balance of the loan being assumed. If a person disposes of the property securing a VA loan for which a commitment was made on or after March 1, 1988, without first notifying the holder of the loan, the holder may demand immediate and full payment of the amount owing on the loan.

Repossessed Houses

In many areas, VA has homes for sale that have been acquired after foreclosure of a VA-guaranteed loan. These homes are available for resale to both veterans and non-veterans. For information, contact local real estate agents for available listings.

Home Loans for Native American Veterans

VA direct home loans are available to eligible Native American veterans who wish to purchase, construct or improve a home on Native American trust land. These loans may be used to simultaneously purchase and improve a home. VA direct loans generally are limited to the cost of the home or $80,000, whichever is less. Before a Native American veteran can obtain a loan under this program, the tribal entity must sign with the Secretary of Veterans Affairs a Memorandum of Understanding spelling out the program. A funding fee of 1.25 percent must be paid to

VA except for veterans receiving compensation because of a service-connected disability. Veterans who qualify based on service in the Reserves or National Guard that was not active duty are charged a funding fee of 2 percent of the loan amount. The funding fee may be paid in cash or it may be included in the loan. Other closing costs may not be included in the loan. Closing costs may vary because of differing local laws and customs. The following may be paid by either the veteran purchaser or the seller: VA appraisal, credit report, loan processing fee, title search, title insurance, recording fees, transfer taxes, survey charges and hazard insurance.

Life Insurance

For information about government life insurance, veterans may call the VA Insurance Center in Philadelphia toll-free, 1-800-669-8477. Specialists are available between the hours of 8:30 a.m. and 6 p.m., ET, to discuss premium payments, insurance dividends, changes of address, policy loans, naming beneficiaries and reporting the death of the insured or a beneficiary. After hours a caller may leave a recorded message, which will be answered on the next workday. If the policy number is unknown, send the veteran's VA file number, Social Security number, military serial number or military service branch and dates of service with date of birth to one of two VA insurance centers.

For states east of the Mississippi River, or for any policy which is being paid by a deduction from VA benefits, military retired pay or a checking account, send to:

Department of Veterans Affairs
Regional Office and Insurance Center
P.O. Box 8079
Philadelphia, PA 19101

For states west of the Mississippi River, and the states of Minnesota, Wisconsin, Illinois, Indiana and Mississippi, send to:

Department of Veterans Affairs
Regional Office and Insurance Center
Bishop Henry Whipple Bldg.
Fort Snelling
St. Paul, MN 55111

Status of Life Insurance Programs

Program	Beginning Date	Ending Date for New Issues	Policy Letter Prefix
U.S. Government (USGLI)	May 1919	April 24, 1951	K
National Service (NSLI)	Oct. 8, 1940	April 24, 1951	V, H
Veterans Special (VSLI)	April 25, 1951	Dec. 31, 1956	RS, W
Service Disabled (SDVI)	April 25, 1951	Still Open	RH
Veterans Reopened (VRI)	May 1, 1965	May 2, 1966	J, JR, JS
Servicemen's Group (SGLI)	Sept. 29, 1965	Still Open	
Veterans Mortgage (VMLI)	Aug. 11, 1971	Still Open	
Veterans' Group (VGLI)	Aug. 1, 1974	Still Open	

Dividends Can Increase Total Insurance

Since July 1, 1972, the maximum amount of government life insurance, exclusive of SGLI, VGLI and VMLI, can be increased from a ceiling of $10,000. Policyholders with WWII National Service Life Insurance (V) can use their dividends to purchase additional paid-up coverage, permitting insureds to have more than $10,000

coverage. Policyholders with Veterans Special Life Insurance (RS, W) and Veterans Reopened Insurance (J, JR, JS) also can purchase additions to coverage.

Service-Disabled Veterans Insurance

Veterans who are granted a service-connected disability but are otherwise in good health may apply to VA for up to $10,000 life insurance coverage at standard insurance rates within two years from the date VA notifies the veteran that the disability has been rated as service-connected. This insurance is limited to veterans who left service after April 24, 1951. Veterans who are totally disabled may apply for a waiver of premiums. For those veterans who are eligible for this waiver, an additional policy of up to $20,000 is available. Premiums, however, cannot be waived on the additional insurance.

Reinstatement of Lapsed Insurance

Lapsed term policies may be reinstated within five years from the date of lapse. However, NSLI on the Limited Convertible Term Plan (Policy prefix W) may not be reinstated if the term insurance expired after the policyholder's 50th birthday. Lapsed permanent plan policies may be reinstated at any time except that "J" and "JR" policies must be reinstated within five years from date of lapse, and an endowment plan must be reinstated within the endowment period.

Automatic Renewal

A five-year term policy which is not lapsed at the end of the term period is automatically renewed for an additional five-year period. The exception is the NSLI Limited Convertible Term Plan (policy prefix W) which may be converted to a permanent plan, but cannot be renewed after the insured's 50th birthday. The premium rate for each renewal is based on the attained age of the insured, except "V" and "RS" prefixed policies renewed beyond age 70. The rate on these policies is based on the age 70 renewal rate, with no further increases occurring over the remaining life of the contract.

Convertibility

Any term policy which is in force may be converted to a permanent plan if requirements are met. NSLI policyholders, however, are not eligible to convert to an endowment plan while totally disabled. Upon reaching renewal at age 70 or older, NSLI "V" and "RS" term policies on total disability premium waiver are automatically converted to a permanent plan of insurance which provides cash and loan value as well as higher annual dividends.

Modified Life

A "modified life at age 65" plan of insurance is available to NSLI policyholders. The comparatively low premium rates for this plan remain the same throughout the premium-paying period, while the face value reduces by 50 percent at age 65. The reduced amount may be replaced with a "special ordinary life" plan, for an additional premium. In 1972, a "modified life at age 70" plan became available, which is like the modified life at age 65 plan except that face value reduction does not occur until age 70. The premium rate is only slightly higher than for the modified life at age 65 plan.

Dividends

Dividends are paid to holders of "K," "V," "RS," "W," "J," "JR," and "JS" insurance on the policy anniversary date. Dividends are not paid to holders of "H" or "RH" policies, or to those insured under SGLI, VMLI and VGLI. The Internal Revenue Service has announced that interest on insurance dividends left on deposit with VA is not taxable. For details on this ruling contact the IRS.

Guaranteed Permanent Plan Policy Values

When a permanent plan policy has had premiums paid or waived for at least one year, and it is not lapsed, the guaranteed values include cash surrender, loan and reduced paid-up provisions. If a permanent plan policy lapses after being in force for at least three months, it will automatically be extended as term insurance. The period of this protection is determined by the net cash value of the policy. The amount of extended coverage is the face value less any indebtedness.

Policy Loans

Policyholders may borrow up to 94 percent of the cash surrender value of their permanent plan on insurance and continue the insurance in force by payment of premiums. All NSLI policy loans applied for on and after Nov. 2, 1987, are charged interest at an adjustable rate which is adjusted each Oct. 1. Changes to the adjustable loan interest rate are tied to the 10-year U.S. Treasury securities index. The annual interest charged on adjustable-rate loans will not go higher than 12 percent or lower than 5 percent. The interest rates on United States Government Life Insurance (USGLI) policy loans and existing fixed rate NSLI policy loans will remain unchanged. Interest on policy loans is compounded annually. The current interest rate may be obtained at any VA office, or by calling the toll-free number, 1-800-669-8477.

Waivers for Total or Permanent Disability

NSLI policyholders who become totally disabled before their 65th birthday and are likely to remain so for six or more months should consult VA about their entitlement to premium waiver. USGLI policyholders who become totally and permanently disabled should consult VA about receiving the proceeds of their policies in monthly payments.

Total Disability Income Provision (TDIP)

Full information about adding the TDIP rider to a policy is available from the VA Regional Office and Insurance Center which maintains the veteran's insurance records, or the nearest VA office. The provision currently provides that an NSLI policyholder will be paid $10 per month, per $1,000 insurance, after being totally disabled for six consecutive months. A few older riders pay $5 per month. In either instance, disability must have commenced before the insured reached the 60th or 65th birthday, depending upon the insurance. USGLI policies also carry a TDIP provision. The amount of the monthly payment, however, differs from that paid to NSLI policyholders. TDIP payments do not reduce the face value of the policy. TDIP is not available for policies with the prefix "RH," "JR" or "JS."

Servicemen's Group Life Insurance (SGLI)

All members of the uniformed services, including commissioned officers of the Public Health Service and the National Oceanic and Atmospheric Administration, and cadets and midshipmen of the four service academies, are automatically insured under Servicemen's Group Life Insurance (SGLI) for $100,000, unless they elect in writing to be covered for a lesser amount or not to be covered at all. They also may purchase up to an additional $100,000 for a total of $200,000. Full-time coverage also is provided, under certain conditions, for (1) persons who volunteer for assignment to the Ready Reserve of a uniformed service, and (2) persons assigned to the Retired Reserve of a uniformed service who have completed at least 20 years of satisfactory service creditable for retirement purposes.

Under certain conditions, part-time coverage is provided to members of the reserves who do not qualify for full-time coverage.

Premiums are deducted automatically from a member's pay, or are collected from members on active duty or in the Ready Reserve by their uniformed service. Members of the Retired Reserve must submit premiums directly to the Office of Servicemen's Group Life Insurance.

Members performing full-time duty under calls or orders not limited to 30 days or less are covered for 120 days following separation from service with no additional premium during that period. This also applies to members of the Ready Reserve who qualify for full-time coverage. Those members who are totally disabled at separation retain SGLI coverage up to one year or until the disability ceases to be total in degree, whichever occurs first, with no additional premium cost during this period.

Members of the reserve who qualify for full-time coverage and who are eligible for assignment to or are assigned to the Retired Reserve may convert their coverage to an individual commercial policy with any of the participating companies. As an alternative, they may continue their SGLI coverage after separation or release from their reserve obligation, provided the initial premium with identifying information is submitted within 120 days of release to the Office of Servicemen's Group Life Insurance, 213 Washington St., Newark, N.J. 07102. If the initial premium is not submitted within the 120 days, coverage may be granted, provided an application — SGLV 8713, Evidence of Insurability — and the initial premium are submitted to OSGLI within one year after the member's SGLI coverage is terminated.

Veterans' Group Life Insurance (VGLI)

SGLI may be converted to renewable five-year term coverage known as VGLI (Veterans' Group Life Insurance). This program is administered by OSGLI (Office of Servicemen's Group Life Insurance), 213 Washington St., Newark, N.J., 07102, and is supervised by the Department of Veterans Affairs. Coverage may be obtained in increments of $10,000 up to a maximum of $200,000, but not more than the amount of SGLI that the member had in force at the time of separation from military service. VGLI is available to:

(a) Individuals being released from active duty after Aug. 1, 1974.

(b) Reservists who, while performing active duty or inactive duty for training for a period of less than 31 days, suffer a disability which renders them uninsurable at standard premium rates.

(c) Members of the Individual Ready Reserve and Inactive National Guard.

Members on active duty entitled to SGLI coverage can convert to VGLI by submitting the premium within 120 days of separating from active duty. The insurance is effective on the 121st day. After 121 days, the veteran still may be granted VGLI provided initial premium and evidence of insurability are submitted within one year after the veteran's SGLI coverage is terminated. Insurance will be effective the day the premium is received in the office of SGLI. Members with full-time SGLI coverage who are totally disabled at the time of separation and whose service makes them eligible for VGLI may purchase the insurance while remaining totally disabled up to one year following separation. The effective date of VGLI will be at the end of the one-year period following separation or the date the disability ends, whichever is earlier, but not prior to 120 days after separation. Members insured under part-time SGLI coverage who incur a disability or aggravate a pre-existing disability during a reserve active or inactive period can apply for VGLI within the 120-day period following the period during which the disability was incurred or aggravated.

Totally disabled members must submit proof of disability with an application and the first premium. As persons separate from active duty, re-enlist and effect other changes in duty status, they may be eligible for both SGLI and VGLI. Any former

member insured under VGLI who may again become eligible for SGLI is automatically insured under the SGLI program. Both plans can be participated in if it is advantageous to the individual, as long as the combined amount of SGLI and VGLI does not exceed $200,000.

A VGLI policyholder has the right to convert to an individual commercial policy at standard premium rates, regardless of health, with any of the participating companies licensed to do business in the veteran's state. The individual policy will be effective the date after the insured's VGLI terminates at the end of any five-year period. The Office of SGLI will advise the insured of the impending date of termination and give information regarding the conversion of VGLI to an individual policy.

Individuals who remain in the Individual Ready Reserve or Inactive National Guard throughout their period of VGLI coverage can renew their VGLI for additional five-year periods instead of converting to an individual policy. They can still convert at the end of subsequent periods of coverage. Veterans wanting further information may contact their nearest VA office, or write to or call the Office of Servicemen's Group Life Insurance at 1-800-419-1473.

Veterans Mortgage Life Insurance (VMLI)

The maximum amount of mortgage life insurance available for those who have been granted or will be granted a specially adapted housing grant is $90,000. Protection is automatic unless eligible veterans decline in writing or fail to respond to a final request for information on which their premium can be based. Premiums are automatically deducted from VA benefit payments or paid direct, if the veteran does not draw compensation, and will continue until the mortgage, up to the maximum amount of insurance, has been liquidated, or the home is sold, or until the coverage terminates when the veteran reaches age 70, or dies. If a mortgage is disposed of through liquidation or sale of the property, VMLI may be obtained on the mortgage of a second or subsequent home.

Small and Disadvantaged Business Utilization

VA has an Office of Small and Disadvantaged Business Utilization (OSDBU) to assist small businesses to contract with and sell to the department. OSDBU provides information to large and small firms interested in doing business with VA. Like other federal purchasers, VA is required to place a fair portion of its contracts and purchases with small and disadvantaged businesses. VA also promotes business with veterans by requiring VA contracting offices to include veteran-owned contractors in mailings to solicit bids. These businesses are identified from the Procurement Automated Source System (PASS) maintained by the SBA. For more information, write to OSDBU (005SB) at the Department of Veterans Affairs, 810 Vermont Ave., N.W., Washington, D.C. 20420.

Special Groups with Veterans Benefits

A number of groups who have provided military-related service to the United States have been granted VA benefits. For the service to qualify, the Defense Secretary must certify that the group has provided active military service. Individual members must be issued a discharge by the Defense Secretary to qualify for VA benefits. Service in the following groups has been certified as active military service for benefits purposes:

1. Women's Air Forces Service Pilots (WASPs).
2. Signal Corps Female Telephone Operators Unit of World War I.
3. Engineer Field Clerks.
4. Women's Army Auxiliary Corps (WAAC).
5. Quartermaster Corps female clerical employees serving with the AEF (American Expeditionary Forces) in World War I.
6. Civilian Employees of Pacific Naval Air Bases who actively participated in defense of Wake Island during World War II.
7. Reconstruction aides and dietitians in World War I.
8. Male civilian ferry pilots.
9. Wake Island defenders from Guam.
10. Civilian personnel assigned to the secret intelligence element of the OSS.
11. Guam Combat Patrol.
12. Quartermaster Corps *Keswick* crew on Corregidor (WWII).
13. U.S. civilian volunteers who actively participated in the defense of Bataan.
14. U.S. merchant seamen who served on blockships in support of Operation Mulberry.
15. American merchant marines in oceangoing service during the period of armed conflict, Dec. 7, 1941, to Aug. 15, 1945.
16. Civilian Navy IFF technicians who served in the combat areas of the Pacific during World War II, Dec. 7, 1941, to Aug. 15, 1945.
17. U.S. civilians of the American Field Service who served overseas in World War I between Aug. 31, 1917, and Jan. 1, 1918.
18. U.S. civilians of the American Field Service who served overseas under U.S. armies and U.S. army groups in World War II between Dec. 7, 1941, and May 8, 1945.
19. U.S. civilian employees of American Airlines who served overseas in a contract with the Air Transport Command between Dec. 14, 1941, and Aug. 14, 1945.
20. Civilian crewmen of U.S. Coast and Geodetic Survey vessels who served in areas of immediate military hazard while conducting cooperative operations with and for the U.S. Armed Forces between Dec. 7, 1941, and Aug. 15, 1945.
21. Honorably discharged members of the American Volunteer Group (Flying Tigers) who served between Dec. 7, 1941, and July 18, 1942.
22. U.S. civilian flight crew and aviation ground support employees of United Air Lines who served overseas in a contract with Air Transport Command between Dec. 14, 1941, and Aug. 14, 1945.

23. U.S. civilian flight crew and aviation ground support employees of Transcontinental and Western Air Inc. (TWA), who served overseas in a contract with the Air Transport Command between Dec. 14, 1941, and Aug. 14, 1945.
24. U.S. civilian flight crew and aviation ground support employees of Consolidated Vultee Aircraft Corp. (Consairway Division) who served overseas in a contract with Air Transport Command between Dec. 14, 1941, and Aug. 14, 1945.
25. U.S. civilian flight crew and aviation ground support employees of Pan American World Airways and its subsidiaries and affiliates, who served overseas in a contract with the Air Transport Command and Naval Air Transport Service between Dec. 14, 1941, and Aug. 14, 1945.
26. Honorably discharged members of the American Volunteer Guard, Eritrea Service Command, between June 21, 1942, and March 31, 1943.

Benefits For Survivors

Dependency and Indemnity Compensation

Death Due to Service-Connected Disability

Dependency and Indemnity Compensation (DIC) payments may be authorized for surviving spouses, unmarried children under 18, helpless children, those between 18 and 23 if attending a VA-approved school, and low-income parents of service personnel or veterans who died from: (a) a disease or injury incurred or aggravated in line of duty while on active duty or active duty for training; or (b) an injury incurred or aggravated in line of duty while on inactive duty training; or (c) a disability compensable by VA. Death cannot be the result of willful misconduct.

Death Due to a Nonservice-Connected Cause

DIC payments also may be authorized for surviving spouses, unmarried children under 18, helpless children, and those between 18 and 23 if attending a VA-approved school, of veterans who were totally service-connected disabled at time of death but whose deaths were not the result of their service-connected disability, if: (1) the veteran was continuously rated totally disabled for a period of 10 or more years immediately preceding death; or (2) the veteran was so rated for a period of not less than five years from the date of discharge from military service. Payments under this provision are subject to offset by the amount received from judicial proceedings brought on account of the veteran's death. When death occurred after service, the veteran's discharge must have been under conditions other than dishonorable.

Definition of Surviving Spouse

Date of Marriage — A surviving spouse generally must have been married to the veteran one year or more, or for any period of time if a child was born of the union.

Residence with Veteran — The surviving spouse must have lived continuously with the veteran from the time of marriage until the veteran's death, except where there was a separation not due to the fault of the surviving spouse.

Surviving Spouse Remarriage — Remarriage makes a surviving spouse ineligible based on the death of that veteran unless the remarriage is made void or is annulled by a court. A surviving spouse also may be ineligible if, after the death of the veteran, the spouse lived with another and was held out openly to the public to be the spouse.

Deemed-Valid Marriage — If she or he meets the other qualifications, a spouse who married a veteran without knowing that a legal impediment to the marriage existed may be eligible for compensation.

DIC Payments to Surviving Spouse

All surviving spouses of veterans who died after Jan. 1, 1993, receive $769 a month. An additional $169 a month will supplement the basic rate if the deceased veteran had been entitled to receive 100 percent service-connected compensation for at least eight years immediately preceding death and the surviving spouse was married to

the veteran for those same eight years. For a surviving spouse entitled to DIC based on the veterans's death prior to Jan. 1, 1993, the amount paid will be the amount based on the veteran's pay grade as given in the following table:

DIC RATE

Pay grade	Monthly rate
E-1 – E-6	$769
E-7	794
E-8	838
E-9*	875
W-1	812
W-2	844
W-3	869
W-4	920
0-1	812
0-2	838
0-3	897
0-4	948
0-5	1,044
0-6	1,177
0-7	1,271
0-8	1,392
0-9	1,492
0-10*	1,636

*There may be special rates for individuals in these pay grades

DIC for Children or Parents

There are additional payments for children. The monthly DIC rates for parents depend upon the income of the parents and whether there is only one parent, two parents not living together or two parents together or remarried. The income limit for two parents together or remarried and with spouse is $11,956; the limit for one parent or two parents not together is $8,893.

Aid and Attendance

Surviving spouses and parents receiving DIC may be granted a special allowance to pay for aid and attendance if they are patients in a nursing home or require the regular assistance of another person. The allowance is $195 monthly, in addition to the DIC rate for a surviving spouse, and $197 monthly additional for a parent receiving DIC.

Housebound

Surviving spouses receiving DIC who are not so disabled as to require the regular aid and attendance of another person but who, due to disability, are permanently housebound may be granted an additional special allowance of $95 a month.

Restored Entitlement Program for Survivors

Certain survivors of veterans who died of service-connected causes incurred or aggravated prior to Aug. 13, 1981, are eligible for benefits. The benefits are similar to the benefits for students and surviving spouses with children between ages 16 and 18 which were eliminated from Social Security benefits. The benefits are

payable in addition to any other benefits to which the family may is entitled. The amount of benefits is based on information from the Social Security Administration.

Death Compensation Relating to Deaths Before Jan. 1, 1957

Death compensation payments are authorized for surviving spouses, helpless children, and dependent parents of servicepersons or veterans who died before Jan. 1, 1957, from a service-connected cause not the result of willful misconduct. Survivors with eligibility for death compensation benefits may elect instead to receive DIC benefits. Generally the DIC benefits will pay greater rates, especially for surviving spouses and children. More specific information about death compensation benefits may be obtained from the nearest VA regional office. If a survivor has eligibility for both death compensation and DIC, the VA office processing the claim will notify the survivor about the dual entitlement.

Nonservice-Connected Death Pension

Surviving spouses and unmarried children under age 18, or until age 23 if attending a VA-approved school, of deceased veterans with wartime service may be eligible for a nonservice-connected pension based on need. Pension is not payable to those with estates large enough to provide maintenance.

The veteran must have been discharged under conditions other than dishonorable and must have had 90 days or more of active military service, at least one day of which was during a period of war, or a service-connected disability justifying discharge for disability. If the veteran died in service not in line of duty, benefits may be payable if the veteran had completed at least two years of honorable service.

Children who became permanently incapable of self-support because of a disability before reaching age 18 may be eligible for a pension as long as the condition exists, unless the child marries or the child's income exceeds the applicable limit.

A surviving spouse who is a patient in a nursing home, is in need of the regular aid and attendance of another person or is permanently housebound may be entitled to higher income limitations or additional benefits, depending upon the type of pension received.

Definition of Surviving Spouse

Date of Marriage — The spouse must have married the veteran at least one year prior to the veteran's death, unless a child resulted from the union.

Residence with Veteran — The spouse must have lived continuously with the veteran from the time of marriage until the veteran's death, unless there was a separation not due to the fault of the surviving spouse.

Remarriage — Remarriage following the death of the veteran makes the surviving spouse ineligible for pension unless the remarriage is made void or is annulled by a court. A surviving spouse also may be ineligible if after the death of the veteran the spouse lived with another and was held out openly to the public to be the spouse.

Deemed-Valid Marriages — A spouse may be eligible for pension if married to the veteran without knowing that a legal impediment to the marriage existed.

Benefits

The Improved Pension program provides a monthly payment to bring an eligible person's income to a support level established by law. The payment is reduced by the annual income from other sources such as Social Security that may be payable to either the surviving spouse or dependent children. Countable income may be reduced by medical expenses. Pension is not payable to those who have assets that can be used to provide adequate maintenance.

Improved Pension

Recipient	Annual Income
Surviving spouse with no dependent children	$5,239
Surviving spouse with one dependent child	$6,863
Surviving spouse in need of regular aid and attendance with no dependent child	$8,380
Surviving spouse in need of regular aid and attendance with one dependent child	$10,000
Surviving spouse permanently housebound with no dependent child	$6,406
Surviving spouse permanently housebound with one dependent child	$8,026
Increase for each additional dependent child	$1,330
Pension rates for each surviving child	$1,330

Montgomery GI Bill (Active Duty) Death Benefit

VA will pay a special death benefit to a designated survivor if the serviceperson's death is in service or is service-connected and within one year after discharge or release. The deceased must have been a participant in the Montgomery GI Bill program. The death benefit also will be paid if the serviceperson would have been eligible to participate but for the high-school diploma requirement and the length-of-service requirement. The amount paid will be equal to the participant's actual military pay reduction less any education benefits paid.

Survivors' and Dependents' Education

Eligibility

Educational assistance benefits are available to spouses and children of:

(a) Veterans who died or are permanently and totally disabled as the result of a disability arising from active service in the Armed Forces.

(b) Veterans who died from any cause while rated permanently and totally disabled

from service-connected disability.
(c) Servicepersons currently missing in action or captured in line of duty by a hostile force.
(d) Servicepersons presently detained or interned in line of duty by a foreign government or power.

Education and Training Available

Benefits may be awarded for pursuit of associate, bachelor or graduate degrees at colleges and universities — including independent study, cooperative training and study abroad programs. Courses leading to a certificate or diploma from business, technical or vocational schools may be taken. Benefits may be awarded for apprenticeships, on-job training programs and farm cooperative courses. Benefits for correspondence courses are available to spouses only. Secondary-school programs may be pursued if the individual is not a high-school graduate. An individual with a deficiency in a subject may receive tutorial assistance benefits if enrolled half-time or more. Remedial, deficiency and refresher training also may be available.

Special Benefits

An eligible child over age 14 with a physical or mental disability that impairs pursuit of an educational program may receive special restorative training to lessen or overcome that impairment. This training may include speech and voice correction, language retraining, lip reading, auditory training, Braille reading and writing, and similar programs. Specialized vocational training also is available to an eligible spouse or child over age 14 who is handicapped by a physical or mental disability that prevents pursuit of an educational program.

Counseling Services

VA will provide counseling services to help an eligible dependent select an educational or vocational objective, develop a plan to achieve it, and overcome any problems interfering with successful completion.

Payments

Payments are made monthly. The full-time rate is $404 a month for full-time school attendance, with lesser amounts for part-time training. A person may receive educational assistance for full-time training for up to 45 months or the equivalent in part-time training.

Period of Eligibility

Benefits to a spouse end 10 years from the date VA first finds the individual eligible. VA may grant an extension of this period if a physical or mental disability prevented the individual from using some portion of the education benefits. The disability must occur during the individual's 10-year period of eligibility. Children generally must be between the ages of 18 and 26 to receive education benefits. Extensions may be granted, including those for time the child spends on active military duty. No extension can go beyond the individual's 31st birthday.

Work-Study

To receive work-study benefits, participants must train at the three-quarter or full-time rate. Payments may be at the federal minimum wage or, if greater, the hourly minimum wage of the state where the services are performed. Work-study may include outreach services under the supervision of a VA employee, preparing and processing VA paperwork, working at a VA medical facility or performing other approved activities.

Educational Loans

Loans are available to spouses who qualify for Survivors' and Dependents' Educational Assistance benefits. Spouses who have passed their 10-year period of eligibility and who have remaining entitlement may be eligible for an educational loan. During the first two years after the end of their eligibility period they may borrow up to $2,500 per academic year to continue a full-time course leading to a college degree or to a professional or vocational objective which requires at least six months to complete. VA may waive the six-month requirement. The loan program is based on financial need.

Home Loan Guaranties

A GI loan guaranty to acquire a home may be available to an unremarried spouse of a veteran or serviceperson who served after Sept. 16, 1940, and who died as a result of service-connected disabilities, or to a spouse of a serviceperson who has been officially listed as missing in action or as a prisoner of war for more than 90 days. Spouses of those listed as POW or MIA are limited to one loan.

Burial Benefits

Burial in National Cemeteries

Benefit

Burial benefits in a VA national cemetery include the gravesite, opening and closing of the grave, and perpetual care. Many national cemeteries have columbaria for the inurnment of cremated remains or special gravesites for the burial of cremated remains. Headstones and markers and their placement are provided at the government's expense. For a list of available cemeteries, see the "VA Facilities" section in the back of this book.

Eligibility

Veterans and armed forces members who die on active duty are eligible for burial in one of VA's 114 national cemeteries. An eligible veteran must have been discharged or separated from active duty under conditions other than dishonorable and have completed the required period of service. A U.S. citizen who served in the armed forces of a government allied with the United States in a war also may be eligible. Spouses and dependent, minor children of eligible veterans and of armed forces members also may be buried in a national cemetery.

A surviving spouse of an eligible veteran who married a nonveteran prior to Oct. 31, 1990, and whose remarriage was terminated by death or divorce prior to or on that date is eligible for burial in a national cemetery. A surviving spouse of an eligible veteran who married a nonveteran prior to Oct. 31, 1990, and whose remarriage was still intact on or after that date, however, is not eligible for burial in a national cemetery. A surviving spouse who marries a nonveteran after Oct. 31, 1990, is not eligible for burial in a national cemetery.

Gravesites in national cemeteries cannot be reserved. Funeral directors or others making burial arrangements must apply at the time of death. Reservations made under previous programs are honored. The National Cemetery System normally does not conduct burials on weekends. A weekend caller, however, will be directed to one of three strategically located VA cemetery offices that remain open during weekends to schedule burials at the cemetery of the caller's choice during the upcoming week.

Arlington National Cemetery

Arlington National Cemetery, which is under the jurisdiction of the Army, has a more limited eligibility than other national cemeteries. Eligibility for inurnment of cremated remains in Arlington's columbarium is the same as eligibility for burial in VA national cemeteries. For information on Arlington burials, write to Superintendent, Arlington National Cemetery, Arlington, VA 22211, or telephone 703-695-3250.

Interior Department, State Veteran Cemeteries

Eligibility criteria similar to VA national cemetery eligibility apply to the two active national cemeteries administered by the Department of the Interior — Andersonville National Cemetery in Georgia and Andrew Johnson National Cemetery in Tennessee. Cemeteries for veterans are operated by many states. For burials in these

cemeteries, contact the Interior Department or the applicable state.

Headstones and Markers

Benefit

VA provides headstones and markers for the graves of veterans anywhere in the world and for eligible dependents of veterans buried in national, state veteran or federal cemeteries. Flat bronze, flat granite, flat marble and upright marble types are available to mark the grave of a veteran or dependent in the style consistent with existing monuments at the place of burial. Niche markers also are available to mark columbaria used for the inurnment of cremated remains.

Headstones and markers are inscribed with the name of the deceased, the years of birth and death, and branch of service. Optional items that also may be inscribed at VA expense are: military grade, rank or rate; war service (such as "World War II"); months and days of birth and death; an emblem reflecting one's beliefs; valor awards received; and the Purple Heart. Additional items may be inscribed at private expense.

When burial is in a national cemetery, military post or state veterans cemetery, the headstone or marker is ordered through the cemetery, which will place it on the grave. Information regarding style, inscription, shipping and placement can be obtained from the cemetery.

When burial occurs in a cemetery other than a national cemetery or a state veterans cemetery, the headstone or marker must be applied for from VA. It is shipped at government expense to the consignee designated on the application. VA, however, does not pay the cost of placing the headstone or marker on the grave. To apply, complete VA Form 40-1330 and forward it to Director, Office of Memorial Programs (403A), National Cemetery System, Department of Veterans Affairs, Washington, DC 20420. Forms and assistance are available at VA regional offices. For information regarding the status of an application, write to the Director, Office of Memorial Programs (403B3), or call 1-800-697-6947.

Eligibility

Eligibility for a VA headstone or marker is the same as for burial in a national cemetery. VA cannot issue a headstone or marker for a spouse or dependent buried in a private cemetery. Twenty-year reservists without active-duty service are eligible for a headstone or grave marker, if they are entitled to military retired pay at the time of death.

Headstones or Markers for Memorial Plots

Benefit

To memorialize an eligible veteran whose remains are not available for burial, VA will provide a plot and headstone or marker in a national cemetery. The headstone or marker is the same as that used to identify a grave except that the mandatory phrase "In Memory of" precedes the authorized inscription. The plot and headstone or marker are available to memorialize eligible veterans or deceased active-duty members whose remains were not recovered or identified, were buried at sea, donated to science, or cremated and scattered. The memorial marker may be provided for placement in a cemetery at other than a national cemetery. In such a case, VA supplies the marker and pays the cost of shipping the marker to the consignee designated on the application, but does not pay for the cost of the plot or the placement of the marker.

Eligibility

Eligibility for memorial plots and headstones or markers is the same as eligibility for burial in a national cemetery. Only a close relative recognized as the next of kin may apply for the benefit. For more information, contact a national cemetery or a VA regional office.

Presidential Memorial Certificates

Benefit

The Presidential Memorial Certificate is a parchment certificate with a calligraphic inscription expressing the nation's grateful recognition of the veteran's service. The veteran's name is inscribed and the certificate bears the signature of the President.

Eligibility

Certificates are issued in the name of honorably discharged, deceased veterans. Eligible recipients include next of kin, other relatives and friends. The award of a certificate to one eligible recipient does not preclude certificates to other eligible recipients. The veteran may have died at any time in the past. The local VA regional office generally originates the application for a Presidential Memorial Certificate if a veteran's death is brought to official attention. The next of kin may request a certificate when a servicemember dies on active duty, or if the veteran was not receiving a VA benefit. Requests should be accompanied by a copy of a document such as a discharge to establish honorable service. VA regional offices can assist in applying for certificates. Requests for certificates recognizing service prior to July 16, 1903, should be sent to the VA Regional Office, 941 N. Capitol St., N.E., Washington, DC 20421.

Burial Flags

VA provides an American flag to drape the casket of a veteran who was discharged under conditions other than dishonorable and to a person entitled to retired military pay, including reservists. After the funeral service, the flag may be given to the next of kin or a close associate of the deceased. VA also will issue a flag on behalf of a servicemember who was missing in action and later presumed dead. Flags are issued at VA regional offices, VA national cemeteries and most local post offices.

Reimbursement of Burial Expenses

VA will pay a burial allowance up to $1,500 if the veteran's death is service-connected. VA also will pay the cost of transporting the remains of a service-disabled veteran to the national cemetery nearest the home of the deceased that has available gravesites. In such cases, the person who bore the veteran's burial expenses may claim reimbursement from VA.

VA will pay a $300 burial and funeral expense allowance for veterans who, at time of death, were entitled to receive pension or compensation or would have been entitled to compensation but for receipt of military retirement pay. Eligibility also is established when death occurs in a VA facility or a nursing home with which VA contracted. Additional costs of transportation of the remains may be reimbursed in those cases. Concerning service-connected deaths, there is no time limit for filing reimbursement claims. In other deaths, claims must be filed within two years after permanent burial or cremation.

VA will pay a $150 burial allowance when the veteran is not buried in a cemetery that is under U.S. government jurisdiction if the veteran is discharged from active duty because of disability incurred or aggravated in line of duty or if the veteran was in receipt of compensation or pension or would have been in receipt of

compensation but for receipt of military retired pay, or if the veteran died while hospitalized by VA. As of Nov. 1, 1990, the plot allowance is no longer payable based solely on wartime service. If the veteran is buried without charge for the cost of a plot or interment in a state-owned cemetery reserved solely for veteran burials, the $150 plot allowance may be paid to the state. If burial expenses were paid by the deceased's employer or a state agency, the burial allowance will not be reimbursed to those making interment arrangements.

Health Care Benefits

Hospital and Nursing-Home Care

Eligibility for VA hospital care and nursing-home care is divided into two categories: "mandatory" and "discretionary." VA must provide hospital care and may provide nursing-home care to veterans in the mandatory category. VA may provide hospital and nursing-home care to veterans in the discretionary category if space and resources are available in VA facilities. VA makes an income assessment to determine whether a nonservice-connected veteran is eligible for cost-free VA medical care. These income levels are adjusted on Jan. 1 of each year, based on the percentage of increase provided to VA improved-pension benefits.

The law requires that VA must provide hospital care to veterans in the mandatory category at the nearest VA facility capable of furnishing the care in a timely fashion. If no VA facility is available, care must be furnished in a Defense Department facility or another facility with which VA has a sharing or contractual relationship. If space and resources at VA hospitals and nursing homes are available after caring for service-connected veterans, then VA may furnish care to those in the discretionary category. Veterans in the discretionary category must agree to pay VA for their care.

Veterans who must be provided hospital care and may be provided nursing-home care and who are not subject to an income eligibility assessment are: veterans with service-connected disabilities, veterans who were exposed to herbicides while serving in Vietnam, veterans exposed to ionizing radiation during atmospheric testing or in the occupation of Hiroshima and Nagasaki, veterans for a condition related to service in the Persian Gulf, former prisoners of war, veterans on VA pension, veterans of the Mexican Border period or World War I and veterans eligible for Medicaid. The following income eligibility assessment applies to all other nonservice-connected veterans:

MANDATORY: Veterans must be provided hospital care if the patient is a nonservice-connected veteran with income of $19,912 or less if single with no dependents, or $23,896 or less if married or single with one dependent. The income maximum is raised $1,330 for each additional dependent. Hospital care in VA facilities must be provided to veterans in the mandatory category. Nursing-home care may be provided in VA facilities, if space and resources are available.

DISCRETIONARY: Veterans may be provided hospital care if the patient is a nonservice-connected veteran and income is above $19,912 if single with no dependents, or $23,896 if married or single with one dependent, plus $1,330 for each additional dependent. The patient must agree to pay an amount equal to what would have been paid under Medicare. The Medicare deductible currently is $696 and is adjusted annually. VA may provide hospital, outpatient and nursing-home care in VA facilities to veterans in the discretionary category, if space and resources are available.

If the patient's medical care is considered discretionary, VA holds the patient responsible for the cost of care up to $696 for the first 90 days of care during any 365-day period. For each additional 90 days of hospital care, the patient is charged half the Medicare deductible. For each 90 days of nursing-home care, an amount equal to the Medicare deductible is charged. In addition to these charges, the patient will be charged $10 per day for hospital care and $5 a day for nursing-home care.

How Income Is Assessed

The patient's total income under the eligibility assessment includes Social Security, U.S. Civil Service retirement, U.S. Railroad Retirement, military retirement, unemployment insurance, any other retirement income, total wages from all employers, interest and dividends, workers' compensation, black lung benefits and any other gross income for the calendar year prior to application for care. The income of spouse and dependents as well as the market value of stocks, bonds, notes, individual retirement accounts, bank deposits, savings accounts and cash also are used. Debts are subtracted from the patient's assets to determine net worth. The patient's primary residence and personal property are excluded. The patient must fill out VA Form 10-10f, Financial Worksheet, at the time care is requested. VA has the authority to compare information provided by the veteran with information obtained from the Department of Health and Human Services and the Internal Revenue Service.

Billing Insurance Companies

All veterans applying for medical care at a VA facility will be asked if they have medical insurance. VA is authorized by law to bill insurance companies for the cost of medical care furnished to veterans, including service-connected veterans, for nonservice-connected conditions covered by health insurance policies. A veteran may be covered by such a policy or be covered as an eligible dependent on a spouse's policy. Veterans are not responsible and will not be charged by VA for any charge required by their health-insurance policies. Veterans will not be responsible for uncovered charges from the insurance company, except for copayments required by federal law.

Nursing-Home Care

Benefit

Skilled nursing care and related medical care in VA or private nursing homes is provided for convalescents or persons who are not acutely ill and not in need of hospital care.

Eligibility

Admission or transfer to VA nursing-home care is the same as for hospital care. Veterans who have a service-connected disability are given first priority. Direct admission to private nursing homes at VA expense is limited to: (1) a veteran who requires nursing care for a service-connected disability after medical determination by VA, (2) any person in an Armed Forces hospital who requires a protracted period of nursing care and who will become a veteran upon discharge from the Armed Forces, and (3) a veteran who had been discharged from a VA medical center and is receiving home health services from a VA medical center. VA may transfer veterans who need nursing-home care to private nursing homes at VA expense from VA medical centers, nursing homes or domiciliaries. VA-authorized care normally may not be provided in excess of six months, except for veterans whose need for nursing-home care is for a service-connected disability or for veterans who were hospitalized primarily for treatment of a service-connected disability. Nursing-home care may be authorized for nonservice-connected veterans whose income exceeds the income limit for hospital care if the veteran agrees to pay the applicable copayment.

Domiciliary Care

Domiciliary care provides rehabilitative and long-term, health-maintenance care for veterans who require minimal medical care but who do not need the skilled nursing services provided in nursing homes. VA provides domiciliary care to veterans

whose annual income does not exceed the maximum annual rate of VA pension and to veterans the Secretary of Veterans Affairs determines have no adequate means of support.

Outpatient Medical Treatment

Benefit

Outpatient medical treatment includes medical examinations and related medical services, drugs and medicines, rehabilitation services, and mental health services. As part of outpatient medical treatment, veterans may be eligible for home health services for the treatment of disabilities.

Eligibility

1. VA must furnish outpatient care without limitation to:
   - Veterans for service-connected disabilities.
   - Veterans with a 50 percent or more service-connected disability, for any disability.
   - Veterans who have suffered an injury as a result of VA hospitalization, for that condition only.

2. VA must furnish outpatient care for any condition to prevent the need for hospitalization, to prepare for hospitalization or to complete treatment after hospital care, nursing-home care or domiciliary care to:
   - 30-40 percent service-connected disabled veterans.
   - Veterans whose annual income is not greater than the maximum annual pension rate of a veteran in need of regular aid and attendance.

3. VA may furnish outpatient care without limitation to:
   - Veterans in a VA-approved vocational rehabilitation program.
   - Former prisoners of war.
   - World War I or Mexican Border Period veterans.
   - Veterans who receive increased pension or compensation based on the need for regular aid and attendance of another person, or who are permanently housebound.

4. VA may furnish outpatient care to prevent the need for hospitalization, to prepare for hospitalization, or for a condition for which the veteran was hospitalized to:
   - 0-20 percent service-connected disabled veterans.
   - Veterans exposed to a toxic substance during service in Vietnam; or to ionizing radiation following the detonation of a nuclear device; or to environmental contaminants in the Persian Gulf Theater, for conditions related to such exposures.
   - Mandatory category veterans whose income is more than the pension rate of a veteran in need of regular aid and attendance.
   - Discretionary category veterans, subject to a copayment of $36 per outpatient visit.
   - Allied beneficiaries, beneficiaries of other federal agencies and certain other nonveterans.

5. Counseling for Women Veterans. Counseling is provided to any woman veteran who requires it to overcome psychological trauma resulting from physical assault, battery of a sexual nature or sexual harassment during active duty. The counseling is provided at VA medical centers and Vet Centers.

Outpatient Pharmacy Services

Veterans receiving medication for treatment of service-connected conditions and veterans rated with 50 percent or more service-connected disability are not charged

for pharmacy services. Veterans whose annual income does not exceed the maximum VA pension are not charged. Veterans with a service-connected condition rated less than 50 percent receiving medication on an outpatient basis from VA facilities for the treatment of nonservice-connected disabilities or ailments are charged $2 for each 30-day supply or less.

Outpatient Dental Treatment

Outpatient dental treatment may include examinations and the full spectrum of diagnostic, surgical, restorative and preventive techniques.

(a) Dental conditions or disabilities that are service connected and compensable in degree will be treated.

(b) Service-connected dental conditions or disabilities that are not compensable in degree may receive one-time treatment if the conditions can be shown to have existed at discharge or within 180 days of release from active service. Veterans who served on active duty for 90 days or more during the Persian Gulf War are included in this category. Veterans must apply to VA for care for the service-connected dental condition within 90 days following separation. Veterans will not be considered eligible if their separation document indicates that necessary treatment was completed by military dentists during the 90 days prior to separation.

(c) Service-connected, noncompensable, dental conditions resulting from combat wounds or service injuries, and service-connected, noncompensable, dental conditions of former prisoners of war who were incarcerated less than 90 days may be treated.

(d) Veterans who were prisoners of war for more than 90 days can receive complete dental care.

(e) Veterans can receive complete dental care if they are receiving disability compensation at the 100-percent rate for service-connected conditions or are eligible to receive it by reason of unemployability.

(f) Nonservice-connected dental conditions that are determined by VA to be associated with an aggravated, service-connected medical problem can be treated.

(g) Disabled veterans participating in a vocational rehabilitation program will be treated.

(h) Veterans can be treated for nonservice-connected dental conditions or disabilities when treatment was begun while in a VA medical center, when it is professionally determined to be reasonably necessary to complete such dental treatment on an outpatient basis.

(i) Veterans scheduled for admission to inpatient services or who are receiving medical services can be provided outpatient dental care if the dental condition is professionally determined to be complicating a medical condition currently under treatment by VA.

Nonservice-connected veterans who are authorized outpatient dental care may be billed the applicable copayment if their income exceeds the maximum threshold.

Persian Gulf, Agent Orange and Ionizing Radiation

Registry Examination Programs

Under the auspices of VA's Persian Gulf, Agent Orange and Ionizing Radiation Registries, veterans who served in the Persian Gulf War or who claim exposure to Agent Orange or atomic radiation are provided with free, comprehensive medical examinations, including base-line laboratory tests and other tests determined necessary by an examining physician to determine current health status. Results of the examinations, which include completion of a questionnaire about the veteran's military service and exposure history, are entered into special, computerized programs maintained by VA. These data bases assist VA in analyzing the types of health conditions being reported by veterans. Registry participants are advised of

the results of their examinations by personal consultation. Each registry serves as an outreach mechanism which assists VA in providing participants with significant information of concern to them. Veterans wishing to participate should contact the nearest VA health-care facility to request an examination. Appointments generally can be arranged within two to three weeks.

Agent Orange, Nuclear Radiation and Environmental Contamination Treatment

VA provides priority treatment to any Vietnam-Era veteran who, while serving in Vietnam, may have been exposed to dioxin or to a toxic substance in a herbicide or defoliant used for military purposes. Priority health-care services are available for any veteran exposed to ionizing radiation from the detonation of a nuclear device in connection with nuclear tests or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning Sept. 11, 1945, and ending July 1, 1946. Treatment was authorized through June 30, 1994, for veterans exposed to Agent Orange or nuclear radiation. VA also provides priority treatment to any Persian Gulf veteran who requires treatment for a condition medically determined to be possibly related to service in the Persian Gulf area.

Beneficiary Travel

Payment or reimbursement for travel costs to receive VA medical care, called beneficiary travel payment, may be made to the following:
(a) Veterans whose service-connected disabilities are rated at 30 percent or more.
(b) Veterans who are traveling in connection with treatment of a service-connected condition.
(c) Veterans who are in receipt of VA pension.
(d) Veterans traveling in connection with a compensation and pension examination.
(e) Veterans whose income is less than or equal to the maximum base VA pension rate.
(f) Veterans whose medical condition requires use of a special mode of transportation, if the veteran is unable to defray the costs and travel is pre-authorized — unless the medical condition is a medical emergency.

Travel is subject to a deductible of $3 for each one-way trip — with an $18 per month cap. Two exceptions to this rule are travel for a compensation and pension examination and travel by special modes of transportation.

Counseling for Persian Gulf Veterans

Marital and family counseling is provided to veterans of the Persian Gulf War and their spouses and children. The counseling is provided at VA medical centers and Vet Centers.

Counseling for Sexual Trauma

Counseling may be furnished to a woman veteran to overcome psychological trauma which, in the judgment of a mental health professional employed by VA, resulted from physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while serving on active duty.

Alcohol and Drug Dependence Treatment

Veterans without service-connected disabilities whose incomes exceed the threshold for free medical care may be authorized treatment for alcohol and drug dependence only if the veteran agrees to pay the applicable copayment. After hospitalization for alcohol or drug treatment, veterans may be eligible for outpatient care or may be

authorized to continue treatment or rehabilitation at VA expense in private facilities such as halfway houses.

Prosthetic Services

Veterans may apply for prosthetic services to treat any condition when receiving hospital, domiciliary or nursing-home care in a VA facility. Veterans who meet the basic requirements for outpatient medical treatment may be provided needed prosthetic services:
(1) For a service-connected disability or adjunct condition.
(2) For any medical condition for a veteran with a service-connected disability rated at 50 percent or more or for a veteran receiving compensation as a result of treatment in a VA facility.
(3) For a disability for which a veteran was discharged or released from active service.
(4) For a veteran participating in a rehabilitation program under 38 USC Chapter 31.
(5) As part of outpatient care to complete treatment of a disability for which hospital, nursing home or domiciliary care was provided.
(6) For a veteran in receipt of increased pension or allowance based on needing aid and attendance or being permanently housebound.
(7) For a veteran of World War I or the Mexican Border period.
(8) For a former prisoner of war.

Blind Aids and Services

Veterans are eligible to receive VA aids for the blind if their blindness is a service-connected disability, if they are entitled to compensation from VA for any service-connected disability or if they are eligible for VA medical services. Veterans with corrected vision of 20/200 or less in the better eye or field defect of 20 degrees or less are considered to be blind. Blind veterans need not be receiving compensation or pension to be eligible for admission to a VA blind rehabilitation center or clinic, or to receive services at a VA medical center. Benefits include:
(a) A total health and benefits review by a VA Visual Impairment Services Team (VIST)
(b) Adjustment to blindness training.
(c) Home improvements and structural alterations to homes (HISA Program).
(d) Specially adapted housing and adaptations.
(e) Low-vision aids and training in their use.
(f) Approved electronic and mechanical aids for the blind, and their necessary repair and replacement.
(g) Guide dogs, including the expense of training the veteran to use the dog and the cost of the dog's medical care.
(h) Talking books, tapes and Braille literature, provided from the Library of Congress.

Readjustment Counseling

Veterans who served on active duty during the Vietnam Era or served in the war or conflict zones of Lebanon, Grenada, Panama or the Persian Gulf theaters during periods of hostilities or war are entitled to counseling to assist in readjusting to civilian life.

Counseling is provided at Vet Centers of the VA's Readjustment Counseling Service to help veterans resolve war-related psychological difficulties and to help them achieve a successful post-war readjustment to civilian life. Assistance includes group, individual and family counseling, community outreach and education. Vet Center staff help veterans find services from VA and non-VA sources if needed. One common readjustment problem is post-traumatic stress disorder, or PTSD.

This refers to such symptoms as nightmares, intrusive recollections or memories, flashbacks, anxiety or sudden reactions after exposure to traumatic conditions. Readjustment difficulties may affect functioning in school, family or work. Counseling also is provided veterans for difficulties due to sexual assault or harassment while on active duty.

The location of the nearest Vet Center usually can be found in the U.S. Government section of the phone book under Department of Veterans Affairs. All Vet Centers are listed in the back of this booklet. In areas which are distant from Vet Centers or VA medical facilities, veterans may obtain readjustment counseling from private sector counselors, psychologists, social workers or other professionals who are on contract with VA. To locate a contract provider, contact the nearest Vet Center.

Income Verification Matching

Income of veterans receiving VA medical care based on income is verified with records maintained by the Internal Revenue Service and the Social Security Administration. Service-connected veterans are not subject to the verification even when evaluated or treated for a nonservice-connected condition. The purpose of the verification is to ensure proper VA medical care is administered to eligible veterans.

Home Improvements and Structural Alterations

The Home Improvements and Structural Alterations (HISA) program helps pay for home improvements necessary to assume continuation of treatment or provide access to the home and essential lavatory and sanitary facilities. For alterations, VA will pay up to $4,100 for veterans being treated for a service-connected disability, and up to $1,200 for the nonservice-connected disability of a veteran receiving post-hospital care or a veteran rated 50 percent or more disabled.

Medical Care for Merchant Seamen

Those Merchant Marine seamen whose World War II service qualifies them for veterans' benefits must present their DD-214 discharge certificate when applying for medical care benefits at VA medical centers. VA regional offices can provide information on obtaining a certificate.

Medical Care for Allied Veterans

VA is authorized to provide reciprocal medical care to veterans of nations allied or associated with the United States during World War I or World War II. Such treatment is available at any VA medical facility but must be authorized and reimbursed by the foreign government. VA also is authorized to provide hospitalization, outpatient and domiciliary care to former members of the armed forces of the governments of Czechoslovakia or Poland who participated during World Wars I and II in armed conflict against an enemy of the United States, if they have been citizens of the United States for at least 10 years. Benefits are the same as those provided to U.S. veterans.

Medical Care for Dependents and Survivors (CHAMPVA)

The VA Civilian Health and Medical Program, known as CHAMPVA, shares the cost of medical services and supplies obtained by eligible dependents and survivors of certain veterans. The following are eligible for CHAMPVA benefits, provided they are not eligible for medical care under CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) or Medicare, Part A, as a result of reaching age 65:

(a) The spouse or child of a veteran who has a permanent and total service-connected disability.
(b) The surviving spouse or child of a veteran who died as a result of a service-connected condition; or who at the time of death was permanently and totally disabled from a service-connected condition.
(c) The surviving spouse or child of a person who died while on active military service in the line of duty.

Beneficiaries age 65 or older who lose eligibility for CHAMPVA by becoming potentially eligible for Medicare, Part A, or who qualify for Medicare, Part A, benefits on the basis of a disability may re-establish CHAMPVA eligibility by submitting documentation from the Social Security Administration certifying their nonentitlement to or exhaustion of Medicare, Part A, benefits. Persons under age 65 who are enrolled in both Medicare Parts A and B may become eligible for CHAMPVA as a secondary payer to Medicare. Apply to the CHAMPVA Center, 4500 Cherry Creek Drive South, Denver, CO 80222, or call 1-800-733-8387.

Homeless Veterans

A number of VA benefits assist eligible homeless veterans, including disability compensation, pension, education and burial benefits. Homeless veterans also are provided special assistance through many program initiatives.

VA also continues to expand its health and rehabilitation programs for homeless veterans. Homeless Chronically Mentally Ill Veterans programs at 50 sites provide comprehensive medical, psychological and rehabilitation treatment programs through case management and community-based residential care. Domiciliary Care for Homeless Veterans programs at 31 sites provide active residential rehabilitation services. VA has a growing number of Compensated Work Therapy/Therapeutic Residence group homes; special day-time, drop-in centers; and Comprehensive Homeless Centers.

VA has joined with the Department of Housing and Urban Development, the Social Security Administration, veterans service organizations, and community nonprofit homeless service providers in special partnerships that help VA provide comprehensive care for homeless veterans. For information, contact the nearest VA regional office or medical center.

Women Veterans

Women veterans are eligible for the same VA benefits as male veterans. In addition, VA is required to provide appropriate and timely medical care to any eligible woman veteran for gender-specific disabilities. Women veteran coordinators have been designated at each VA medical center and regional office to counsel women veterans seeking treatment and benefits.

VA medical centers have made structural changes or renovated areas to ensure privacy for women veteran patients. In addition to routine medical care, each VA medical facility will provide the following to eligible women veterans: complete physical exams that include breast and pelvic examinations; inpatient gynecology services; outpatient gynecology services; and referrals for necessary services that may not be available at that facility.

VA also may provide counseling to overcome psychological trauma resulting from physical assault, battery of a sexual nature or sexual harassment during active duty. The counseling is provided at VA medical centers and Vet Centers.

Overseas Benefits

Medical Benefits

Medical care, including prosthetic services, is provided through reimbursement to veterans outside of the United States for the treatment of adjudicated, service-connected disabilities and conditions related to those disabilities. Prior to treatment, an authorization must be obtained from the nearest American embassy or consulate. In Canada, veterans should contact the local office of Veterans Affairs Canada. Nursing-home care is not available in foreign jurisdictions.

Other Overseas Benefits

Virtually all VA monetary benefits — compensation, pension, educational assistance, burial allowances — are payable regardless of place of residence or nationality. There are, however, some program limitations in foreign jurisdictions. Home-loan guaranties are available only in the United States and selected territories and possessions. Educational benefits are limited to approved degree-granting programs in institutions of higher learning. Beneficiaries residing in foreign countries should contact the nearest American embassy or consulate for information and claims assistance. In Canada, the local office of Veterans Affairs Canada should be contacted.

Other Federal Benefits

Some benefits available to veterans and their dependents are not administered by the Department of Veterans Affairs. The following information describes these benefits and provides information on contacting the proper agency.

Job-Finding Assistance

State employment offices throughout the country help veterans find jobs. Local veterans employment representatives provide free job counseling, testing, training referral and placement services to veterans. Priority in referral to job openings and training opportunities is given to eligible veterans. The highest priority in referrals is provided to disabled veterans. Employment offices also assist veterans by providing information about unemployment compensation, job marts and on-the-job and apprenticeship training opportunities, in cooperation with VA regional offices and Vet Centers. Veterans should apply for such assistance at the nearest state employment office.

Servicemembers Occupational Conversion and Training Program

This program is designed to assist individuals being released early from military service to obtain employment. Veterans discharged on or after Aug. 2, 1990, may be eligible for the program. To be eligible, the individual must be unemployed at the time of application and must have been unemployed for at least eight of the 15 weeks immediately before applying, or have a primary or secondary military occupational specialty that is not readily transferable to the civilian workforce. Also eligible are separating individuals entitled to compensation for a disability rated at 30 percent or more — or who would be but for the receipt of military retired pay.

The program pays participating employers one-half of the employee's salary. The total amount paid to the employer may not exceed $12,000 for individuals with a service-connected disability rated at 30 percent or more, or $10,000 for all others.

Some work is not reimbursable under the program. Ineligible employment includes employment which is seasonal, intermittent or temporary; employment dependent primarily on commissions; employment involving political or religious activities; employment with the federal government; and employment outside of a state. All training programs must be certified by the Department of Veterans Affairs. For information, veterans and employers should contact a state employment office.

Job Training Partnership Act

The Job Training Partnership Act provides for a national job training program conducted by the Department of Labor. The Assistant Secretary for Veterans Employment and Training, Labor Department, is responsible for administering a training program specifically for disabled, Vietnam Era and recently separated veterans. Veterans should inquire about the availability of such programs at the nearest state employment office. Job training programs may be conducted through public agencies and private nonprofit organizations.

Disabled Veterans Outreach Program

Administered by the Assistant Secretary for Veterans Employment and Training of the Department of Labor, this program provides states with funds to locate disabled veterans and help them find jobs, especially veterans of the Vietnam Era. Staff members performing these outreach duties are usually disabled veterans themselves who work closely with VA, veterans organizations and other community groups. Most staff members are located in offices of the state employment service but some may be stationed in VA's regional offices, psychological and readjustment counseling centers, and other VA facilities.

Reemployment Rights

Under the Veterans' Reemployment Rights (VRR) law (Chapter 43, Title 38, U.S. Code), a person who left a civilian job to enter active duty in the Armed Forces, either voluntarily or involuntarily, may be entitled to return to his or her civilian job after discharge or release from active duty. This law covers reemployment rights for those who rendered active-duty service, initial active duty for training, active duty for training, or inactive duty for training. There are four requirements that must be met under the Veterans' Reemployment Rights law:

1. The person must have been employed in other than a temporary civilian job.
2. The person must have left the civilian job for the purpose of entering military service.
3. The person must not remain on active duty longer than four years, unless the period beyond four years is at the request and for the convenience of the federal government and the military discharge form carries this statement. Active duty during a period of declared national emergency, if at the request of and for the convenience of the federal government, does not count toward this four-year limitation. In some cases, the limitation may be extended to five years.
4. The person must be discharged or released from active duty under honorable conditions.

The VRR law calls for the returning veteran to be placed in the job as if the veteran had remained continuously employed instead of going on active duty. This means that the person may be entitled to benefits that are generally based on seniority, such as pensions, pay increases, missed promotions and missed transfers.

The law also protects a veteran from discharge without just cause for one year from the date of reemployment, and a Reservist or National Guard member from discharge without just cause for six months after returning from initial active duty for training. In addition, the law also prohibits discrimination in hiring, promotion or other advantage of employment because of one's obligation as a member of a reserve or Guard unit.

Applications for reemployment should be given verbally or in writing to a person who is authorized to represent the company for hiring purposes. A record should be kept of when and to whom the application was given. If there are problems in attaining reemployment, the applicant may be eligible for representation by the Department of Labor, if not employed by the federal government. Questions on the VRR law, or requests for assistance in attaining reemployment, if there are problems, should be directed to the Department of Labor's Director for Veterans' Employment and Training (DVET) for the state in which the employer is located. Consult telephone directories under Department of Labor for the telephone number of DVET or call 1-800-442-2838 for the appropriate DVET telephone number.

The Office of Personnel Management administers the VRR law for federal employees, including those in the Postal Service. Employees returning from military duty

should contact their agency personnel office about restoration rights. If a job is not restored properly, the employee has the right to appeal to the Merit Systems Protection Board.

A veteran must apply to the pre-service employer within 90 days after separation from active duty. If the veteran is hospitalized or recuperating when discharged, the 90-day application period begins upon release from the hospital or completion of recuperation, which may last up to one year. The application period is 31 days for reservists and National Guard members returning from initial active duty for training.

Unemployment Compensation

The purpose of unemployment compensation for ex-servicemembers is to provide a weekly income for a limited period of time to help them meet basic needs while searching for employment. The amount and duration of payments are governed by state laws, which vary considerably. Benefits are paid from federal funds. Ex-servicemembers should apply immediately after leaving military service at their nearest state employment office, and present copy 4 of their military discharge form DD-214 to determine their eligibility.

Affirmative Action

Federal legislation prohibits employers with federal contracts or subcontracts of $10,000 or more from discriminating in employment against Vietnam-Era and "special disabled" veterans. Special disabled veterans, covered throughout their working lives, are those veterans entitled to compensation — or veterans who but for the receipt of military retired pay would be entitled to compensation — who are rated under laws administered by VA for disability at 30 percent or more, or rated at 10 or 20 percent in the case of a veteran who has been determined to have a serious employment handicap, or a person who was discharged or released from active duty because of a service-connected disability. Federal legislation requires these contractors to take affirmative action to employ and advance in employment Vietnam-Era and special disabled veterans. Vietnam-Era veterans are covered by this program through 1994. Legislative requirements are administered by the U.S. Labor Department's Office of Federal Contract Compliance Programs (OFCCP). Complaints may be filed at any OFCCP regional office of the Labor Department. Complaints must be filed within 180 days of the discriminatory act.

Employment in the Federal Government

The Veterans Readjustment Appointment (VRA) authority promotes maximum job opportunities within the federal government for qualified disabled veterans. The VRA authority allows agencies to make noncompetitive appointments, at their discretion, to federal jobs for Vietnam-Era and post-Vietnam-Era veterans. Such appointments lead to conversion to career or career-conditional employment upon satisfactory completion of two years of service. Veterans seeking VRA appointment should apply directly to the agency where they wish to work.

The Office of Personnel Management administers the Disabled Veterans Affirmative Action Program (DVAAP). All federal departments and agencies are required to establish action plans to facilitate the recruitment, employment and advancement of disabled veterans. OPM reviews agencies' DVAAP action plans to determine if they meet requirements.

Veterans who are disabled or who served during certain periods have preference in federal employment. This preference includes additional points added to passing

scores in examinations; first consideration for certain jobs; and preference for retention in reductions in force. Preference also is provided for unremarried widows and widowers of deceased veterans and mothers of military personnel who died in service; spouses of service-connected disabled veterans who are no longer able to work in their usual occupations; and mothers of veterans who have permanent and total service-connected disabilities.

Individuals interested in federal employment should contact the personnel offices of the federal agencies in which they wish to be employed. Information also may be obtained by contacting the Federal Employment Information Centers of the U.S. Office of Personnel Management. The centers are listed in telephone books under U.S. Government. Veterans also may obtain a nationwide listing of the Federal Employment Information Centers by writing to the U.S. Office of Personnel Management, Federal Employment Information Center, 1900 E Street, N.W., Washington, D.C. 20415.

Transition Assistance Program

The Labor Department assists servicemembers who are scheduled for separation from active duty through the Transition Assistance Program (TAP). The program, in a partnership with the Defense Department, the Department of Veterans Affairs and the Labor Department, provides employment and training information to servicemembers within 180 days of separation. Three-day workshops to assist in civilian employment are conducted at military installations. Additional counseling is available to disabled servicemembers. For information, contact the Director for Veterans' Employment and Training for the appropriate state.

Operation Transition

The military services provide civilian-transition counseling at least 90 days prior to each servicemember's discharge in a program called Operation Transition.

A Defense Department document (DD Form 2586) is prepared to verify information valuable for civilian jobs and education, including military experience, training history, associated civilian equivalent job titles and recommended educational credit information. The document is delivered to servicemembers 90 to 180 days before the scheduled separation.

The Defense Outplacement Referral System (DORS) refers mini-resumes to potential employers through 350 local Transition offices worldwide. Resumes are provided to employers by electronic mail, fax or mail, based on the geographic and occupational preferences of each individual.

Employers may place job ads on the electronic Transition Bulletin Board (TBB) kept by Transition offices. Those employers having the proper computer equipment are able to place their ads electronically, others may mail or fax their ads to the TBB. Servicemembers are encouraged to respond directly to employers with their resumes. The electronic bulletin board also contains business opportunities, a calendar of transition seminars and events, and other helpful information.

Two special registries have been developed at Transition offices to help separating servicemembers obtain public community service jobs. The "Registry of Public and Community Service Organizations" contains information on organizations desiring to hire servicemembers. The "Personnel Registry" lists servicemembers who desire employment in public and community service occupations. Defense matches people and employers on the two registries, and counsels separating servicemembers on how to apply for positions with public and community service organizations.

Credit For Farms and Homes

Loans and guaranties can be provided by Farmers Home Administration (FmHA) to qualified individuals to buy, improve or operate farms. Loans and guaranties are available for housing in towns generally up to 10,000 population. In some circumstances the town population can be as large as 20,000. For individual loans, applications from eligible veterans have preference for processing. For further information contact FmHA, U.S. Department of Agriculture, Washington, D.C. 20250, or apply at local FmHA offices, usually located in county seats.

FHA Home Mortgage Insurance

HUD administers the Federal Housing Administration Home Mortgage Insurance Program for Veterans. These home loans require less downpayment than other FHA programs. Veterans on active duty are eligible if they enlisted before Sept. 8, 1980, or entered on active duty before Oct. 14, 1982, and were discharged under other than dishonorable conditions with at least 90 days service. Veterans with enlisted service after Sept. 7, 1980, or who entered on active duty after Oct. 16, 1981, must have served at least 24 months unless discharged for hardship or disability. Active duty for training is qualifying service. Submit VA Form 26-8261a, available at any VA office, to VA for a Certificate of Veteran Status. This certificate is submitted by the lender to FHA.

Naturalization Preference

Aliens with honorable service in the U.S. Armed Forces during periods in which the United States was engaged in conflicts or hostilities may be naturalized without having to comply with the general requirements for naturalization. Such aliens must have been lawfully admitted to the United States for permanent residence or have been inducted, enlisted, re-enlisted or extended an enlistment in the Armed Forces while within the United States, Puerto Rico, Guam, the Virgin Islands of the United States, the Canal Zone or American Samoa. Hostilities must be periods declared by the President.

Aliens with honorable service in the U.S. Armed Forces for three years or more during periods not considered a conflict or hostility by Executive Order may be naturalized provided they have been lawfully admitted to the United States for permanent residence. Applications must be made while serving in the Armed Forces or within six months of discharge.

Aliens who have served honorably for at least 12 years may also be granted special immigrant status. To be eligible for this benefit the person must have enlisted outside the United States pursuant to a treaty or agreement between the United States and the Philippines, the Federated States of Micronesia or the Republic of the Marshall Islands. The service must have occurred after Oct. 15, 1978.

In addition, Filipinos with active-duty service during World War II in the Philippine Scouts, Commonwealth Army of the Philippines or a recognized guerrilla unit may be naturalized without having been admitted for lawful permanent residence or having enlisted or reenlisted in the United States. Such persons must submit their applications to the Immigration and Naturalization Service by Feb. 2, 1995.

Aliens who died as a result of wounds incurred or disease contracted during periods of hostilities declared by the President may receive recognition as U.S. citizens. An application may be submitted by the person's next of kin or other authorized representative. This posthumous citizenship is honorary only and does not confer any other benefits to the person's surviving relatives. For assistance, contact the nearest office of the Immigration and Naturalization Service, Justice Department.

Small Business Administration

A number of SBA programs are designed to help small business enterprise, including businesses owned or operated by veterans. Help available from the SBA includes business training, conferences, counseling, surety bonding, government procurement and financial management assistance. Most SBA loans are made under its Loan Guaranty Program. The loan amount is advanced by the bank or other lending institution, with SBA guaranteeing up to 90 percent of the total amount. Since 1983, the SBA has administered a direct-loan program for Vietnam-Era and disabled veterans. A Vietnam-Era or disabled veteran who meets SBA's credit criteria may qualify for a direct loan if unable to obtain financing from commercial or other lenders. In each SBA field office a veterans affairs officer is designated as the contact person to assist veterans. Information on any of SBA's programs is available without charge from any of its approximately 100 field offices. Veterans should check the U.S. Government section of their local phone book for the address of the nearest SBA office. The SBA maintains a national toll-free number: 1-800-827-5722 (1-800-U-ASK-SBA).

Social Security

Monthly retirement, disability, and survivor benefits under Social Security are payable to a veteran and dependents if the veteran has earned enough work credits under the program. A one-time payment of $255 also is made upon the veteran's death and can be paid only to the veteran's eligible spouse or child entitled to benefits. In addition, the veteran may qualify at age 65 for Medicare's hospital insurance and medical insurance. Medicare protection also is available to people who have received Social Security disability benefits for 24 months and to insured people and their dependents who need dialysis or kidney transplants.

Active duty or active duty for training in the U.S. uniformed services has counted toward Social Security since January 1957, when taxes were first withheld from a serviceperson's basic pay. Since Jan. 1, 1988, work as a member of the Armed Services reserve components while on active duty training also counts toward Social Security. Service personnel and veterans receive an extra $300 credit for each quarter in which they received any basic pay for active duty or active duty for training after 1956 and before 1978. After 1977, a credit of $100 is granted for each $300 of reported wages up to a maximum credit of $1,200 if reported wages are $3,600 or more. No additional Social Security taxes are withheld from pay for these extra credits. Also, noncontributory Social Security credits of $160 a month may be granted to veterans who served after Sept. 15, 1940, and before 1957.

Further information about Social Security credits and benefits is available from any of the more than 1,300 Social Security offices. For the address and phone number, look in the telephone directory under Social Security Administration or U.S. Government. A toll-free number, 1-800-772-1213, also is available.

Supplemental Security Income

For those age 65 or older and those who are blind or otherwise disabled, Supplemental Security Income (SSI) is provided in monthly payments, if they have little or no income or resources. States may supplement the federal payments to eligible persons and may disregard additional amounts of income. Although VA compensation and pension benefits are counted in determining income for SSI purposes, certain types or amounts of income do not count. Also, not all resources count in determining eligibility. For example, the person's home and the land it is on do not count, regardless of value. Personal effects or household goods, automobiles and life insurance may not count, depending on their value. Information and assistance

in making application for these payments may be obtained at any Social Security office or by calling the toll-free number, 1-800-772-1213.

Passports to Visit Overseas Cemeteries

"No-fee" passports are available for family members visiting overseas gravesites of veterans. Those eligible for such passports include widows, parents, children, sisters, brothers and guardians of the deceased who are buried or commemorated in permanent American military cemeteries on foreign soil. For additional information, write to the American Battle Monuments Commission, Room 5127, Pulaski Building, 20 Massachusetts Avenue, N.W., Washington DC 20314.

Medals

Medals awarded while in active service will be issued by the appropriate service if requested by veterans or, if deceased, their next of kin. Requests for medals pertaining to service in the Navy, Marine Corps and Coast Guard should be sent to the U.S. Navy Liaison Office, National Personnel Records Center, Room 3475, 9700 Page Blvd., St. Louis, MO 63132-5100. Requests for medals pertaining to service in the Army should be sent to Army Commander, U.S. Army Reserve Personnel Center, ATTN: DARP-PAS-EAW, 9700 Page Blvd., St. Louis, MO 63132-5100. Requests for medals pertaining to service in the Air Force should be sent to the National Personnel Records Center (Military Personnel Records), 9700 Page Blvd., St. Louis, MO 63132-5100.

The veteran's full name should be printed or typed, so that it can be read clearly. The request must contain the signature of the veteran or the signature of the next of kin if the veteran is deceased. Include the veteran's branch of service, service number or Social Security number, whichever is appropriate, and dates of service, or at least the approximate years. If available, include a copy of the discharge/separation document, WDAGO Form 53-55 or DD Form 214. If possible, send the request on Standard Form 180, "Request Pertaining To Military Records." These forms are generally available from VA offices or veterans organizations.

Commissary and Exchange Privileges

Honorably discharged veterans with a service-connected disability rated at 100 percent, unremarried surviving spouses of members or retired members of the Armed Forces, recipients of the Medal of Honor, eligible dependents and orphans of the foregoing categories are entitled to unlimited exchange and commissary store privileges in the United States. Certain reservists and dependents also are eligible. Entitlement to these privileges overseas is governed by international law, and privileges are available only to the extent agreed upon by the foreign governments concerned. Certification of total disability will be given by VA. Assistance in completing DD Form 1172 (Application for Uniformed Services Identification and Privilege Card) may be provided by VA.

Review of Discharges

Each of the military services maintains a Discharge Review Board with authority to change, correct, or modify discharges or dismissals that are not issued by a sentence of a general court martial. The board has no authority to address medical discharges. The veteran or — if deceased or incompetent — the surviving spouse, next of kin or legal representative may apply for a review of discharge by writing to the military department concerned using Department of Defense Form 293 (DD-293), which may be obtained at any VA office. If more than 15 years have passed since discharge, DD Form 149 should be used for applications to the Board for the Correction of Military Records.

Service discharge review boards conduct hearings in Washington, D.C. Traveling review boards also visit selected cities to hear cases based on demand as evidenced by the number of applicants who have submitted a DD Form 293. In addition, the Army sends teams to locations to videotape the testimony of applicants. These tapes are reviewed by a board in Washington, D.C.

Under Public Law 95-126, discharges awarded as a result of unauthorized absence in excess of 180 days make persons ineligible for receipt of VA benefits regardless of action taken by discharge review boards unless VA determines there were compelling circumstances for the absences. In addition, boards for the correction of military records may consider such cases. Applications to these boards are made with DD Form 149.

Veterans with disabilities incurred or aggravated during active military service may qualify for medical or related benefits regardless of separation and characterization of service. Veterans separated administratively under other than honorable conditions may request that their discharges be reviewed for possible recharacterization, provided they file their appeal within 15 years from the date of separation.

Questions regarding the review of a discharge may be addressed to the appropriate discharge review board at the following addresses:
Army — Army Discharge Review Board, Attention: SFMR-RBB, Room 200A, 1941 Jefferson Davis Highway, Arlington, VA 22202-4504.
Navy and USMC — Navy Discharge Review Board, 801 N. Randolph St., Suite 905, Arlington, VA 22203.
Air Force — Air Force Military Personnel Center, Attention: DPMDOA1, Randolph AFB, TX 78150-6001.
Coast Guard — Coast Guard, Attention: GPE1, Washington, DC 20593.

Military Records

A veteran and spouse should be aware of the location of the veteran's discharge and separation papers. If the veteran cannot locate discharge and separation papers, duplicate copies may be obtained by contacting the National Personnel Records Center, Military Personnel Records, 9700 Page Blvd., St. Louis, MO 63132-5100. Specify that a duplicate separation document or discharge is needed. The veteran's full name should be printed or typed so that it can be read clearly, but the request must also contain the signature of the veteran or the signature of the next of kin, if the veteran is deceased. Include the veteran's branch of service, service number or Social Security number, whichever is appropriate, and exact dates or approximate years of service. If possible, use Standard Form 180, Request Pertaining To Military Records. This form is available from VA offices and veterans organizations. It is not necessary to request a duplicate copy of a veteran's discharge or separation papers solely for the purpose of filing a claim for VA benefits. If complete information about the veteran's service is furnished on the benefit application, VA will obtain verification of service from the National Personnel Records Center or the service department concerned. In case of a medical emergency, information from a veteran's records may be obtained by phoning the National Personnel Records Center: Air Force, (314) 538-4243; Army (314) 538-4261; Navy, Marine Corps or Coast Guard, (314) 538-4141.

Correction of Military Records

The secretary of a military department, acting through a board for correction of military records, has authority to correct any military record when necessary to correct an error or remove an injustice. Applications for correction of a military

record, including review of discharges issued by court-martial, may be considered by a correction board. A request for correction generally must be filed by the veteran, survivor or legal representative within three years after discovery of the alleged error or injustice. The board may excuse failure to file within the prescribed time, however, if it finds it would be in the interest of justice to do so. It is the responsibility of the applicant to show why the filing of the application was delayed and why it would be in the interest of justice for the board to consider the application despite the delay. To justify any correction, it is necessary to show to the satisfaction of the board that the alleged entry or omission in the records was in error or unjust. Applications should include all evidence which may be available, such as signed statements of witnesses or a brief of arguments supporting the requested correction. Application must be made on DD Form 149, which may be obtained at any VA office. Send completed application to the address indicated on the form.

Death Gratuity

Military services provide a death gratuity of $6,000 to a deceased servicemember's spouse or children. Parents, brothers or sisters may be provided the gratuity, if designated by the deceased. This is paid as soon as possible by the last military command of the deceased. If the beneficiary has not been paid within a reasonable time, application may be made to the service concerned. The death gratuity is payable in case of any death in active service, or any death within 120 days thereafter from causes related to active service.

Armed Forces Retirement Homes

Veterans may be eligible to live in two retirement homes run by an independent federal agency, the Armed Forces Retirement Home, and managed locally by advisory boards. For information, write to the Admissions Office, U.S. Soldiers' and Airmen's Home, Washington, DC 20317, or phone 1-800-422-9988; or write to U.S. Naval Home, 1800 Beach Dr., Gulfport, MI 39507, or phone 1-800-322-3527.

Appeals

Claimants for VA benefits have the right to appeal determinations made by a VA regional office or medical center. Typical issues which may be appealed are determinations dealing with compensation or pension benefits, education benefits, waiver of recovery of overpayments, and reimbursement of unauthorized medical services.

A claimant has one year from the date of the notification of a VA decision to file an appeal. An appeal is initiated by filing a notice of disagreement, which should be filed with the VA office, such as a regional office or medical center, responsible for making the decision that is being appealed.

Following receipt of the written notice, the VA office will furnish the claimant a "Statement of the Case" setting forth the issue, facts, applicable law and regulations, and the reasons for the determination.

To complete the request for appeal, the claimant must file a "Substantive Appeal" within 60 days after the date of the Statement of the Case, or within one year from the notification of the original determination, whichever is later.

Board of Veterans' Appeals

The Board of Veterans' Appeals conducts the appellate program for the Secretary of Veterans Affairs and makes final VA decisions on appeals involving all benefits administered by VA. A claimant may be represented by a veterans service organization, an agent or an attorney. Attorneys and recognized agents may charge a fee for representing a claimant or appellant before VA, including the Board of Veterans' Appeals, under certain circumstances. The Board reviews the reasonableness of fee agreements of attorneys and agents recognized by VA. The Board also makes decisions concerning the eligibility of attorneys for payment of fees from the claimant's past-due benefits.

Hearings on appeal before a member of the Board of Veterans' Appeals may be arranged following the filing of a Notice of Disagreement. At the election of the appellant, the hearing may be held in Washington, D.C., or at a VA regional office.

The appellate decisions of the Board of Veterans' Appeals have been indexed to facilitate access to the contents of decisions (BVA Index I-01-1). The index is published quarterly in microfiche form. It is organized to provide citations to BVA decisions by subject. The index is available at VA regional offices and at the Board of Veterans' Appeals in Washington, D.C. Microfiche copies can be purchased from Promisel and Korn, Inc., 7201 Wisconsin Avenue, Suite 480, Bethesda, MD 20814. For further information, contact Department of Veterans Affairs, Board of Veterans' Appeals (01C1), Washington, DC 20420.

U.S. Court of Veterans Appeals

A VA claim may be appealed from the Board of Veterans' Appeals to the Court of Veterans Appeals. This seven-judge court is separate from the Department of Veterans Affairs. Only the claimant may seek a review by the court.

To appeal to the court, the claimant must have filed a Notice of Disagreement, which starts the appeal process at the VA regional office or medical center, on or after Nov.

18, 1988. The notice of appeal must be received by the court within 120 days after the board mails its final decision.

The court does not hold trials or receive new evidence. The court reviews the record which was considered by VA and was available to the board. Oral argument is held only at the direction of the court. Either party may appeal a decision of the court to the U.S. Court of Appeals for the Federal Circuit and to the Supreme Court of the United States. Appellants may represent themselves before the court or have lawyers or nonlawyers as representatives.

For information about the court's rules and procedures, contact the clerk's office at 625 Indiana Ave. NW, Suite 900, Washington, DC 20004, or call 1-800-869-8654.

VA Facilities

Where to Go for Help

Veterans and dependents throughout the country may obtain information on VA benefits from regional offices by calling a toll-free number, 1-800-827-1000. Other toll-free telephone services include:

Life Insurance	1-800-669-8477
Radiation Helpline	1-800-827-0365
Debt Management Center	1-800-827-0648
Education Loan	1-800-326-8276
Telecommunication Device for the Deaf (TDD)	1-800-829-4833
CHAMPVA	1-800-733-8387

Many VA medical centers operate outpatient clinics. Some clinics operate independently of medical centers. All clinics can make referrals for care in VA medical centers.

Some national cemeteries can accept only cremated remains or casketed remains of eligible family members of those already buried. Contact the cemetery director for information on the availability of space.

Note: The following designations for medical centers indicate additional programs available: * for nursing-home care units; # for domiciliaries

ALABAMA

Medical Centers:

Birmingham 35233 (700 S. 19th St., 205-933-8101)
Montgomery 36109 (215 Perry Hill Rd., 205-228-4670)
*Tuscaloosa 35404 (3701 Loop Rd. East, 205-554-2000)
*Tuskegee 36083 (205-727-0550)

Clinics:

Anniston 36201 (226 E. 9th St., 205-236-1661)
Decatur 35602 (401 Lee St. N.E., Suite 606 (205-350-1531)
Florence 35630 (401 E. Spring St., 205-766-5683)
Huntsville 35801 (201 Governor's Dr. SW, 205-533-1645)
Huntsville 35801 (2006 Franklin St. SE, Suite 104 205-534-1691)
Mobile 36604 (1359 Springhill Ave., 205-415-3900)
Tuscaloosa (2017 Rainbow Dr., 205-546-9239)

Regional Office:

Montgomery 36104 (474 S. Court St., local, 262-7781; statewide, 1-800-827-1000)

Vet Centers:

Birmingham 35205 (1425 S. 21st St., Suite 108, 205-933-0500)
Mobile 36604 (951 Government St., Suite 122, 205-694-4194)

National Cemeteries:

Fort Mitchell (Seale 36875, 553 Highway 165, 205-855-4731)
Mobile 36604 (1202 Virginia St.; for information, call Barrancas, FL, NC, 904-452-3357)

ALASKA

Clinics:

Anchorage Outpatient Clinic and Regional Office 99508-2989 (2925 De Barr Rd., 907-257-4700)
Fort Wainwright 99703 (Bassett Army Community Hospital, Rm. 262, 907-353-5112)

Regional Office:

Anchorage 99508-2989 (2925 DeBarr Rd., local, 257-4700; statewide 1-800-827-1000)

Benefits Office:

Juneau 99802 (709 W. 9th St., #263, 907-586-7472)

Vet Centers:

Anchorage 99508 (4201 Tudor Centre Dr., Suite 115, Fairbanks 99701 (520 E. 5th Ave., Suite 104, 907-456-0475)
Kenai 99611 (P.O. Box 1883, 907-283-5205)
Wasilla 99654 (851 E. Westpoint Ave., Suite 109, 907-376-4318)

National Cemeteries:

Fort Richardson 99505 (P.O. Box 5-498, Bldg. 997, Davis Highway, 907-384-7075)
Sitka 99835 (P.O. Box 1065; for informa tion, call Ft. Richardson, AK, NC, 907-384-7075)

ARIZONA

Medical Centers:

*Phoenix 85012 (650 East Indian School Rd., 602-277-5551)
#Prescott 86313 (Highway 89 North, 602-445-4860)
*Tucson 85723 (3601 S. 6th Ave., 602-792-1450)

Regional Office:

Phoenix 85012 (3225 N. Central Ave., local, 263-5411; statewide, 1-800-827-1000)

Vet Centers:

Phoenix 85004 (141 E. Palm Ln., Suite 100, 602-379-4769)
Prescott 86301 (637 Hillside Ave., Suite A, 602-778-3469)
Tucson 85719 (3055 N. 1st Ave., 602-882-0333)

National Cemeteries:

National Memorial Cemetery of Arizona (Phoenix 85024, 23029 N. Cave Creek Rd., 602-379-4615)
Prescott 86301 (VA Medical Center, 500 Highway 89N., 602-776-6028)

ARKANSAS

Medical Centers:

Fayetteville 72703 (1100 N. College Ave., 501-443-4301)
#*Little Rock 72205 (4300 W. 7th St., 501-370-6601)

Regional Office:

North Little Rock 72115 (Bldg. 65, Ft. Roots, P.O. Box 1280, local, 370-3800; statewide, 1-800-827-1000.

Vet Center:

North Little Rock 72114 (201 W. Broadway, Suite A, 501-324-6395)

National Cemeteries:

Fayetteville 72701 (700 Government Ave., 501-444-5051)
Fort Smith 72901 (522 Garland Ave. and S. Sixth St., 501-783-5345)
Little Rock 72206 (2523 Confederate Blvd., 501-324-6401)

CALIFORNIA

Medical Centers:

*Fresno 93703 (2615 E. Clinton Ave., 209-225-6100)
*Livermore 94550 (4951 Arroyo Rd., 415-447-2560)
*Loma Linda 92357 (11201 Benton St., 714-825-7084)
*Long Beach 90822 (5901 E. 7th St., 310-494-2611)
#*Palo Alto 94304 (3801 Miranda Ave., 415-493-5000)
*San Diego 92161 (3350 La Jolla Village Dr., 619-552-8585)
San Francisco 94121 (4150 Clement St., 415-221-4810)
*Sepulveda 91343 (1611 Plummer St., 818-891-7711)

#*West Los Angeles 90073 (Wilshire & Sawtelle Blvds., 310- 478-3711)

Clinics:

Los Angeles 90012 (351 E. Temple, 213-253-2677)
Pleasant Hill 94523 (N. Calif. System of Clinics, 2300 Contra Costa Blvd., 510-372-2000)
Oakland 94612 (2221 Martin Luther King Jr. Way, 510-273-7096)
Redding 96001 (2787 Eureka Way, 916-246-5056)
Sacramento 95820 (4600 Broadway, 916-731-7300)
San Diego 92108 (2022 Camino Del Rio North, 619-220-4065)
Santa Barbara 93110 (4440 Calle Real, 805-683-1491)

Regional Offices:

Los Angeles 90024 (Fed. Bldg., 11000 Wilshire Blvd., serving counties of Inyo, Kern, Los Angeles, Orange, San Bernardino,San Luis Obispo, Santa Barbara and Ventura, local, 479-4011; statewide, 1-800-827-1000)
San Diego 92108 (2022 Camino Del Rio North, serving counties of Imperial, Riverside and San Diego, local, 297-8220; statewide, 1-800-827-1000)
Oakland 94612 (1301 Clay St., Rm. 1300 North, local, 637-1325; statewide,1-800-827-1000) (Recorded benefits, 24-hour availability, 974-0138)
Counties of Alpine, Lassen, Modoc and Mono served by Reno, Nev., RO.

Benefits Office:

East Los Angeles 90022 (5400 E. Olympic Blvd., Commerce, 310-722-4927)

Vet Centers:

Anaheim 92805 (859 S. Harbor Blvd., 714-776-0161)
Benicia 94510 (555 1st St., Suite 200, 707-747-9772)
Burlingame 94010 (1234 Howard Ave., 415-344-3126)
Chico 95926 (109 Parmac Rd., 916-899-8549)
Commerce 90040 (VA East L.A. Clinic, 5400 E. Olympic Blvd., #140, 213-728-9966)
Concord 94520 (1899 Clayton Rd., Suite 140, 415-680-4526)
Eureka 95501 (305 V St., 707-444-8271)
Fresno 93726 (3636 N. 1st St., Suite 112, 209-487-5660)
Los Angeles 90003 (S. Central L.A., 251 W. 85th Pl., 310-215-2380)
Los Angeles 90025 (West L.A., 2000 Westwood Blvd., 310-475-9509)
Marina 93933 (455 Reservation Rd., Suite E, 408-384-1660)
Oakland 94612 (287 17th St., 510-763-3904)
Riverside 92504 (4954 Arlington Ave., Suite A, 909-359-8967)
Rohnert Park 94928 (6225 State Farm Dr., Suite 101, 707-586-3295)
Sacramento 95825 (1111 Howe Ave., Suite 390, 916-978-5477)
San Diego 92103 (2900 6th Ave., 619-294-2040)
San Jose 95112 (278 N. 2nd St., 408-993-0729)
Santa Barbara 93101 (1300 Santa Barbara St., 805-564-2345)
Sepulveda 91343 (16126 Lassen St., 818-892-9227)
Upland 91786 (313 N. Mountain Ave., 909-982-0416)
Vista 92083 (1830 West Dr., Tri City Plaza, Suite 103, 619-945-8941)

National Cemeteries:

Fort Rosecrans (San Diego 92166, Point Loma, P.O. Box 6237, 619-553-2084)
Golden Gate (San Bruno 94066, 1300 Sneath Ln., 415-589-7737)
Los Angeles 90049 (950 S. Sepulveda Blvd., 310-824-4311)
Riverside 92508 (22495 Van Buren Blvd., 909-653-8417)
San Francisco 94129 (P.O. Box 29012, Presidio of San Francisco, 415-561-2008)
San Joaquin Valley (Gustine 95322, 32053 W. McCabe Rd., 209-854-1040)

COLORADO

Medical Centers:

*Denver 80220 (1055 Clermont St., 303-399-8020)
*Fort Lyon 81038 ("C" St., 719-384-3100)
*Grand Junction 81501 (2121 North Ave., 303-384-3100)

Clinic:

Colorado Springs 80909 (1785 N. Academy Blvd., 719-360-0004)

Regional Office:

Denver 80225 (44 Union Blvd., P.O. Box 25126, local, 980-1300; statewide, 1-800-827-1000)

Vet Centers:

Boulder 80302 (2128 Pearl St., 303-440-7306)
Colorado Springs 80903 (411 S. Tejon, Suite G, 719-471-9992)
Denver 80204 (1815 Federal Blvd., 303-433-7123)

National Cemeteries:

Fort Logan (Denver 80235, 3698 S. Sheridan Blvd., 303-761-0117)
Fort Lyon 81038 (VA Medical Center, "C" St., 719-384-3152, ext. 231)

CONNECTICUT

Medical Centers:

Newington 06111 (555 Willard Ave., 203-666-6951)
*West Haven 06516 (W. Spring St., 203-932-5711)

Regional Office:

Hartford 06103 (450 Main St., local, 278-3230; statewide, 1-800-827-1000)

Vet Centers:

Hartford 06120 (370 Market St., 203-240-3543)
New Haven 06511 (562 Whalley Ave., 203-773-2232 or 773-2236)
Norwich 06360 (16 Franklin St., Rm. 109, 203-887-1755)

DELAWARE

Medical Center:

*Wilmington 19805 (1601 Kirkwood Highway, 302-994-2511)

Regional Office:

Wilmington 19805 (1601 Kirkwood Highway, local, 998-0191; statewide, 1-800-827-1000)

Vet Center:

Wilmington 19805 (VAMROC Bldg. 2, 1601 Kirkwood Highway, 302-994-1660)

DISTRICT OF COLUMBIA

Medical Center:

*Washington, D.C. 20422 (50 Irving St., N.W., 202-745-8000)

Regional Office:

Washington, D.C. 20421 (941 N. Capitol St., N.E., local, 872-1151)

Vet Center:

Washington, D.C. 20003 (801 Pennsylvania Ave., S.E., 202-745-8400/02)

FLORIDA

Medical Centers:

#*Bay Pines 33504 (10000 Bay Pines Blvd., N., 813-398-6661)
*Gainesville 32608 (1601 Southwest Archer Rd., 904-376-1611)

*Lake City 32055 (801 S. Marion St., 904-755-3016)
*Miami 33125 (1201 N.W. 16th St., 305-324-4455)
*Tampa 33612 (13000 Bruce B. Downs Blvd., 813-822-6011)

Clinics:

Daytona Beach 32117 (1900 Mason Ave., 904-274-4600)
Fort Myers 33901 (2070 Carrell Rd., 813-939-3939)
Jacksonville 32206 (1833 Boulevard, 904-232-2712
Key West 33040 (1111 12th St., Suite 207, 305-536-6696)
Miami 33130 (900 Southwest 2nd Ave., 305-324-4455)
Oakland Park 33334 (5599 N. Dixie Highway, 305-771-2101)
Orlando 32806 (83 W. Columbia St., 407-425-7521)
Pensacola 32503 (312 Kenmore Rd., 904-476-1100)
Port Richey 34668 (8911 Ponderosa, 813-869-3203)
Riviera Beach 33404 (Executive Plaza, 301 Broadway, 407-845-2800)
Tallahassee 32308 (1607 St. James Ct., 904-878-0191)

Regional Office:

St. Petersburg 33701 (144 1st Ave. S., local, 898-2121; statewide, 1-800-827-1000)

Benefits Offices:

Fort Myers 33901 (2070 Carrell Rd.)
Jacksonville 32206 (1833 Boulevard, Rm. 3109)
Miami 33130 (Federal Bldg., Rm. 120, 51 S.W. 1st Ave.)
Oakland Park 33334 (5599 N. Dixie Highway)
Orlando 32806 (83 W. Columbia St.)
Pensacola 32503-7492 (312 Kenmore Rd., Rm.1G250)
Riviera Beach 33404 (Executive Plaza, 310 Broadway)

Vet Centers:

Ft. Lauderdale 33301 (315 N.E. 3rd Ave., 800-827-2204)
Jacksonville 32202 (255 Liberty St., 904-791-3621)
Lake Worth 33461 (2311 10th Ave., North #13-Palm Beach, 407-585-0441)
Miami 33129 (2700 S.W. 3rd Ave., Suite 1A, 305-859-8387)
Orlando 32809 (5001 S. Orange Ave., Suite A, 407-648-6151)
Pensacola 32501 (15 W. Strong St., Suite 100 C, 904-479-6665)
Sarasota 34239 (1800 Siesta Dr., 813-952-9406)
St. Petersburg 33713 (2837 1st Ave., N., 813-893-3791)
Tallahassee 32303 (249 E. 6th Ave., 904-942-8810)
Tampa 33604 (1507 W. Sligh Ave., 813-228-2621)

National Cemeteries:

Barrancas (Pensacola 32508, Naval Air Station, 904-452-3357)
Bay Pines 33504 (P.O. Box 477, 813-398-9426)
Florida (Bushnell 33513, P.O. Box 337, 904-793-7740)
St. Augustine 32084 (104 Marine St.; for information, call Florida NC, 904-793-7740)

GEORGIA

Medical Centers:

*Augusta 30910 (1 Freedom Way, 706-251-7189 uptown; 706-251-3934 downtown)
*Decatur 30033 (1670 Clairmont Rd., 404-321-6111)
#*Dublin 31021 (1826 Veterans Blvd, 700-258-2717)

Regional Office:

Atlanta 30365 (730 Peachtree St., N.E., local, 881-1776; statewide, 1-800-827-1000)

Clinic:

Columbus 31902 (1008 Broadway, 706-649-7879)
Savannah 31406 (325 W. Montgomery Crossroad, 912-920-0214)

Note: The following designations for medical centers indicate additional programs available: * for nursing-home care units; # for domiciliaries

Vet Centers:

Atlanta 30309 (922 W. Peachtree St., 404-347-7264)
Savannah 31406 (8110 White Bluff Rd., 912-927-7360)

National Cemetery:

Marietta 30060 (500 Washington Ave., 404-428-5631)

HAWAII

Medical & Regional Office:

Honolulu 96850 (P.O. Box 50188, 300 Ala Moana Blvd., Rm.1204; Medical Office, 808-541-1409; Regional Office: from Oahu, 808-541-1000; toll-free from neighbor islands, 1-800-827-1000; toll-free service from Guam, 475-838)

Vet Centers:

Hilo 96720 (120 Keawe St., Suite 201, 808-969-3833)
Honolulu 96814 (1680 Kapiolani Blvd., Suite F, 808-541-1767)
Kailua-Kona 96740 (Pottery Terrace, Fern Bldg., 75-5995 Kuakini Hwy., #415, 808-329-0574)
Lihue 96766 (3367 Kuhio Hwy., Suite 101-Kauai, 808-246-1163)
Wailuku 96793 (Ting Bldg., 35 Lunalilo, Suite 101, 808-242-8557)

National Cemetery:

National Memorial Cemetery of the Pacific (Honolulu 96813, 2177 Puowaina Dr., 808-541-1427)

IDAHO

Medical Center:

*Boise 83702 (500 West Fort St., 208-336-5100)

Clinic:

Pocatello 83201 (1651 Alvin Rickin Dr., 208-232-6214)

Regional Office:

Boise 83702 (805 W. Franklin St., local, 334-1010; statewide, 1-800-827-1000)

Vet Centers:

Boise 83706 (1115 W. Boise Ave., 208-342-3612)
Pocatello 83201 (1975 S. 5th St., 208-232-0316)

ILLINOIS

Medical Centers:

Chicago 60611 (Lakeside, 333 E. Huron St., 312-943-6600)
Chicago 60680 (Westside, 820 S. Damen Ave., P.O. Box 8195, 312-666-6500)
*Danville 61832 (1900 E. Main St., 217-442-8000)
*Hines 60141 (Roosevelt Rd. & 5th Ave., 708-343-7200)
*Marion 62959 (2401 W. Main St., 618-997-5311)
#*North Chicago 60064 (3001 Green Bay Rd., 708-688-1900)

Clinic:

Peoria 61605 (411 W. Martin Luther King Jr. Dr., 309-671-7350)

Regional Office:

Chicago 60680 (536 S. Clark St.; P.O. Box 8136, local, 663-5510; statewide, 1-800-827-1000)

Vet Centers:

Chicago 60637 (5505 S. Harper, 312-684-5500)
Chicago Heights 60411 (1600 Halsted St., 708-754-0340)
East St. Louis 62203 (1269 N. 89th St., Suite 1, 618-397-6602)
Moline 61265 (1529 46th Ave., Rm. #6, 309-762-6954)
Oak Park 60302 (155 S. Oak Park Ave., 708-383-3225)
Peoria 61603 (605 N.E. Monroe St., 309-671-7300)
Springfield 62702 (624 S. 4th St., 217-492-4955)
Evanston 60202 (656 Howard St., 708-332-1019)

National Cemeteries:

Alton 62003 (600 Pearl St.; for information, call

Jefferson Barracks, MO, NC 314-263-8691/2)
Camp Butler (Springfield 62707, R.R. #1, 217-522-5764)
Danville 61832 (1900 E. Main St., 217-431-6550)
Mound City 62963 (P.O. Box 38, Junction of Hwys 37 & 51, for information, call Jefferson Barracks, MO, NC, 314-263-8691/2)
Quincy 62301 (36th & Maine Sts., for information, call Keokuk, IA, NC, 319-524-1304)
Rock Island (Moline 61265, P.O. Box 737, 309-782-2094)

INDIANA

Medical Centers

*Fort Wayne 46805 (2121 Lake Ave., 219-426-5431)
*Indianapolis 46202 (1481 W. 10th St., 317-635-7401)
*Marion 46952 (E. 38th St., 317-674-3321)

Clinics:

Crown Point 46307 (9330 Broadway, 219-662-0001)
Evansville 47713 (500 E. Walnut, 812-465-6202)

Regional Office:

Indianapolis 46204 (575 N. Pennsylvania St., local, 226-5566; statewide, 1-800-827-1000)

Vet Centers:

Evansville 47711 (311 N. Weinbach Ave., 812-473-5993 or 473-6084)
Fort Wayne 46802 (528 West Berry St., 219-460-1456)
Gary 46408 (2236 West Ridge Rd., 219-887-0048)
Indianapolis 46208 (3833 Meridian, 317-927-6440)

National Cemeteries:

Crown Hill (Indianapolis 46208, 700 W. 38th St.; for information, call Marion, IN, NC, 317-674-0284)
Marion 46952 (1700 E. 38th St., 317-674-0284)
New Albany 47150 (1943 Ekin Ave.; for information, call Zachary Taylor, KY, NC, 502-893-3852)

IOWA

Medical Centers:

#Des Moines 50310 (30th & Euclid Ave., 515-255-2173)
Iowa City 52246 (Hwy. 6 West, 319-338-0581)
#*Knoxville 50138 (1515 W. Pleasant St., 515-842-3101)

Clinic:

Bettendorf 52722 (2979 Victoria Dr., 319-338-0581)

Regional Office:

Des Moines 50309 (210 Walnut St., local, 284-0219; statewide, 1-800-827-1000)

Vet Centers:

Des Moines 50310 (2600 Harding Rd., 515-284-4929)
Sioux City 51101 (706 Jackson, 712-255-3808)

National Cemetery:

Keokuk 52632 (1701 J St., 319-524-1304)

KANSAS

Medical Centers:

#*Leavenworth 66048 (4101 S. 4th St., Trafficway (913-682-2000)
*Topeka 66622 (2200 Gage Blvd., 913-272-3111)
*Wichita 67218 (5500 E. Kellogg, 316-685-2221)

Regional Office:

Wichita 67218 (5500 E. Kellogg, local, 682-2301; statewide, 1-800-827-1000)

Vet Centers:

Wichita 67211 (413 S. Pattie, 316-265-3260)

National Cemeteries:

Fort Leavenworth 66027 (For information, call Leavenworth, KS, NC, 913-758-4105)
Fort Scott 66701 (P.O. Box 917, 316-223-2840)
Leavenworth 66048 (P.O. Box 1694, 913-758-4105)

KENTUCKY

Medical Centers:

*Lexington 40511 (Leestown Rd., 606-233-4511)
Louisville 40206 (800 Zorn Ave., 502-895-3401)

Regional Office:

Louisville 40202 (545 S. Third St., local, 584-2231; statewide, 1-800-827-1000)

Vet Centers:

Lexington 40503 (1117 Limestone Rd., 606-276-5269)
Louisville 40208 (1355 S. 3rd St., 502-636-4002)

National Cemeteries:

Camp Nelson (Nicholasville 40356, 6980 Danville Rd., 606-885-5727)
Cave Hill (Louisville 40204, 701 Baxter Ave., for information, call Zachary Taylor, KY, NC, 502-893-3852)
Danville 40442 (377 N. First St., for information, call Camp Nelson, KY, NC, 606-885-5727)
Lebanon 40033 (R.R. 1, Box 616, 502-893-3852)
Lexington 40508 (833 W. Main St., for information, call Camp Nelson, KY, NC, 606-885-5727)
Mill Springs (Nancy 42544, for information call Camp Nelson, KY, NC, 606-885-5727)
Zachary Taylor (Louisville 40207, 4701 Brownsboro Rd. 502-893-3852)

LOUISIANA

Medical Centers:

*Alexandria 71301 (Shreveport Hwy., 318-487-0084)
New Orleans 70146 (1601 Perdido St., 504-589-5210)
Shreveport 71130 (510 E. Stoner Ave., 318-221-8411)

Clinics:

Baton Rouge 70806 (216 S. Foster Dr., 318-389-0628)
Jennings 70546 (1624 Elton Rd., 318-473-0010)

Regional Office:

New Orleans 70113 (701 Loyola Ave., local, 589-7191; statewide, 1-800-827-1000)

Vet Centers:

Bossier City 71112 (2103 Old Minden Rd., 318-742-2733)
New Orleans 70116 (1529 N. Claiborne Ave., 504-943-8386)
Shreveport 71104 (Bldg. 3, Suite 260, 2620 Centenary Blvd., 318-425-8387)

National Cemeteries:

Alexandria (Pineville 71360, 209 Shamrock St., 318-473-7588)
Baton Rouge 70806 (220 N. 19th St., for information, call Port Hudson, LA, NC, 504-389-0788)
Port Hudson (Zachary 70791, 20978 Port Hickey Rd., 504-389-0788)

MAINE

Medical Center:

*Togus 04330 (Route 17 East, 207-623-8411)

Regional Office:

Togus 04330 (Route 17 East, local, 623-8000; statewide, 1-800-827-1000)

Benefits Office:

Portland 04101 (475 Stevens Ave., 207-780-3569)

Vet Centers:

Bangor 04401 (352 Harlow St., 207-947-3391)
Caribou 04736 (228 Sweden St., 207-496-3900)
Lewiston 04240 (475 Pleasant St., 207-783-0068)
Portland 04101 (63 Preble St., 207-780-3584)
Sanford 04073 (441 Main St., 207-490-1513)

National Cemetery:

Togus 04330 (VA Medical & Regional Office Center, for information, call Massachusetts NC, 207-623-8411)

MARYLAND

Medical Centers:

Baltimore 21201 (10 N. Greene St., 410-605-7000)
Baltimore 21201 (Prosthetic Assessment Information Center,103 S. Gay St. 410-962-3934)
*Fort Howard 21052 (N. Point Rd., 410-477-1800)
*Perry Point 21902 (301-642-2411)

Clinic:

Cumberland 21502 (710 Memorial Ave., 301-724-0061)

Regional Office:

Baltimore 21201 (31 Hopkins Plaza, Fed. Bldg., local, 685-5454; counties of Montgomery & Prince Georges served by Washington, DC, RO, 202-872-1151; other areas, 1-800-827-1000)

Vet Centers:

Baltimore 21230 (777 Washington Blvd., 410-539-5511)
Cambridge 21613 (5510 W. Shore Dr., Carey Bldg., 410-228-6305)
Elkton 21921 (7 Elkton Commercial Plaza, South Bridge St., 410-398-0171)
Silver Spring 20910 (1015 Spring St., Suite 101, 202-745-8397

National Cemeteries:

Annapolis 21401 (800 West St., for information, call Baltimore, MD, NC, 410-644-9696)
Baltimore 21228 (5501 Frederick Ave., 410-644-9696)
Loudon Park (Baltimore 21229, 3445 Frederick Ave., for information, call Baltimore, MD, NC, 410-644-9696)

MASSACHUSETTS

Medical Centers:

#*Bedford 01730 (200 Springs Rd., 617-275-7500)
Boston 02130 (150 S. Huntington Ave. 617-278-4591)
*Brockton 02401 (940 Belmont St., 508-583-4500)
*Northampton 01060 (421 N. Main St., 413-584-4040)
West Roxbury 02132 (1400 VFW Pkwy., 617-323-7700)

Clinics:

Boston 02114 (251 Causeway St., 617-248-1364)
Lowell 01851 (130 Marshall Rd., 508-459-3866)
Springfield 01103 (1550 Main St., 413-785-0301)
Worcester 01605 (605 Lincoln St., 508-856-0104)

Regional Office:

Boston 02203 (JFK Federal Bldg., Government Center, local, 227-4600; statewide, 1-800-827-1000)
Towns of Fall River & New Bedford, counties of Barnstable, Dukes, Nantucket, Bristol, part of Plymouth served by Providence, R.I., RO)

Vet Centers:

Boston 02215 (665 Beacon St., Suite 100, 617-424-0665)
Brockton 02401 (1041 Pearl St., 508-856-7428)
Lawrence 01840 (45 Franklin St., 508-682-6109)
Lowell 01852 (Community Care Center, 81 Bridge St., 508-934-9124)
Lowell 01853 (73 East Merrimack St., 508-453-1151)
Northampton 01060 (Veterans Community Care Center, 57 King St., 413-582-3079)
Pittsfield 01201 (Veterans Community Care Center, Doctor's Park, 197 South St., 413-499-2672)
Springfield 01133 (583 State St., 413-732-9966)
Springfield 01103 (1985 Main St., 413-737-5167)
Winchendon 01475 (Town Hall, 508-297-3028)

National Cemetery:

Massachusetts (Bourne 02532, 508-563-7113/4)

Note: The following designations for medical centers indicate additional programs available: * for nursing-home care units; # for domiciliaries

MICHIGAN

Medical Centers:

*Allen Park 48101 (Southfield & Outer Drive, 313-562-6000)
*Ann Arbor 48105 (2215 Fuller Rd., 313-769-7100)
*Battle Creek 49016 (5500 Armstrong Rd., 616-966-5600)
*Iron Mountain 49801 (H Street, 906-774-3300)
*Saginaw 48602 (1500 Weiss St., 517-793-2340)

Clinics:

Gaylord 49735 (850 S. Otsego, 517-732-7525)
Grand Rapids 49505 (3019 Colt , N.E., 616-365-9575)

Regional Office:

Detroit 48226 (Patrick V. McNamara Federal Bldg., 477 Michigan Ave., local, 964-5110; statewide, 1-800-827-1000)

Vet Centers:

Grand Rapids 49507 (1940 Eastern Ave., S.E., 616-243-0385)
Lincoln Park 48146 (1766 Fort St., 313-381-1370)
Oak Park 48237 (20820 Greenfield Rd., 313-967-0040)

National Cemetery:

Fort Custer (Augusta 49012, 15501 Dickman Rd., 616-731-4164)

MINNESOTA

Medical Centers:

*Minneapolis 55417 (One Veterans Dr., 612-725-2000)
#*St. Cloud 56303 (4801 8th St. North, 612-252-1670)

Regional Office and Insurance Center:

St. Paul 55111 (Federal Bldg., Fort Snelling, local, 726-1454; statewide, 1-800-827-1000. Insurance, 612-725-3311)
Counties of Becker, Beltrami, Clay, Clearwater, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Otter Tail, Pennington, Polk, Red Lake, Roseau, Wilkin served by Fargo, N.D., RO)

Vet Centers:

Duluth 55802 (405 E. Superior St., 218-722-8654)
St. Paul 55114 (2480 University Ave., 612-644-4022)

National Cemetery:

Fort Snelling (Minneapolis 55450, 7601 34th Ave. So., 612-726-1127/8)

MISSISSIPPI

Medical Centers:

#*Biloxi 39531 (400 Veterans Ave., 601-388-5541)
*Jackson 39216 (1500 E. Woodrow Wilson Dr., 601-364-1201)

Regional Office:

Jackson 39269 (100 W. Capitol St., local, 965-4873; statewide,1-800-827-1000)

Vet Centers:

Biloxi 39531 (2196 Pass Rd., 601-388-9938)
Jackson 39206 (4436 N. State St., Suite A3, 601-965-5727)

National Cemeteries:

Biloxi 39535 (P.O. Box 4968, 601-388-6668)
Corinth 38834 (1551 Horton St., for information, call Memphis,TN, NC, 901-386-8311)
Natchez 39120 (41 Cemetery Rd., 601-445-4981)

MISSOURI

Medical Centers:

*Columbia 65201 (800 Hospital Dr., 314-443-2511)
Kansas City 64128 (4801 Linwood Blvd., 816-861-4700)
*Poplar Bluff 63901 (1500 N. Westwood Blvd., 314-686-4151)

St. Louis 63106 (John Cochran Div., 915 N. Grand Blvd., 314-652-4100)
*St. Louis 63125 (Jefferson Barracks Div., 314-487-0400)

Clinic:

Mt. Vernon 65712 (600 N. Main St., 417-466-4000)

Regional Office:

St. Louis 63103 (Federal Bldg., 1520 Market St., local, 342-1171; statewide, 1-800-827-1000)

Benefits Office:

Kansas City 64106 (Federal Office Bldg., 601 E. 12th St.)

Vet Centers:

Kansas City 64111 (3931 Main St., 816-753-1866 or 753-1974)
St. Louis 63103 (2345 Pine St., 314-231-1260)

National Cemeteries:

Jefferson Barracks (St. Louis 63125, 101 Memorial Dr., 314-263-8691/2)
Jefferson City 65101 (1024 E. McCarty St., for information, call Jefferson Barracks, MO, NC, 314-263-8691/2)
Springfield 65804 (1702 E. Seminole St., 417-881-9499)

MONTANA

VA Medical & Regional Office:

Fort Harrison 59636 (William St. off Hwy. 12 W., 406-442-6410)

Medical Center:

*Miles City 59301 (210 S. Winchester, 406-232-3060)

Clinic:

Billings 59102 (1127 Alderson Ave., 406-657-6786)

Regional Office:

Fort Harrison 59636, local, 447-7975; statewide, 1-800-827-1000)

Vet Centers:

Billings 59102 (1948 Grand Ave., 406-657-6071)
Missoula 59802 (500 N. Higgins Ave., 406-721-4918)

NEBRASKA

Medical Centers:

*Grand Island 68803 (2201 N. Broadwell, 308-382-3660)
Lincoln 68510 (600 S. 70th St., 402-489-3802)
Omaha 68105 (4101 Woolworth Ave., 402-346-8800)

Regional Office:

Lincoln 68516 (5631 S. 48th St., local, 437-5001; statewide,1-800-827-1000)

Vet Centers:

Lincoln 68508 (920 L St., 402-476-9736)
Omaha 68106 (5123 Leavenworth St., 402-553-2068)

National Cemetery:

Fort McPherson (Maxwell 69151, HCO 1, Box 67, 308-582-4433)

NEVADA

Medical Center:

*Reno 89520 (1000 Locust St., 702-786-7200)
Las Vegas 89102 (1703 W. Charleston, 702-385-3700)

Regional Office:

Reno 89520 (1201 Terminal Way, local, 329-9244; statewide,1-800-827-1000)

Benefits Office:

Las Vegas 89102 (3233 W. Charleston Blvd.)

Vet Centers:

Las Vegas 89101 (704 S. 6th St., 702-388-6368)
Reno 89503 (1155 W. 4th St., Suite 101, 702-323-1294)

NEW HAMPSHIRE

Medical Center:

*Manchester 03104 (718 Smyth Rd., 603-624-4366)

Regional Office:

Manchester 03101 (Norris Cotton Federal Bldg., 275 Chestnut St., local, 666-7785; statewide, 1-800-827-1000)

Vet Center:

Manchester 03104 (103 Liberty St., 603-668-7060/61)

NEW JERSEY

Medical Centers:

*East Orange 07019 (Tremont Ave. , 201-676-1000)
#*Lyons 07939 (Valley & Knollcroft Rd., 908-647-0180)

Clinic:

Brick 08724 (970 Rt. 70, 908-206-8900)
Linwood 08221 (222 New Rd., Bldg. 2, Suite 2, 609-926-1180)
Vineland 08360 (New Jersey Vets Memorial Home, Northwest Blvd., 609-692-2881)

Regional Office:

Newark 07102 (20 Washington PL, local, 645-2150; statewide,1-800-827-1000)

Vet Centers:

Jersey City 07302 (115 Christopher Columbus Dr., Rm. 200, 201-656-6986)
Linwood 08221 (222 New Road, Bldg. 2, Suite 3-4-5, 609-927-8387)
Newark 07102 (75 Halsey St., 201-645-5954)
Trenton 08611 (171 Jersey St., Bldg 36, 609-989-2260)

National Cemeteries:

Beverly 08010 (R.D. #1, Bridgeboro Rd., 609-989-2137)
Finn's Point (Salem 08079, R.F.D. #3, Fort Mott Rd., Box 542, for information, call Beverly, NJ, NC, 609-989-2137)

NEW MEXICO

Medical Center:

*Albuquerque 87108 (2100 Ridgecrest Dr., S.E., 505-265-1711)

Regional Office:

Albuquerque 87102 (Dennis Chavez Federal Bldg., 500 Gold Ave., S.W., local, 766-3361; statewide, 1-800-827-1000)

Vet Centers:

Albuquerque 87104 (1600 Mountain Rd. NW, 505-766-5900)
Farmington 87402 (4251 E. Main, Suite B, 505-327-9684)
Santa Fe 87505 (1996 Warner St., Warner Plaza, Suite 5, 505-988-6562)

National Cemeteries:

Fort Bayard 88036 (P.O. Box 189, for information, call Fort Bliss, TX, NC, 915-540-6182)
Santa Fe 87504 (501 N. Guadalupe St., P.O. Box 88, 505-988-6400)

NEW YORK

Medical Centers:

*Albany 12208 (113 Holland Ave., 518-462-3311)
*Batavia 14020 (222 Richmond Ave., 716-343-7500)
#*Bath 14810 (Veterans Ave., 607-776-2111)
*Bronx 10406 (130 W. Kingsbridge Rd., 718-584-9000)
#*Brooklyn 11209 (800 Poly Place, 718-836-6600)
*Buffalo 14215 (3495 Bailey Ave., 716-834-9200)
#*Canandaigua 14424 (Fort Hill Ave., 716-394-2000)
*Castle Point 12511 (Rte. 9D, 914-831-2000)
#*Montrose 10548 (Rte. 9A, 914-737-4400)
New York City 10010 (423 E. 23rd St., 212-686-7500)

*Northport 11749 (79 Middleville Rd., 516-261-4400)
*Syracuse 13210 (800 Irving Ave., 315-476-7461)

Clinics:

Albany 12206 (91 Central Ave., 518-432-1068)
Brooklyn 11205 (35 Ryerson St., 718-330-7851)
Buffalo 14209 (2963 Main St., 716-834-4270)
Elizabethtown 12932 (Community Hospital, Park St., 518-873-2179)
Fort Drum 13602 (Bldg. T2407, Dunn Ave., 315-773-7231)
Massena 13662 (1 Hospital Dr., 315-764-1711)
New York City 10036 (423 E. 23rd St., 212-951-5983)
Plattsburgh 12903 (380th Medical Group/SGAM, 518-565-7482)
Rochester 14614 (100 State St., 716-263-5734)
Sidney 13838 (39 Pearl St. West, 607-563-3970)
St. Albans 11425 (179th St. & Linden Blvd., 718-526-1000)
Syracuse 13210 (1031 E. Fayette St., 315-423-5690)

Regional Offices:

Buffalo 14202 (Federal Bldg., 111 W. Huron St., local, 846-5191; statewide, 1-800-827-1000) Serves counties not served by New York City Regional Office.
New York City 10001 (252 Seventh Ave. at 24th St., local, 620-6901; statewide, 1-800-827-1000) Serves counties of Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton. Kings, Montgomery, Nassau, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Benefits Offices:

Albany 12207 (Leo W. O Brian Federal Bldg., Clinton Ave. & N. Pearl St.,)
Rochester 14614 (Federal Office Bldg. & Courthouse, 100 State St.
Syracuse 13202 (344 W. Genesee St.)

Vet Centers:

Albany 12206 (875 Central Ave., 518-438-2505)
Babylon 11702 (116 West Main St., 516-661-3930)
Brooklyn 11201 (165 Cadman Plaza, East, 718-330-7851)
Buffalo 14209 (351 Linwood Ave., 716-882-0505)
New York 10036 (120 W. 44th St., 212-944-2931/32)
New York 10027 (55 W. 125 St., 212-870-8126)
Rochester 14614 (134 S. Fitzhugh St., 716-263-5710)
Staten Island 10301 (150 Richmond Terrace, 718-816-4499)
Syracuse 13203 (210 North Townsend St., 315-423-5690)
White Plains 10601 (200 Hamilton Ave., 914-682-6251)
Woodhaven 11421 (75-108 91st Ave., 718-296-2871)

National Cemeteries:

Bath 14810 (VA Medical Center, 607-776-2111, ext. 1293)
Calverton 11933 (210 Princeton Blvd., 516-727-5410 or 727-5770)
Cypress Hills (Brooklyn 11208, 625 Jamaica Ave., for information, call Long Island, NY, NC, 516-454-4949)
Long Island (Farmingdale 11735, 516-454-4949)
Woodlawn (Elmira 14901, 1825 Davis St., for information, call Bath, NY, NC, 607-776-2111, ext. 1293)

NORTH CAROLINA

Medical Centers:

*Asheville 28805 (1100 Tunnel Rd., 704-298-7911)

Note: The following designations for medical centers indicate additional programs available: * for nursing-home care units; # for domiciliaries

*Durham 27705 (508 Fulton St., 919-286-0411)
*Fayetteville 28301 (2300 Ramsey St., 910-822-7059)
*Salisbury 28144 (1601 Brenner Ave., 704-638-9000)

Clinic:

Winston-Salem 27155 (Federal Bldg., 251 N. Main St., 910-631-5517)

Regional Office:

Winston-Salem 27155 (Federal Bldg., 251 N. Main St., local, 748-1800, statewide, 1-800-827-1000)

Vet Centers:

Charlotte 28202 (223 S. Brevard St., Suite 103, 704-333-6107)
Fayetteville 28301 (4 Market Square, 910-323-4908)
Greensboro 27406 (2009 Elm-Eugene St., 910-333-5366)
Greenville 27834 (150 Arlington Blvd., Suite B, 919-355-7920)

National Cemeteries:

New Bern 28560 (1711 National Ave., 919-637-2912)
Raleigh 27610 (501 Rock Quarry Rd., 919-832-0144)
Salisbury 28144 (202 Government Rd., 704-636-2661)
Wilmington 28403 (2011 Market St., 910-637-2912)

NORTH DAKOTA

Medical Center:

*Fargo 58102 (2101 Elm St., 701-232-3241)

Regional Office:

Fargo 58102 (2101 Elm St.; local, 239-3777; statewide, 1-800-827-1000)

Vet Centers:

Fargo 58103 (1322 Gateway Dr., 701-237-0942)
Minot 58701 (108 E. Burdick Expressway, 701-852-0177)

OHIO

Medical Centers:

#*Brecksville 44141 (10000 Brecksville Rd., 216-526-3030)
*Chillicothe 45601 (17273 State Route 104, 614-773-1141)
#*Cincinnati 45220 (3200 Vine St., 513-861-3100)
Cleveland 44106, 10701 East Blvd., 216-791-3800)
#*Dayton 45428 (4100 W. 3rd St., 513-268-6511)

Clinics:

Canton 44702 (221 Third St., S.E., 216-489-4660)
Columbus 43221 (2090 Kenny Rd., 614-469-5164)
Toledo 43614 (3333 Glendale Ave., 419-259-2000)
Youngstown 44505 (2031 Belmont, 216-740-9200)

Regional Office

Cleveland 44199 (Anthony J. Celebrezze Federal Bldg., 1240 E. 9th St., local, 621-5050; statewide, 1-800-827-1000)

Benefits Offices:

Cincinnati 45202 (36 E. 7th St., Suite 210)
Columbus 43215 (Federal Bldg., Rm. 309, 200 N. High St., 800-827-8272)

Vet Centers:

Cincinnati 45219 (30 E. Hollister St., 513-569-7140)
Cleveland 44111 (11511 Lorain Ave., 216-671-8530)
Cleveland Heights 44118 (2134 Lee Rd., 216-932-8471)
Columbus 43205 (1054 E. Broad St., 614-253-3500)
Dayton 45402 (6 S. Patterson Blvd., 513-461-9150)

National Cemetery:

Dayton 45428 (VA Medical Center, 4100 W. Third St., 513-262-2116)

OKLAHOMA

Medical Centers:

Muskogee 74401 (Honor Heights Dr,., 918-683-3261)

Oklahoma City 73104 (921 N.E. 13th St., 405-270-0501)

Clinics:

Ardmore 73401 (1015 S. Commerce , 405-223-2266)

Clinton 73601 (1/4 mile south of I-40 on Highway 183, PO Box 1209, 405-323-5540)

Lawton 73502 (Comanche Co. Hospital, PO Box 49, 405-357-6611)

Tulsa 74101 (1855 E. 15th St., 918-581-7105)

Regional Office:

Muskogee 74401 (Federal Bldg., 125 S. Main St., local 687-2500; statewide, 1-800-827-1000)

Benefits Office:

Oklahoma City 73102 (200 N.W. 5th St.)

Vet Centers

Oklahoma City 73105 (3033 N. Walnut, Suite 101W, 405-270-5184)

Tulsa 74101 (1855 E. 15th St., 918-581-7105)

National Cemetery:

Fort Gibson 74434 (1423 Cemetery Rd., 918-478-2334)

OREGON

Medical Centers:

#*Portland 97207 (3710 SW U.S. Veterans Hospital Rd., 503-220-8262)

Roseburg 97470 (913 NW New Garden Valley Blvd., 503-220-8262)

Clinics

Bandon 97411 (1010 1st St. SE, Suite 100, 33 Michigan St., SE, 503-347-4736)

Eugene 97401 (138 W. 8th , 503-465-6481)

Portland 97207 (8909 SW Barbur Blvd., 503-244-9222)

Domiciliary:

White City 97503 (Hwy. 62, 503-826-2111)

Regional Office:

Portland 97204 (Federal Bldg., 1220 SW 3rd Ave., local, 221-2431; statewide, 1-800-827-1000)

Vet Centers:

Eugene 97403 (1966 Garden Ave., 503-465-6918)

Grants Pass 97526 (211 SE 10th St., 503-479-6912)

Portland 97220 (8383 N.E. Sandy Blvd., Suite 110, 503-273-5370)

Salem 97301 (318 Church St., NE, 503-362-9911)

National Cemeteries:

Eagle Point 97524 (27663 Riley Rd., 503-826-2511)

Roseburg 97470 (VA Medical Center, 913 NW Garden Valley Blvd., 503-440-1000)

Willamette (Portland 97266, 11800 S.E. Mt. Scott Blvd., 503-273-5250)

PENNSYLVANIA

Medical Centers

*Altoona 16602 (2907 Pleasant Valley Blvd., 814-943-8164)

#*Butler 16001 (325 New Castle Rd., 412-287-4781)

#*Coatesville 19230 (1400 Black Horse Hill Rd., 215-384-7711)

*Erie 16504 (135 E. 138th St., 814-868-8661)

*Lebanon 17042 (1700 S. Lincoln Ave., 717-272-6621)

*Philadelphia 19104 (University & Woodland Aves., 215-383-2400)

Pittsburgh 15206 (7180 Highland Dr., 412-363-4900)

*Pittsburgh 15240 (University Drive C, 412-683-3000)

*Wilkes-Barre 18711 (1111 E. End Blvd., 717-824-4304)

Clinics

Allentown 18103 (2937 Hamilton Blvd., 610-776-4304)

Camp Hill 17011 (25 N. 32 N. 32nd St., 717-730-9782)

Sayre 18840 (Guthrie Square, 717-888-8062)

Springfield 19064 (1489 Baltimore Pike, 215-543-1588)

Regional Offices:

Philadelphia 19101 (RO & Insurance Center, P.O. Box 8079, 5000 Wissahickon Ave., local, 438-5225; statewide, 1-800-827-1000; insurance, 1-800-669-8477; recorded benefits information, 215-951-5368, 24-hour availability) serves counties of Adams, Berks, Bradford, Bucks, Cameron, Carbon, Centre,Chester, Clinton, Columbia, Cumberland, Dauphin, Delaware, Franklin, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna,Tioga, Union, Wayne, Wyoming, York.

Pittsburgh 15222 (1000 Liberty Ave., local, 281-4233; statewide, 1-800-827-1000) Serves the remaining counties of Pennsylvania.

Benefits Office:

Wilkes-Barre 18701 (19-27 N. Main St.)

Vet Centers

Erie 16501 (G. Daniel Baldwin Blvd., 1000 State St., 814-453-7955)

Harrisburg 17102 (1007 N. Front St., 717-782-3954)

McKeesport 15132 (500 Walnut St., 412-678-7704)

Philadelphia 19107 (1026 Arch St., 215-597-0544)

Philadelphia 19120 (101 E. Olney Ave., 215-951-5438)

Pittsburgh 15222 (954 Penn Ave., 412-765-1193)

Scranton 18509 (959 Wyoming Ave., 717-344-2676)

National Cemeteries:

Indiantown Gap (Annville 17003, R.R.2, P.O. Box 484, 717-865-5254/5)

Philadelphia 19138 (Haines St. & Limekiln Pike; for information,call Beverly, NJ, NC, 609-989-2137)

PHILIPPINES

Regional Office:

Manila 96440 (1131 Roxas Blvd., APO AP 96440, local, 810-521-7521; from U.S. 011632-521-7116, ext. 2501)

PUERTO RICO

Medical Center:

*San Juan 00927 (1 Veterans Plaza), 809-758-7575)

Clinics:

Mayaguez 00708 (Carr, Estatal #2, Frente A Res. Sultana, 809-831-3400)

Ponce 00731 (Reparada Industrial-Lot #1, Calle Principal, 809-841-3115)

St. Croix 00853 (Box 12 RR 02, 809-778-5553)

Regional Office:

San Juan 00936 (U.S. Courthouse & Federal Bldg., Carlos E. Chardon St., Hato Rey, GPO Box 364867, local, 766-5141; all other San Juan areas and the Virgin Islands, 1-800-827-1000) To call San Juan from U.S. Virgin Islands, 1-800-827-1000.

Vet Centers:

Arecibo 00612 (52 Gonzalo Marin St., 809-879-4510 or 879-4581)

Ponce 00731 (35 Mayor St., 809-841-3260)

Rio Piedras 00921 (Condomino Medical Center Plaza, Suite LC8A & LC9, La Riviera, 809-783-8794)

National Cemetery:

Puerto Rico (Bayamon 00960, PO Box 1298, 809-798-8400)

RHODE ISLAND

Medical Center:

Providence 02908 (830 Chalkstone Ave., 401-273-7100)

Regional Office:

Providence 02903 (380 Westminster Mall, local, 273-4910; statewide, 1-800-827-1000,

Vet Center:

Cranston 02910 (789 Park Ave., 401-528-5236)
Providence 02904 (909 N. Main St., 401-528-5271)

SOUTH CAROLINA

Medical Centers:

Charleston 29401 (109 Bee St., 803-577-5011)
*Columbia 29209 (Garners Ferry Rd., 803-776-4000)

Clinics:

Greenville 29601 (3510 Augusta Rd., 803-299-1600)
Savannah 31406 (325 W. Montgomery Crossroads, 912-920-0214)

Regional Office:

Columbia 29201 (1801 Assembly St., local, 765-5861; statewide, 1-800-827-1000)

Vet Centers:

Columbia 29201 (1313 Elmwood Ave., 803-765-9944)
Greenville 29601 (904 Pendelton St., 803-271-2711)
North Charleston 29418 (5603A Rivers Ave., 803-747-8387)

National Cemeteries:

Beaufort 29902 (1601 Boundary St., 803-524-3925)
Florence 29501 (803 E. National Cemetery Rd., 803-669-8783)

SOUTH DAKOTA

Medical Centers:

*Fort Meade 57741 (I 90/Hwy. 34, 605-347-2511)
#Hot Springs 57747 (Off 5th St., 605-745-4101)
*Sioux Falls 57117(2501 W. 22nd St., 605-336-3230)

Regional Office:

Sioux Falls 57117 (P.O. Box 5046, 2501 W. 22nd St., local, 336-3496; statewide, 1-800-827-1000)

Vet Centers:

Rapid City 57701 (610 Kansas City St., 605-348-0077 or 348-1752)
Sioux Falls 57102 (115 North Dakota St., 605-332-0856)

National Cemeteries:

Black Hills (Sturgis 57785, P.O. Box 640, 605-347-3830)
Fort Meade 57785 (VA Medical Center, for information, call Black Hills, SD, NC, 605-347-3830)
Hot Springs 57747 (VA Medical Center, 605-745-4101)

TENNESSEE

Medical Centers:

*Memphis 38104 (1030 Jefferson Ave., 901-523-8990)
#*Mountain Home 37684 (Sidney & Lamont St., 615-926-1171)
*Murfreesboro 37129 (3400 Lebanon Rd., 615-893-1360)
Nashville 37212 (1310 24th Ave., South, 615-327-4751)

Clinics:

Chattanooga 37411 (Bldg. 6200 East Gate Center, 615-855-6550)
Cookville 38501 (121 S. Dixie Ave., 615-893-1360)
Knoxville 37923 (9031 Cross Park Dr., 615-545-4582))

Regional Office:

Nashville 37203 (110 9th Ave. South, local, 736-5251; statewide, 1-800-827-1000)

Vet Centers:

Chattanooga 37404 (425 Cumberland St., Suite 140, 615-752-5234)

Note: The following designations for medical centers indicate additional programs available: * for nursing-home care units; # for domiciliaries

Johnson City 37601 (703 S. Roan St., 615-928-8387)
Knoxville 37914 (2817 E. Magnolia Ave., 615-971-5866)
Memphis 38104 (1835 Union, Suite 100, 901-722-2510)

National Cemeteries:

Chattanooga 37404 (1200 Bailey Ave., 615-855-6590)
Knoxville 37917 (939 Tyson St., NW, 615-929-5360)
Memphis 38122 (3568 Townes Ave., 901-386-8311)
Mountain Home 37684 (P.O. Box 8, 615-461-7935)
Nashville (Madison 37115, 1420 Gallatin Rd. So., 615-327-5360)

TEXAS

Medical Centers:

*Amarillo 79106 (6010 Amarillo Blvd., West, 806-355-9703)
*Big Spring 79720 (2400 S. Gregg St., 915-263-7361)
#*Bonham 75418 (1201 East Ninth, 903-583-2111)
#*Dallas 75216 (4500 S. Lancaster Rd., 214-376-5451)
*Houston 77030 (2002 Holcombe Blvd., 713-791-1414)
*Kerrville 78028 (3600 Memorial Blvd., 210-896-2020)
Marlin 76661 (1016 Ward St., 817-883-3511)
*San Antonio 78284 (7400 Merton Minter Blvd., 210-617-5300)
#*Temple 76504 (1901 S. First, 817-778-4811)
#*Waco 76711 (4800 Memorial Dr., 817-752-6581)

Clinics:

Austin 78741 (2901 Montopolis Drive, 389-7101)
Beaumont 77701 (3385 Fannin St., 409-839-2480)
Corpus Christi 78405 (5283 Old Brownsville Rd., 512-512888-3251)
El Paso 79925 (5919 Brook Hollow Dr., 915-540-7811)
Fort Worth 76104 (300 W. Rosedale St., 817-335-2202)
Laredo 78043 (2359 E. Saunders Ave., 512-725-7060)
Lubbock 79410 (4902 34th St., #10, 806-796-7900)
Lufkin 75901 (1301 Frank Ave., 409-637-1342)
McAllen 78501 (2101 S. Rowe Blvd., 210-618-7147)
San Antonio 78229 (9502 Computer Dr., 210-617-2645)
Victoria 77901 (2710 E. Airline Dr., 512-572-0006)

Regional Offices:

Houston 77054 (8900 Lakes at 610 Dr., local, 664-4664; statewide, 1-800-827-1000, serves counties of Angelina, Aransas, Atacosa, Austin, Bandera, Bee, Bexar, Blanco, Brazoria, Brewster, Brooks, Caldwell, Calhoun, Cameron, Chambers, Colorado, Comal, Crockett, DeWitt, Dimitt, Duval, Edwards, Fort Bend, Frio, Galveston, Gillespie, Goliad, Gonzales, Grimes, Guadalupe, Hardin, Harris, Hays, Hidalgo, Houston, Jackson, Jasper, Jefferson, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kerr, Kimble, Kinney, Kleberg, LaSalle, Lavaca, Liberty, Live Oak, McCulloch, McMullen, Mason, Matagorda, Maverick, Medina, Menard, Montgomery, Nacogdoches, Newton, Nueces, Orange, Pecos, Polk, Real, Refugio, Sabine, San Augustine, San Jacinto, San Patricio, Schleicher, Shelby, Starr, Sutton, Terrell, Trinity, Tyler, Uvalde, Val Verde, Victoria, Walker, Waller, Washington, Webb, Wharton, Willacy, Wilson, Zapata, Zavala)

Waco 76799 (1400 N. Valley Mills Dr., local, 817-772-3060; statewide, 1-800-827-1000) Serves rest of the state) Bowie County served by Little Rock, AR, Regional Office, 1-800-827-1000.

Benefits Offices:

Dallas 75242 (Santa Fe Bldg., 1114 Commerce St.)
Fort Worth 76104 300 W. Rosedale St.)
Lubbock 79401 (Federal Bldg., 1205 Texas Ave.)
San Antonio 78229-2041 (3601 Bluemel Rd.)

Vet Centers:

Amarillo 79109 (3414 E. Olsen Blvd., Suite E., 806-376-2127)
Austin 78723 (3401 Manor Rd., Suite 102, 512-476-0607)
Corpus Christi 78404 (3166 Reid Dr., Suite 1, 512-888-3101)

Dallas 75244 (5232 Forest Lane, Suite 111, 214-361-5896)
El Paso 79903 (2121 Wyoming St., 915-542-2851)
Fort Worth 76104 (1305 W. Magnolia, Suite B, 817-921-3733)
Houston 77004 (4905A San Jacinto, 713-522-5354 or 522-5376)
Houston 77007 (8100 Washington Ave., Suite 120, 713-880-8387)
Laredo 78041 (6020 McPherson Rd. #1, 512-723-4680)
Lubbock 79410 (3208 34th St., 806-743-7551)
McAllen 78501 (1317 E. Hackberry St., 512-631-2147)
Midland 79703 (3404 W. Illinois, Suite 1, 915-697-8222)
San Antonio 78212 (231 W. Cypress St., 512-229-4025)

National Cemeteries:

Fort Bliss 79906 (5200 Fred Wilson Rd., P.O. Box 6342, 915-540-6182)
Fort Sam Houston (San Antonio 78209, 1520 Harry Wurzbach Rd., 210-820-3891)
Houston 77038 (10410 Veterans Memorial Dr., 713-447-8686)
Kerrville 78028 (VA Medical Center, 3600 Memorial Blvd. For information call Fort Sam Houston, TX, NC, 210-820-3891)
San Antonio 78202 (517 Paso Hondo St. For information, call Fort Sam Houston, TX, NC, 210-820-3891)

UTAH

Medical Center:

*Salt Lake City 84148 (500 Foothill Dr., 801-582-1565)

Regional Office:

Salt Lake City 84147 (P.O. Box 11500, Federal Bldg., 125 S.State St., local, 524-5960; statewide, 1-800-827-1000)

Vet Centers:

Provo 84601 (750 North 200 West, Suite 105, 801-377-1117)
Salt Lake City 84106 (1354 East 3300, South, 801-584-1294)

VERMONT

Medical Center:

*White River Junction 05009 (N. Hartland Rd., 802-295-9363)

Clinics:

Burlington 05401 (Appletree Bay Medical Center, 1205 North Ave., 802-864-4492)
North Troy 05859 (Mobile Clinic, American Legion Post, 802-296-6399)
St. Albans 05478 (Mobile Clinic, Highgate Shopping Center, 802-296-6399)

Regional Office:

White River Junction 05001 (N. Hartland Rd., local, 296-5177; statewide, 1-800-827-1000)

Vet Centers:

Burlington 05401 (359 Dorset St., 802-862-1806)
White River Junction 05001 (2 Holiday Dr., Gilman Office Bldg. #2, 802-295-2900)

VIRGINIA

Medical Centers:

#*Hampton 23667 (100 Emancipation Dr., 804-722-9951)
*Richmond 23249 (1201 Broad Rock Rd., 804-230-0001)
*Salem 24153 (1970 Roanoke Blvd., 703-982-2463)

Clinics:

Norfolk 23508 (6500 Hampton Blvd., 804-444-5517)

Regional Office:

Roanoke 24011 (210 Franklin Rd., S.W., local, 982-6440; statewide, 1-800-827-1000)
Northern Virginia counties of Arlington & Fairfax, cities of Alexandria, Fairfax, Falls Church served by Washington, D.C., RO, 202-872-1151.

Vet Centers:

Norfolk 23518 (2200 Colonial Ave., Suite 3, 804-623-7584)
Richmond 23230 (3022 W. Clay St., 804-353-8958)
Roanoke 24016 (320 Mountain Ave., SW, 703-982-6429)
Springfield 22150 (7024 Spring Garden Dr., 703-866-0924)

National Cemeteries:

Alexandria 22314 (1450 Wilkes St., for information, call Quantico, VA, NC, 703-690-2217)
Balls Bluff (Leesburg 22075, for information, call Culpeper, VA, NC, 703-825-0027)
City Point (Hopewell 23860, 10th Ave. & Davis St., for information, call Richmond, VA, NC, 804-222-1490)
Cold Harbor (Mechanicsville 23111, Rt. 156 North, for information, call Richmond, VA, NC, 804-222-1490)
Culpeper 22701 (305 U.S. Ave., 703-825-0027)
Danville 24541 (721 Lee St., for information, call Salisbury, NC, NC, 704-636-2661)
Fort Harrison (Richmond 23231, 8620 Varina Rd., for informa tion, call Richmond, VA, NC, 804-222-1490)
Glendale (Richmond 23231, 8301 Willis Church Rd., for information, call Richmond, VA, NC, 804-222-1490)
Hampton 23669 (Cemetery Rd. at Marshall Ave., 804-723-7104)
Hampton 23669 (VA Medical Center, 804-723-7104)
Quantico (Triangle 22172, P.O. Box 10, 18424 Joplin Rd., 703-690-2217)
Richmond 23231 (1701 Williamsburg Rd., 804-222-1490)
Seven Pines (Sandston 23150, 400 E. Williamsburg Rd., for information, call Richmond, VA, NC, 804-222-1490)
Staunton 24401 (901 Richmond Ave., for information, call Culpeper, VA, NC, 703-825-0027)
Winchester 22601 (401 National Ave., for information, call Culpeper, VA, NC, 703-825-0027)

VIRGIN ISLANDS

Vet Centers:

St. Croix 00820 (United Shopping Plaza, Suite 4 Christiansted, 809-778-5553 or 778-5755
St. Thomas 00801 (Havensight Mall, 809-774-6674)
For information on VA benefits, call 1-800-827-1000.

WASHINGTON

Medical Centers:

*Seattle 98108 (1660 S. Columbian Way, 206-762-1010)
*Spokane 99205 (N. 4815 Assembly St., 509-328-4521)
#*Tacoma 98493 (American Lake, 206-582-8440)
*Walla Walla 99362 (77 Wainwright Dr., 509-525-5200)

Regional Office:

Seattle 98174 (Federal Bldg., 915 2nd Ave., local, 624-7200; statewide, 1-800-827-1000)

Vet Centers:

Seattle 98121 (2230 8th Ave., 206-553-2706)
Spokane 99201 (W. 1708 Mission St., 509-327-0274)
Tacoma 98467 (4916 Center St., Suite E, 206-473-0731)

WEST VIRGINIA

Medical Centers:

*Beckley 25801 (200 Veterans Ave., 304-255-2121)
Clarksburg 26301 (1 Medical Center Dr., 304-623-3461)
Huntington 25704 (1540 Spring Valley Dr., 304-429-6741)
#*Martinsburg 25410 (Route 9, 304-263-0811)

Regional Office:

Huntington 25701 (640 Fourth Ave., local, 529-5720; statewide,1-800-827-1000; Counties of Brooke, Hancock, Marshall,Ohio, served by Pittsburgh, Pa., RO)

Vet Centers:

Beckley 25801 (101 Ellison Ave., 304-252-8220)
Charleston 25302 (512 Washington St. West, 304-343-3825)
Huntington 25701 (1005 6th Ave., 304-523-8387)
Martinsburg 25401 (105 S. Spring St., 304-263-6776)
Morgantown 26505 (1191 Pineview Dr., 304-291-4001)
Mt. Gay 25637 (304-752-4453)
Princeton 24740 (905 Mercer St., 304-425-5653)
Wheeling 26003 (1070 Market St., 304-232-0587)

National Cemeteries:

Grafton 26354 (431 Walnut St., for information call West Virginia NC, 304-265-2044)
West Virginia (Grafton 26354, Rt. 2, Box 127, 304-265-2044)

WISCONSIN

Medical Centers:

Madison 53705 (2500 Overlook Terrace, 608-256-1901)
#*Milwaukee 53295 (5000 W. National Ave., 414-384-2000)
*Tomah 54660 (500 E. Veterans St., 608-372-3971)

Clinic:

Superior 54880 (3520 Tower Ave., 715-392-9711)

Regional Office:

Milwaukee 53295 (5000 W. National Ave., Bldg. 6, local, 383-8680; statewide, 1-800-827-1000)

Vet Centers:

Madison 53703 (147 S. Butler St., 608-264-5343)
Milwaukee 53208 (3400 Wisconsin, 414-344-5504)

National Cemetery:

Wood (Milwaukee 53295, 5000 W. National Ave., Bldg. 122, 414-382-5300)

WYOMING

Medical Center:

*Cheyenne 82001 (2360 E. Pershing Blvd., 307-778-7550)
Sheridan 82801 (1898 Fort Rd., 307-672-3473)

Regional Office:

Cheyenne 82001 (2360 E. Pershing Blvd., local 778-7396; statewide, 1-800-827-1000)

Vet Centers:

Casper 82601 (111 S. Jefferson, 307-235-8010)
Cheyenne 82001 (3130 Henderson Dr., 307-778-7370)

Note: The following designations for medical centers indicate additional programs available: * for nursing-home care units; # for domiciliaries

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Department of Veterans Affairs

Women Veterans Health Programs

Including Sexual Trauma Counseling Services

Introduction

A number of women veterans were victims of sexual assault while serving on active military duty. While some of these women have sought counseling for their sexual trauma, many women have never discussed their assault with anyone. They are very uncomfortable talking about it now, and even wonder if they can, or if it would matter. Yet, these women know that they have "not felt the same" since it occurred.

Unfortunately, this is a very common reaction of victims of sexual assault. Many events are never reported. There are reasons for this silence, many of them based on misconceptions about women who have been victimized sexually. Nearly one-third of all rape victims develop Post Traumatic Stress Disorder (PTSD) sometime during their lifetime. PTSD symptoms are often accompanied by physical problems and generally "not feeling well."

Department of Veterans Affairs (VA) health care professionals are sensitive to the experience of sexual assault and the impact it can have on a victim's physical and emotional health. They understand the feelings of fear, anxiety, shame, anger and embarrassment that victims of sexual assault can have when they try to talk about their trauma. VA health care professionals can help women who are coping with the trauma of sexual assault to regain their confidence, self esteem, and quality of life. VA provides confidential, priority counseling and related health care services to eligible women veterans.

Q. What is the Women Veterans Health Programs Act of 1992?

A. Public Law 102-585, Veterans Health Care Act of 1992, Title I - Women Veterans Health Programs, enacted November 4, 1992, established programs to improve health care services for women veterans, including priority counseling for sexual trauma and related health care services to eligible women veterans.

Q. Who is eligible for care under the Women Veterans Health Programs Act of 1992?

A. VA may provide counseling to women veterans who VA determines require such counseling to overcome psychological trauma. The trauma may result from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while serving on active military duty. Public Law 102-585, defines sexual harassment as repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.

Q. When must a woman veteran seek care under the Women Veterans Health Programs Act of 1992?

A. Currently VA may provide counseling services through December 31, 1995. To be eligible to receive counseling, a woman veteran must seek counseling from VA within two years after the date of her discharge or release from active military service. Currently a woman veteran who was discharged or released from active military service before December 31, 1991, must seek counseling from VA prior to December 31, 1993.

Q. Is a woman veteran eligible to receive care for sexual trauma, although the assault was never reported when it occurred?

A. Yes. To be eligible to receive sexual trauma counseling and related health care from VA, there is no requirement that a woman veteran must have reported the sexual trauma when it occurred or at any time during her active military service.

Q. Where can a woman veteran receive care or more information regarding the VA sexual trauma services?

A. A woman veteran seeking counseling and related health care for sexual trauma should contact the Women Veterans Coordinator at the nearest VA medical center or vet center for assistance. The telephone number for the medical center or vet center can be found in the telephone directory under "U.S. Government" listings.

Q. What is disability compensation and who is eligible for this benefit?

A. Veterans who are disabled by injury or disease incurred or aggravated during active service in the line of duty during wartime or peacetime service and discharged or separated under other than dishonorable conditions are eligible for monthly payments from VA. The amount of these payments, called disability compensation, is based on the degree of disability. Disabilities are rated from zero to 100 percent disabling, in increments of 10 percent. If there are two or more disabilities, the individual percentages of each are used to determine a combined disability evaluation. Compensation is not payable at the zero percent level.

Q. Can a woman veteran who was the victim of sexual assault while serving on active duty qualify for disability compensation?

A. VA may pay compensation to a woman veteran for disabilities incurred or aggravated in the line of duty, including disabilities or injuries resulting from sexual trauma. A Veterans Benefits Counselor (VBC) at a VA medical center or regional office can explain the compensation program in greater detail and assist in filing a claim. Information may also be obtained by calling 1-800-827-1000, and speaking with a VBC at the nearest VA regional office.

Q. Does a woman veteran who was the victim of sexual assault while serving on active duty automatically qualify for disability compensation?

A. No. As stated above, payment of compensation is based on the degree of the service connected disability or disabilities. VA must first determine whether there are current disabilities related to military service. If disabilities are deemed service related, VA then evaluates the degree of disability, which determines the amount of compensation payable. Once again, compensation is not payable for a zero percent evaluation. A woman who has been the victim of sexual trauma may or may not have residual disability which can be deemed service connected, or may exhibit residuals which are not compensable (i.e., evaluated at the zero percent level).

Q. Does sexual assault have an impact on the mental and physical health of the victim?

A. Having been the victim of rape appears to significantly impact on the overall health of the victim. According to the 1988 report, "Rape in America," nearly one-third (31%) of all rape victims develop Post Traumatic Stress Disorder (PTSD) sometime during their lifetime. Additionally, researchers are beginning to notice a relationship between PTSD symptoms and an increase in physical health problems and reports of "not feeling well."

Q. What is Post Traumatic Stress Disorder (PTSD)?

A. Post Traumatic Stress Disorder is a recurrent emotional reaction to a terrifying, uncontrollable or life-threatening event. The symptoms frequently develop after a person's sense of safety and security is violated. Individuals with PTSD experience a variety of symptoms that often impede their daily lives. These may include sleep disturbances, nightmares, emotional instability, feelings of fear and anxiety around seemingly non-threatening situations, impaired concentration, and increased stress or problems in intimate and other interpersonal relationships. These reactions are common after a trauma and are part of the initial adjustment process.

Q. What other problems are commonly associated with rape-related PTSD?

A. Recent research shows that women who have experienced rape or other violent crimes are more likely to develop problems with depression, drug and/or alcohol abuse, and suicidal thoughts than women who have not had such an experience. Also, it is not uncommon for women to feel shame, guilt or confusion about the rape itself.

Q. What kind of help does a person with some of these symptoms need?

A. Frequently, people exposed to life-threatening trauma benefit from psychological counseling. Talking about one's experience, symptoms, fears and concerns with a trained professional usually results in the reduction of such problems and helps a person restore his/her sense of personal safety. Victims of sexual assault or harassment have been successfully treated in both individual and group therapy settings.

Q. How does a woman know whether she needs treatment or what kind of treatment would be best for her?

A. If a woman has been the victim of a sexual assault and is experiencing any of the symptoms mentioned above, or if she has experienced a general and continuing feeling of personal discomfort, the most important thing for her to do is to receive an evaluation by an appropriate health care professional who knows about the impact sexual assault can have on a person's physical and emotional health. The health care professional can provide advice regarding available treatment options or an appropriate referral.

Q. I have never discussed my assault with anyone and I am very frightened about talking about it now, and even wonder if I can. What can I do about this fear?

A. Unfortunately, this is a very common fear of women who have been the victims of sexual assault. In fact, it is estimated that only sixteen percent of the rapes that occur in this country are ever officially reported. Many of the reasons for this silence are based on society's stereotypes of women who have been victimized sexually. It is important to remember that health care professionals have become increasingly sensitized to the experience of sexual assault and the impact it can have on the victim. As a result, they are much more able to respond to the fears and anxieties you are experiencing. They will also understand the difficulty you have in discussing them with another person and will be able to help you express yourself in a way that is most comfortable for you.

The Women Veterans Health Program includes:

- Priority outpatient counseling services and related health care services;
- Education and counseling on the normal and expected responses to sexual trauma;
- Assessment of the specific problem(s);
- Treatment to assist with restoring physical and emotional health;
- Information and referrals for services and benefits available.

For more information:

We welcome inquiries about any aspect of the Women Veterans Health Programs Act of 1992, including VA sexual trauma counseling services. To find out more about the VA health care services for women veterans, contact the Women Veterans Coordinator at your nearest VA medical center or your nearest VA vet center or VA regional office.

You can get more information by calling 1-800-827-1000 or by contacting the VA regional office, medical center or vet center near you.

An Introductory Handbook

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14 Linking Employers and Veterans

ENDORSEMENTS FOR THE PROJECT

Our first priority has to be investing in our people.

PRESIDENT CLINTON

I am always impressed by the exceptional professionalism of the women in our armed forces. WREI is to be applauded for its efforts to link this important pool of talent and efficiency with civilian jobs. Businesses won't find greater potential in prospective employees than that offered by our women veterans.

REP. G.V. "SONNY" MONTGOMERY (D-MS), CHAIRMAN,
HOUSE VETERANS AFFAIRS COMMITTEE

People are our greatest asset. We need to make sure that those leaving the Department of Defense are treated fairly in return for the sacrifices they made while serving our country. Transferring the skills of our military and civilian work force is vital to the economic recovery and well-being of our communities.

SECRETARY OF DEFENSE LES ASPIN

I applaud WREI's efforts to bring together private businesses and government agencies with the talents of our separating women veterans.

REP. PATRICIA SCHROEDER (D-CO),
HOUSE ARMED SERVICES COMMITTEE

If the American work force as a whole is to enjoy a high standard of living in the future, and if America is to be competitive in the world economy, government must stand ready to encourage the private sector as a whole to treat its work force as its most precious asset.

SECRETARY OF LABOR ROBERT REICH

I commend WREI for its impressive efforts to promote civilian job opportunities for women veterans.

SEN. TED KENNEDY (D-MA), CHAIRMAN,
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

The experience and leadership talents of those leaving our armed forces will be an asset to our businesses and industries. I wholeheartedly support WREI's efforts to link businesses and associations with this talented and experienced group of separating women veterans.

SEN. NANCY KASSEBAUM (R-KS), RANKING REPUBLICAN,
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

I strongly encourage private sector employers to consider our nation's women veterans when hiring. The skills, experience, and dedication which they have developed during their tenure in the armed forces would be an asset in any business endeavor.

REP. TIM HUTCHINSON (R-AR),
HOUSE VETERANS AFFAIRS COMMITTEE

Our women veterans have made the same sacrifices as the men they served alongside and deserve the same opportunities for employment when they leave the military. I am thankful that now, through the efforts of WREI, an important first step is being taken to provide that equal opportunity.

REP. RONALD DELLUMS (D-CA), CHAIRMAN,
HOUSE ARMED SERVICES COMMITTEE

WREI is doing the economy, the business community, and the veterans a real service by providing this bridge between military service and civilian employment. I view this program as an opportunity to support those who have served us.

REP. JOHN LA FALCE (D-NY), CHAIRMAN,
HOUSE SMALL BUSINESS COMMITTEE

In an era of reductions in our armed forces personnel, WREI's "Hire a Vet" project provides a vital service to both veterans and business by promoting the skills of the women in our armed forces and their ability to make a significant contribution to our nation's private enterprises.

REP. CONSTANCE MORELLA (R-MD),
SCIENCE, SPACE AND TECHNOLOGY COMMITTEE

I enthusiastically support WREI's project encouraging corporate America to hire women as they leave the military. The many and varied skills that military women have is impressive. Fluor Corporation has found that these women have the ***technical expertise, motivation, and discipline*** *needed in the present competitive business climate. It makes good sense to capitalize on this proven resource as we invest in the future.*

LESLIE G. MCCRAW, CHAIRMAN AND CEO,
FLUOR CORPORATION

Ford Motor Company has a long and proud history of providing employment opportunity to all constituencies, including veterans. Our experience with veterans, both men and women, has given us a genuine appreciation for the ***initiative, self-discipline, experience, and technical and administrative skills*** *they bring to a highly competitive industry. We acknowledge the importance of programs designed to return accomplished veterans to private sector employment and we commit our support to these goals and objectives.*

JACK HALL, VICE PRESIDENT, EMPLOYEE RELATIONS,
FORD MOTOR COMPANY

Associated Builders and Contractors encourages the talented women leaving military service to explore the rewarding career opportunities awaiting them in the construction industry. The construction workforce is changing and contractors need to attract the brightest and the best! ABC is proud to be associated with WREI.

STEVEN D. WESTRA, IMMEDIATE PAST PRESIDENT
ASSOCIATED BUILDERS AND CONTRACTORS

It gives me particular pleasure to comment on the enormously talented resource pool we have consistently found in women veterans who have become Betac Corporation employees. Whether assigned to demanding information systems engineering tasks or in more traditional support roles, women veterans have more than held their own in comparison to their male peers. They are ***highly motivated, possess a strong dedication to producing quality work,*** *and are* ***attentive to meeting project deadlines.***

EARL F. LOCKWOOD, PRESIDENT AND CEO,
BETAC CORPORATION

The main resource of Lockheed Support Systems, Inc. is its employees. As such, it is imperative that we have well-trained, professional employees. Since 1980, LSSI has looked to veterans to fill these requirements. They have not disappointed us. Too often, companies overlook women for high-tech positions. At LSSI, however, we have found that women veterans are highly qualified for these jobs. Our workforce includes women aircraft mechanics who are responsible for working on highly sophisticated equipment. In many cases, lives depend upon their performance. The training these women received in the military assures our customers top service with an emphasis on safety and quality. The military experience of these women assures not only ***technical ability,*** *but* ***dedication, commitment, and pride in their work*** *as well. I believe our veterans should be considered a top resource for any corporation. I strongly recommend that any corporation consider women veterans, to provide a diverse, highly skilled workforce.*

ROBERT E. TOKERUD, PRESIDENT,
LOCKHEED SUPPORT SYSTEMS, INC.

A WORD FROM WREI

In recent years, the Department of Defense has greatly increased the number of women it employs, not only in its civilian workforce but also in its uniformed forces—the Army, the Navy, the Air Force, and the Marine Corps.

As the number of women in uniform has grown, their opportunities to be trained in a variety of job skills—many of them not "traditional" for women—have also grown by leaps and bounds.

It surprised me to learn the extent of the education and training that enlisted personnel as well as officers in our armed forces undergo. And typically it's not "one-shot" training—our military are encouraged and expected to keep on honing skills and learning new ones. So while the idea that workers need to engage in life-long learning may still be somewhat novel among civilian workers, it is a given for military men and women.

The nation's investment of our corporate and individual tax dollars in training military personnel is, of course, to ensure that we have an effective defense force. But it is an investment in human capital that can strengthen your company's bottom line, as well.

Because not everyone who joins the armed services remains in the active force for a full career. Even men and women who stay in for 20 years or more, or who retain a Reserve or National Guard status, will eventually be looking for a place in the civilian labor force.

Moreover, the ongoing drawdown of our active duty forces means that many thousands of capable, well-trained men and women who under other circumstances would probably make a career in the military are leaving early. Over this fiscal year (1994) alone, more than 300,000 people will be leaving the active duty forces. Some 36,000 of these veterans will be women.

Women veterans have job skills—in many cases, skills not traditionally associated with women. Women veterans are accustomed to learning new skills because they have been in services that are geared to continuous training as a necessity in a complex, high-tech, multi-discipline, and diverse working environment. Many women veterans have developed extensive supervisory and management experience in an environment that teaches, uses, and values

leadership. And it goes without saying that women veterans are experienced team-players in a workforce where diversity is the norm.

In short, employers can be confident that a woman making the transition from the armed forces to civilian employment has already proven she has what it takes to be a productive and dependable worker. Women vets will bring vital skills to your operation, bring talent and diversity to your workforce, and give your company the chance to benefit very directly from the investment you have made in the armed forces of the United States.

This handbook is intended both to encourage you to employ women veterans and to give you practical tips on how to go about it. We offer profiles of a number of women veterans who exemplify what we mean when we say "Hire a Vet * She's a Good Investment." We tell you about some companies that have already discovered the truth of that maxim. We let you know how to gain access to U.S. government programs designed to help you connect with veterans who have the particular skills and/or experience you are looking for, as well as to programs that can assist in retraining veterans with the government footing the bill.

We at WREI believe that there is a natural fit between the skills and talents of women veterans and the needs of employers determined to meet the competitive challenges of the 21st century.

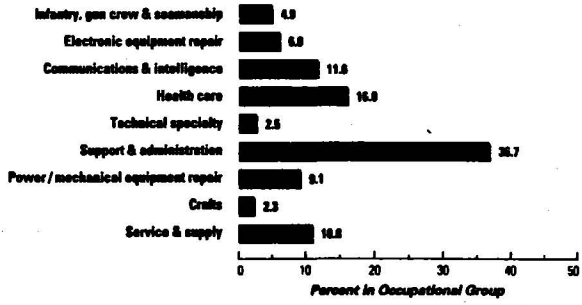
Betty Dooley

Betty Dooley
Executive Director
Women's Research and Education Institute (WREI)

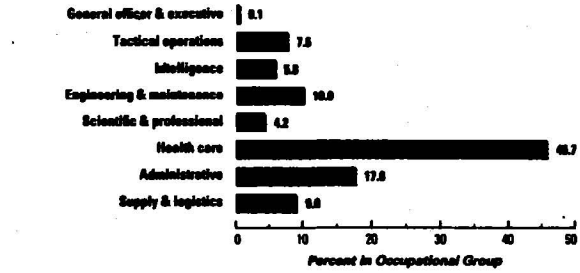
SKILLS AND EXPERIENCE

No precise data are available about the occupations of the women (and men) who are currently leaving or will soon leave the active duty armed services. However, the occupational profile of recently- or soon-to-be-separated women veterans should roughly parallel the occupational profile of active duty women, as shown below.

Enlisted Women



Women Officers



FY 1982 data provided to WRRI by Defense Manpower Data Center

ACTIVE DUTY ROLES

Media attention to the 1990-91 engagement of U.S. forces in the Middle East—Operations Desert Shield/Desert Storm—highlighted as never before the great variety of jobs that women are assigned in our contemporary armed forces. Stereotypes were shattered in countless American homes as the media gave daily coverage to the roles of women who went in harm's way as members of the Army, Navy, Marine Corps, Air Force, and Coast Guard.

As women leave the active duty services to enter the civilian workforce, it is useful to remember the jobs done by military women sent to the Persian Gulf. Here are some of them:

ADMINISTRATIVE SUPPORT • AIRCRAFT MECHANIC • AMBULANCE DRIVER • AVIATION ORDNANCE TECHNICIAN • BOILER TECHNICIAN • CHIEF ENGINEER • COMBAT SIGNALER • COMMUNICATIONS • COOK • DAMAGE CONTROL ASSISTANT • DENTIST • DIETICIAN • DINING FACILITY MANAGER • ELECTRICIAN • FLIGHT OPERATIONS CLERK • FOOD SERVICES OFFICER • FUEL HANDLER • F-111F CREW CHIEF • HEAD OF SHIP'S FOUNDRY • HELICOPTER PILOT • INFORMATION MANAGEMENT INTELLIGENCE ANALYST • LEGAL SUPPORT • M60 GUNNER • MACHINIST MATE • MILITARY POLICE • NURSE • PHOTOGRAPHER • PHYSICIAN • PSYCHIATRIST • STOCK CONTROL • SUPPLY • TANK REPAIR • TRUCK DRIVER • TRUCK MECHANIC • WEAPONS ASSEMBLER AND LOADER • WELDER

U.S. Air Force

A radio and television repairer works on a portable recorder used to gather information for stories and interviews.

Women also built bunkers, dug trenches, filled sandbags, set up and broke down tents, guarded encampments, and pulled KP—as GIs have done from time immemorial.

Source: U.S. General Accounting Office (GAO). GAO/NSLAD-93-93 Women in the Military. GAO, Washington, DC: 1993.)

U.S. Air Force

A sergeant driving a forklift in the 52nd Supply Squadron's area.

U.S. Army

A petty officer on the USS Cape Cod uses a horizontal milling machine to finish a piece of metal for the ship's boiler room.

U.S. Army

A lance corporal refuels an F/A - 18C preparing the aircraft for its next mission.

U.S. Air Force

PROFILES

Veterans and Some Companies That Employ Them

Peggy Estes

Army veteran, works in Opelika, Alabama for UNIROYAL GOODRICH TIRE COMPANY (MICHELIN)

Peggy Estes entered the Army with a BS in mechanical engineering. As an engineering officer, she saw duty as a platoon leader, a terrain intelligence officer, and civil engineer, and she saw history up close as a company commander in Germany when the Berlin Wall went down. And she still managed to fit in courses towards her master's degree. Now Peggy Estes works as a mechanical engineer for Uniroyal; her transition was supported by her family, the Army, and Michelin—just the way the system is supposed to work.

American Protective Services (APS)

Oakland, California

The fourth largest security firm in the nation, APS has been supplying security professionals to clients in industries such as transportation, finance, utilities, high tech, defense, and health care for almost 50 years. Headquartered in Oakland, California, the company has 52 offices and 12,000 employees across the country. APS, which believes that its employees are its most important resource, and which seeks a diverse and dependable workforce, has hired over 100 women veterans in positions ranging from branch managers to security officers.

Christine Harper

Marine Corps veteran, works in Greenville, South Carolina for FLUOR DANIEL

While she was an enlisted Marine on active duty, Christine Harper finished her associate degree. In line with her history as a self-starter, she continued her schooling at night while working for Fluor Daniel as a secretary. She is now the proud owner of a bachelor's degree in human resources, and her employer is putting her military and civilian education and skills to work.

We are very pleased with the thousands of men and women veterans who have chosen a career with Schneider National. Their self-discipline, hustle, and creative thinking keeps our customers excited and us a leader in the truckload industry.

FRITZ HARRIS, VICE PRESIDENT,
CAPACITY DEVELOPMENT AND TRAINING,
SCHNEIDER NATIONAL, INC.

By not taking advantage of this mature and well-trained workforce, industry would be derelict in its civic responsibility and also miss a golden opportunity to strengthen their workforce.

NOEL G. WATSON, PRESIDENT AND CEO,
JACOBS ENGINEERING GROUP INC.

Consolidated Edison Company of New York
New York, New York

Con Edison is an investor-owned utility that provides electric, gas, and steam service to New York City and Westchester County—a combined population of more than eight million. Con Edison has hired former officers and enlisted personnel for many years, for positions throughout the company. Recently it has focused on hiring junior military officers into the operating areas of the company. The latest women veterans recruited by Con Edison are working as technical supervisors in its power plants, its electric operations area, and its power generation maintenance organization. Con Edison has found these employees to be highly motivated and self-confident, with a "can do approach to getting the job done."

Elaine Hauck
Air Force veteran, works in Las Vegas, NV for AMSERV HEALTHCARE

What better place than the private sector healthcare industry for a former Air Force nurse? This South Dakota native took advantage of high-powered educational opportunities in the Air Force, getting a degree in Health Services Administration and an MBA. After 21 years on active duty, she is putting her nursing and management skills and educational achievements to work as a branch director in a national nursing service that provides supplemental nurse staffing in hospitals, nursing homes, and patients' homes.

Lori Ann Lindholm
Navy veteran, works in Arlington, Virginia for GPS TECHNOLOGIES

Lori Lindholm joined the Navy to see the world, and saw it from the flight decks of Navy ships—as a helicopter pilot and as the Navy's first woman aviator to be a flight deck officer. Continuing her education while wearing Navy blue, she got her master's degree in systems management, and achieved the rank of lieutenant commander. In a natural leap to civilian life, she is now a senior engineer in a defense industry, working on a joint services development program for aircraft simulation training devices.

Michele Moore

Air Force veteran, works in St. Louis, Missouri for McDONNELL DOUGLAS AEROSPACE-EAST

From Medical Service Corps to pilot to instructor pilot to base executive officer to developing, implementing and evaluating flight programs—Michele Moore's experience when she left the service for a pre-eminent aerospace company speaks for itself. At McDonnell Douglas, she went from aircrew training to program development representative, working with Air Force and Navy customers to develop flight training systems. She became an operations analyst, and now is facilitating TQM (Total Quality Management). Versatile, experienced, a team player, growing on the job—Michele Moore is an employee any company would be proud to hire.

Nancy Ortega

Air Force veteran, works in Round Lake, Illinois for BAXTER HEALTH-CARE CORPORATION

Nancy Ortega had a degree from the City College of New York when she put on the uniform. During her eleven years in the Air Force, her jobs included flight commander, officer-in-charge of an aircraft maintenance unit, and program manager for special programs. She earned a master of science in aeronautics too. All provided leadership and management education and skills to put to work on the "outside," and Nancy Ortega uses them all in her present job, where she is responsible for directing and managing all human resources for a Baxter manufacturing facility.

Deborah Parker

Army veteran, works in Alexandria, Virginia as a CONSULTANT IN HUMAN RESOURCES

As an Army personnel officer, Deborah Parker supervised hundreds of soldiers, ran administrative and logistical programs, and developed human resource policies and procedures. Major Parker transferred from the active forces to the Reserves, and used her human resources skills and background at companies such as Philip Morris and Mobil Oil. Now she is an independent consultant, working with government agencies, non-profit organizations, and private industry. She says of her military background and its relationship to her civilian careers, "The leadership and organizational skills I learned, along with the quality of self-discipline, have functioned as a base for working in many professional and personal environments."

Terri Russell

Army veteran, works in Amarillo, Texas for MASON & HANGER-SILAS MASON CO.

With a bachelor's degree in physical education in hand, Terri Russell received her commission in the Military Police Corps. During 14 years on active duty, she served in a variety of roles—plans, operations and training; instructor; parachutist; NBC (nuclear, biological and chemical) officer. Now she uses her Army experience in her job as a training supervisor in the security department of Mason & Hanger - Silas Mason Company—another skills match to civilian employer requirements.

Loretta Sherod

Air Force veteran, works in Louisville, Kentucky for UNITED PARCEL SERVICE (UPS)

Loretta Sherod joined the Air Force fresh out of high school, and spent 14 years as an electronic warfare systems specialist. She was not only an instructor in that field, she also developed an electronic warfare course. She transferred what might be considered "warfare skills" to the civilian sector at UPS, where—no surprise—she works in aviation education. Now she is a curriculum development technician for the UPS aircraft maintenance skills enhancement program. Loretta Sherod is an excellent example of a vet whose training and skills fit civilian sector needs.

Schneider National, Inc.

Green Bay, Wisconsin

Founded in 1938, Schneider National is the largest truckload carrier organization in North America, providing van, flatbed, heavy haul, and tank trailer transportation services. Schneider serves customers throughout the United States, Canada, and Mexico. The firm also provides direct-dial and dedicated telecommunications services to businesses throughout the Midwest. Schneider's employees must keep pace with the demands of its industry and share its values and commitment to continuous improvement. Schneider National says, "Women veterans know how to meet challenges in this environment." Women veterans have started new careers with Schneider as drivers and managers in the transportation and communications fields.

LINKING EMPLOYERS AND VETERANS

The Department of Labor, Department of Defense, and Department of Veterans Affairs all provide services to assist veterans in their transition from the military to the civilian workforce.

The following government programs are computerized systems to link separating military personnel with employers:

America's Job Bank (AJB) (formerly Interstate Job Bank/IJB)

What: An automated system that keeps track of the job orders that employers place with various state job service offices as well as federal job openings. Enables state job service clients to consider jobs that are open in other states in addition to local employment.

Sponsored By: U.S. Department of Labor

Where: Local job service offices *

Who Uses It: Job seekers. Private sector and government employers.

More Info: Contact local job service office

Defense Outplacement Referral System (DORS) and an electronic **Transition Bulletin Board (TBB)**

What: DORS is an automated registry of military, civilian, and spouse applicant mini-resumes for use by potential employers; employers request these resumes by phone. Employers may also place job ads on the TBB, available to 350 military installations worldwide; ads can be mailed, electronically entered, or faxed to the TBB office.

Sponsored By: Department of Defense

Where: Accessible through any touch tone phone

Who Uses It: Military service members and Department of Defense civilian personnel and their spouses. Private sector and government employers.

More Info: Call (800) 727-3677

* Job service or employment service offices offer employers assistance in locating qualified jobseekers. In most states, employment services are part of the Department of Labor, the Department of Human Services, or are a separate Employment Security agency. Check the telephone directory under "State Government" for the appropriate agency listing.

Additional transition assistance programs for service members:

The Service Members Occupational Conversion and Training Act (SMOCTA), passed by Congress in 1992, allocates $75 million for veterans' job training, to assist the large number of military personnel who are separating due to the current downsizing of our armed forces. SMOCTA assists veterans and employers in setting up a 6–18 month training program after veterans are hired, and will reimburse eligible employers up to 50% of certain veteran's training costs. Employers can obtain applications from a local job service office.

The **Transition Assistance Program (TAP)**, sponsored jointly by the Departments of Labor, Defense, and Veterans Affairs, gives job-search assistance to armed forces members who are within 180 days of separation or retirement, through 3-day workshops at military installations.

The **Disabled Veterans' Outreach Program (DVOP)** and the **Local Veterans' Employment Representatives (LVER)** are sponsored by the Department of Labor Veterans' Employment and Training Service, and operate on a state level to offer employment and training services to veterans. Most DVOP specialists and all LVER are located in local job service offices.

The Department of Veterans Affairs has made it easier to promote the link between veterans, employers, and state employment officers, by housing state employment service representatives in a number of **VA Regional Offices**.

Veterans may receive training and other help to find suitable employment under the Federal **Job Training Partnership Act (JTPA)**. This program operates through JTPA service centers in each state.

For more information about these programs, call (800) 4422-VET.

About Women Vets—Did You Know—

★ 4% of living veterans are women?

★ the number of women veterans is expected to increase by 17% from 1990 to 2010, while the number of male veterans will go down by 28%?

★ about 60% of women veterans have attended college compared to less than 50% of men?

★ 613,000 women veterans were in the labor force at the 1990 census?

Facts on Working Women

U.S. Department of Labor
Women's Bureau

No. 92-3
September 1992

BENEFITS TO EMPLOYERS WHO HIRE WOMEN VETERANS

Background

Nearly 57 million civilian women participate in the nation's labor force. Their impact has increased significantly in the past two decades: Today's women own businesses, supervise employees, and work as craftspeople in nontraditional jobs. Their skills, abilities, and educational levels rank them among the most highly qualified in the world.

Another group of women--those who have served their country in the military--form another significant part o today's work force. Currently, women in the military number 211,000, or 11.2 percent of active-duty militar personnel. An additional 150,000, or 13.2 percent, participate in the Selected Reserve forces. In total, there are more than 1.2 million women veterans in the United States and Puerto Rico.

With military downsizings through the mid-1990s, increasing numbers of these women will be available for civilian jobs. The talents and skills they have acquired in the military make them uniquely qualified for today's highly competitive workplaces.

Women Veterans: A New Applicant Pool

Women veterans provide employers with a new and added source of employees. They are well educated, highly trained, and motivated individuals available to meet the needs of both the high-tech and service-oriente industries of today and tomorrow.

Consider these characteristics:

- Women enter the military for the same reasons as men: to serve and protect their country, to continue their education, and enjoy the give-and-take of satisfying work.

- Over 95 percent of all women who serve in the armed forces have a high-school education. Many have attended or graduated from college.

- Women veterans comprise an applicant pool with a demonstrated ability to work independently and to be part of a team. Many are trained in--and have mastered--management techniques and leadership skills.

- With few exceptions, the skills and experiences acquired by military personnel mirror those needed in the civilian economy.

Skills and Experience Women Veterans Bring to the Workplace

Hiring women veterans can add to workplace competencies and may offer some added advantages. While women veterans' skills run the gamut--from pilots to administrative assistants to mechanics--the following statistics demonstrate their range of expertise:

- About 18 percent of women officers serve as administrators.

- A solid 43 percent of officers have experience as health-care specialists.

Enlisted women possess an equally impressive range of skills:

- 35 percent have functional and administrative support skills.

- 14 percent are medical and dental specialties.

- 11 percent have experience in communications and intelligence gathering.

- 10 percent have worked in service and supply areas.

- 9 percent are trained in electrical/mechanical equipment repair.

During the last 20 years, the skills of women veterans have expanded into nontraditional fields. In 1973 just over 2 percent of active-duty military women served as craft workers, mechanics, and repair specialists. Today that figure has expanded to 17 percent, representing a talented group of women who, as part of the military, have been regularly tested and evaluated on their skills. Many have benefitted from ongoing training as well as cross training in complementary areas such as personnel, equal employment opportunity, and recreational services.

Additionally, women who have served in the military have acquired many of the workplace basics that employers value, including self-discipline, adaptability, and a sense of responsibility. Those who are highly trained bring leadership skills to the workplace. In addition, most women who have served in the armed forces are comfortable with goal setting and problem solving. Those who opt to join the Selected Reserves continue to receive training in personal development and leadership skills. These skills and work qualities readily translate to the employment setting.

Resources for Employers

For employers considering women veterans for job openings, the following agencies and organizations may offer help:

The Defense Outplacement Referral System (DORS), operated by the Department of Defense, is a mini-resume registry and referral system that provides employers with easy access to military personnel and thei spouses who are seeking civilian employment. Under the system, military jobseekers can enter their qualifications, education, type of work they are seeking, and geographic preferences in a computer databas For a nominal fee, employers can tap into this pool of jobseekers by touch-tone telephone and receive up t mini-resumes by fax or up to 100 by mail. Employers can register with DORS by calling: 1-800-727-3677

DORS subscribers are also eligible to advertise job openings on the system's electronic Transition Bulletin Board (TBB). With compatible computer equipment, they can place their ads electronically via a toll-free number. Those without compatible equipment can fax or mail their ads for the TBB. For additional information about TBB access, contact the DORS number above.

The National Women Veterans' Conference (NWVC) operates a national resource center for women in the military and veterans. For information, call: (303) 433-2119.

The Veterans' Employment and Training Service (VETS), U.S. Department of Labor, has offices in each state. Please check the "Federal Government" listing of the telephone directory for the nearest location.

The national office of VETS can provide additional information and referral assistance to employers. For more information, call: 1-800-4422-VET.

Job service or employment service offices offer employers assistance in locating qualified jobseekers. In m States, employment services are part of the Department of Labor, the Department of Human Services, or a separate Employment Security agency. Check the telephone directory under "State Government" for the appropriate agency listing.

The American Legion, AMVETS, Veterans of Foreign Wars, and Vietnam Veterans of America are among the national veterans service organizations that may be able to help in locating women veterans ready for work. Check the telephone directory for addresses and telephone numbers of local posts.

The Retired Officers Association (TROA) and the Noncommissioned Officers Association (NCOA) also provide employers with help in finding work-ready veterans. TROA's current database lists over 3000 individuals whose qualifications can be matched to available jobs. The NCOA also maintains a database accessible to employers, and sponsors job fairs throughout the United States and abroad. Check the telepho directory for addresses and telephone numbers of local posts of both these organizations.

Disabled American Veterans, Blinded Veterans Association, and Paralyzed Veterans of America are among the service organizations offering help to veterans with disabilities. They are also listed in telephone directories.

The Job Accommodation Network (JAN) is a national information clearinghouse to aid employers in adapting the workplace for persons with disabilities, including veterans with disabilities. Toll-free numbers: 1-800-526-7234; in West Virginia: 1-800-526-4698.

Additional Information for Employers

Employers should be aware of certain laws pertaining to the employment of veterans. Among them:

- Under the Federal Veterans' Reemployment Rights Statute, employers are obligated to retain or reinstate certain eligible employees who are veterans or members of the reserve forces. For information, call the Department of Labor's Veterans Employment and Training Service (VETS): 1-800-4422-VET.

- Under the Federal Employment Training of Veterans Statute, companies receiving Federal contracts of $10,000 or more must actively recruit persons with disabilities and certain veteran populations (qualified special disabled veterans and veterans of the Vietnam-era). Again, call the Labor Department's VETS number for more information.

- Workers are protected from discrimination in employment on the basis of sex, race, color, religion, or national origin under the Civil Rights Act of 1964, Title VII. In addition, two other pieces of legislation--the Americans with Disabilities Act and the Age Discrimination in Employment Act--prohibit discrimination. The Equal Employment Opportunity Commission (EEOC) has primary responsibility for enforcement of these laws. Contact the EEOC at 1-800-669-EEOC for additional information or a poster.

The Women's Bureau has developed this fact sheet as part of an ongoing series to help increase employment opportunities for women. For a list of fact sheets or other Bureau publications, please contact:

Women's Bureau
U.S. Department of Labor
Room S-3311
200 Constitution Avenue, N.W.
Washington, D.C. 20210

ATTACHMENT TO QUESTIONS #2
(HONORABLE JACK QUINN) AND #7
(HONORABLE LANE EVANS)

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

IL 10-93-027

In Reply Refer To: 10A3/116

September 27, 1993

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Women Veterans Health Care Guidelines

1. Providing high quality, compassionate health care services to women veterans is one of the Department of Veterans Affairs (VA) priorities. In the General Accounting Office (GAO) report on VA Health Care for Women published in January 1992, in the subsequent Congressional hearing on health care to women veterans in June 1993, it was recognized VA has made substantial progress in providing quality health care to women veterans; however, it was also identified that significant work still remains to ensure that all VA health care facilities can provide women veterans appropriate services.

2. To develop a strategy to address the need for improved services to women veterans, the Under Secretary for Health appointed a committee to develop comprehensive guidelines for women veterans health care services. The guidelines produced by the committee address -- *Medical Care, Environment, Culture and Outreach.* The guidelines were shared with the Secretary of Veterans Affairs and he has approved distributing them to all VA facilities.

3. You are to distribute copies of these guidelines to the Associate Chief of Staff for Ambulatory Care, Chiefs of satellite outpatient clinics, and others involved in providing care to women veterans. In keeping with the spirit of Continuous Quality Improvement, I ask that you share my commitment to further improving the care provided by VA to women veterans by prompt implementation of these guidelines.

John T. Farrar

John T. Farrar, M.D.
Acting Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 9/28/93
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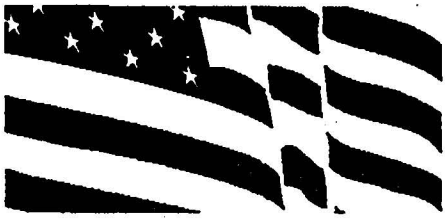
IL 10-93-027
September 27, 1993

ATTACHMENT A

Department of
Veterans Affairs

Women Veterans



Health Programs

Women Veterans Health Care Guidelines

Veterans Health Administration

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Introduction

The first manual chapter devoted to female veterans (M-2, Part I, Chapter 29) was published in 1986 and begins "Planning for and providing comprehensive health services to women veterans is a priority goal of the Department of Veterans Affairs, Veterans Health Administration, which is committed to providing equitable care to all veterans, female and male." Since that time, the role of women and the number of women serving in the military, as well as the visibility of women in the military, have all increased dramatically and more and more women are seeking care in VA facilities. Many VA medical centers have developed good comprehensive programs for the women under their care. However, there is a need to strengthen the programs and to provide better guidance to ensure consistency throughout the system. In addition to excellence in clinical care, education and research are essential if the Veterans Health Administration is truly to provide equity of access, service and benefits to the growing number of women veterans. This document provides guidance to VHA facilities on providing health care services to the women veterans who are currently seeking care within those facilities and to the increasing number expected to do so in the future. This guidance will provide the framework for a new manual chapter which will address the four basic areas of medical care, the environment, the culture and outreach.

MEDICAL CARE FOR WOMEN VETERANS

I. Medical Care for Women Veterans

A. Primary Care

1. All VA medical centers and outpatient clinics will provide basic primary care for women.

2. Primary care consists of:

   a. Intake and Initial Assessment

   b. Preventive Health Care Services

      (1) Breast screening, including mammograms

      (2) Pap smears

      (3) Other services as indicated

   c. Acute and chronic biopsychosocial care

      (1) This may include some gender-specific care such as treatment of vulvovaginitis, management of menopause, and counseling.

      (2) Treatment may be provided by a variety of clinicians, including physicians, psychologists, and Nurse Practitioners and Physician Assistants using approved protocols.

   d. Referral Coordination

      (1) Gynecology

      (2) Specialty Clinic Referrals, including counseling for sexual trauma, if indicated

      (3) Community Referrals

e. Accessing other appropriate levels of care

(1) Inpatient

(2) Extended Care, including Nursing Home and Domiciliary

(3) Other

3. There is a need to address barriers to access in the provision of primary care. Many of these barriers are created by the perceptions of women who may feel particularly vulnerable when they have to seek care from VA. As a result, they may perceive that they are not welcome, that they are too much a minority ever to receive fair or equitable treatment in the VA system, or that they will be unsafe or otherwise overwhelmed by the male orientation of the system. In order to overcome these, often erroneous, perceptions, two steps can be taken organizationally at the local level.

a. **Women Veterans Clinics** - Women's Clinics function as an excellent entre' into the system. They can provide primary care to women in an acceptable environment through the use of general medical physicians and other health care providers, such as Nurse Practitioners and Physician Assistants. They may be expanded to provide more specialized care by including a gynecologist and other specialists on the staff as the workload justifies. The Clinic will also house the data base that facilities need to comply with oversight requirements imposed by Congress. However, because the Women Veterans Clinic in most locations cannot meet every day and may have a waiting list, all VAMCs should also have Women Veterans Primary Health Care Teams.

b. **Women Veterans Primary Health Care Teams** - These teams allow the medical center to identify staff who are sensitive to and interested in the health concerns of women. Team members will be knowledgeable about the medical needs, gender-specific concerns, community resources, etc., relevant to the biopsychosocial care of women veterans.

Specific training can be targeted to the teams and at least some team members should be available on a daily basis during regular working hours. The Women Veterans Health Care Team will consist of a core group made up of a physician, nurse and/or nurse practitioner, social worker, and the Women Veterans Coordinator (WVC) who may be either a nurse or a social worker on the core team. The WVC will serve as the Chairman of the team. While the team members may see males as well as females in the course of their regular duties, they will function as a team for women veterans. They will be expected to meet regularly to manage the care of the female patients under their purview and to identify and address areas of special concern for female patients in the facility.

B. Gender-Specific Care

1. All VA medical centers and outpatient clinics will provide gender-specific and gynecologic services to eligible women veterans. The goal is that these services will be provided in-house to the extent possible. The service most in demand will be gynecology, but other gender-related services will include counseling and other treatment for sexual trauma, psychiatric services such as drug and alcoholic treatment and group therapy, etc., which may have gender variations, endocrinology, and oncology (breast and reproductive cancers.)

2. Gynecology - all VA medical centers will provide gynecology services by at least one mechanism in addition to fee-basis so that outpatient gynecology will be available to female patients needing it on a par with outpatient services available to male patients.

   a. While Primary Care Teams will be expected to provide those basic "office gynecology" services that are a legitimate part of primary care, such as routine Pap smears and treatment of uncomplicated vulvovaginitis, a gynecologist will need to be available to both inpatients and outpatients for:

      (1) Referrals for complicated conditions

(2) Referrals for abnormal Pap smears; and

(3) Evaluation of contraceptive needs such as fitting of diaphragms, and the initial prescription of oral or implantable contraceptives.

3. Reproductive and Breast Oncology - network referrals, fee basis, sharing agreements.

4. Endocrinology - network referrals, fee basis, sharing agreements.

5. Sexual Trauma Counseling - should be available at all VAMCs with Psychology Services

   a. referral networks for more complex cases

   b. fee-basis for geographic inaccessibility

   c. Vet Centers

C. Medical Equipment, Supplies, and Pharmaceuticals

1. It will be the responsibility of the Women Veterans Primary Care Team, working with the gynecology staff, to identify necessary equipment and supplies.

2. The Women Veterans Coordinator or other member of the Primary Care Team will coordinate input from the Primary Care Team and the gynecology staff and will work closely with the Pharmacy and Therapeutics Committee to assure that appropriate pharmaceuticals are available.

D. Education and Training

1. **Staff In-Service Training** - All medical center employees should receive orientation on the Women Veterans Program. Assessment of the specific educational needs of various services should be on going with programs designed to prepare staff and volunteers to deal with the health care needs of female patients and to be aware of VA and community referral sources.

2. **Patient Education** - The Women Veterans Clinic staff and the Women Veterans Coordinator should work with the medical center patient education committee to assure that the patient education needs of female patients are being met. Equitable allocation of resources should support the purchase of patient education materials, such as audiovisuals, pamphlets, and teaching models.

E. **Quality Assurance Monitoring** - Quality indicators should be developed to monitor aspects of women veterans health care.

F. **Women Veterans Coordinators** - This program has been in existence since 1985. Each facility is charged with appointing a Women Veterans Coordinator with responsibility for assessing the needs of women veterans at that facility, and then assisting in planning, organizing and coordinating facility services and programs to meet those needs. In addition the Coordinator makes recommendations to the Director to assure compliance with new policies and regulations. In the past, qualifications for the position stressed knowledge about women's health care, empathy, communication skills, and interpersonal relations. In almost all facilities this constituted a collateral duty. As a result of various audits and oversight activities, it is apparent that this program needs to be expanded. As a result there will be many changes in the coming months. The following discusses a few of those changes, which will be expanded in directives and manual chapters:

1. Each Region has or will have a full-time Regional Women Veterans Coordinator.

2. Women Veterans Coordinators were funded at 22 VHA facilities in FY 1993. This will be a pilot program which will be used to shape the program in the future.

3. In all other VHA facilities, there will be a designated Women Veterans Coordinator who will be either a nurse or a social worker and who will be involved in providing medical care services to women as a part of his/her regular responsibilities. The WCV's job description will be amended to allow a minimum of 5 hours per week for coordination activities.

4. The Women Veterans Coordinator will be a member of the Women Veterans Primary Health Care Team, and will function as the chairman of the team in calling meetings and providing follow-up.

It is recognized that many dedicated individuals have served as Women Veterans Coordinators who will not meet the new criteria or who will not be able to serve on the Women Veterans Health Care Team. It is hoped that the interests and skills of these individuals can continue to be utilized on ad hoc or standing women veterans committees. While not mandated, many facilities have found committees a useful way to cover the many issues involved in women veterans health care and to elicit input from volunteers and women veterans within the community.

SELF-ASSESMENT CHECKLIST FOR WOMEN VETERANS TREATMENT PROGRAM
(These represent basic elements in a VAMC's Women Veterans Program. All VAMCs should be able to describe their program providing the following specific information)

I. Database - last fiscal year and YTD

A. Female veteran inpatients _____

Medicine _____
Surgery _____
Psychiatry _____

B. Female veteran outpatients _____

C. Congressionally mandated statistics
(number of procedures performed)

Pap smears _____
Mammography _____
General Reproductive Health Care (Gynecology) _____

II. Women Veterans Health Team

Physician(s)_____
_____
_____
Nurse(s)_____
_____
Nurse Practitioner_____
Physician Assistant_____
Social Worker_____
Women Veterans Coordinator (may be one of the above)
_____

III. Women Veterans Health Clinic

A. Schedule

Meets weekly Days per week _____
Meets monthly Days per month_____

B. Workload

Average number of women seen per session_____
Number of Women seen in previous fiscal year _____

C. Staff:

Physician _____
Nurse(s) _____
_____
Nurse Practitioner_____
Physician Assistant_____
Social Worker_____
Women Veterans Coordinator(may be one of the above)
_____
Other providers, such as dietitian, psychologist, etc.
_____
_____
_____

D. Space:

Waiting Room

Separate Waiting Area
Common Waiting Area

Offices/Examining Rooms

Privacy Curtains
Table facing away from the door

Proximity to Women's Restroom

IV. Gynecology

In-house

Staff Gynecologist _____
Full-time_____ Part-time _____
House staff _____
Contract Gynecologist _____

Referral

Another VAMC _____
DOD facility _____
Contract_____
Fee-basis_____

V. Mammography

A. In-house (i.e., Mammography equipment on site)
Yes_____ No_____

B. If not in-house, how is mammography provided?

Referral to another VA medical center _____
Sharing Agreement with _____
Contract with _____
Fee basis_____
Other_____

VI. Other Gender-specific Services

Medicine
Surgery
Mental Health and Behavioral Sciences
Pharmacy
Other

VII. Women Veterans Coordinator

Name _____
Professional designation _____
Full-time _____ Part-time _____
If part-time:
Hours assigned to WVC function _____
Other duties _____
Time spent providing services to women_____

VIII. Privacy Considerations - Plans should be in progress to identify and correct existing privacy deficiencies. The WVC should be involved with the process and review all plans for the correction of privacy deficiencies

Bedrooms, toilet and bathing facilities for inpatients

Outpatient areas
- waiting rooms
- examining rooms
- rest rooms

IX. Education and Training Programs (in past two years)

Staff Education
Patient Education

Guidelines for Physical Examinations

Allegations of sexual misconduct by physicians and other health care providers are among the most sensitive and difficult areas to investigate and resolve. The episodes leading to such allegations are rarely witnessed and often lead to great public distress for both the physician and the patient. As in many areas of health care, prevention is usually the best remedy. The following guidelines for VA physicians and other health care providers are similar to those promulgated by a number of state medical boards to prevent misunderstandings and to protect both physician and patients.

1. Patient dignity must be maintained during the course of a physical examination with adequate privacy at all times. The examination room should be safe, clean and well maintained and should provide both auditory and visual privacy. The actual examination area should be shielded by privacy curtains and the placement of the examining table should also minimize any inadvertent exposure of the patient during a physical examination. Gowns, sheets and/or other appropriate apparel should be available to protect the patient's dignity and decrease embarrassment. The patient should never be asked to disrobe in the health care provider's immediate presence.

2. A third party should be readily available at all times during a physical examination. A third party should actually be present when the health care provider performs an examination of the sexual or reproductive organs or rectum. The health care provider must inform the patient of the option to have a third party present regardless of the provider/patient gender.

3. The health care provider should explain the necessity of a complete physical examination or the components being performed during that examination, as well as the necessity for various diagnostic studies, and the purpose of disrobing, in order to minimize the patient's anxiety and possible misunderstanding.

4. Following a physical examination the health care provider should also discuss any positive findings with the patient and give the patient a chance to ask questions. During this discussion, the patient should be fully dressed. This will increase both patient and provider satisfaction with the physical examination process.

THE ENVIRONMENT

II. The Environment

The environment may directly and indirectly affect the quality of care provided by a health care facility to women veterans and has a significant impact on a patient's comfort and feeling of security. For women veterans it can affect whether or not they feel welcome and will invariably affect their perception of the care she receives. Ongoing review of the environment should occur in all VA medical facilities to ensure that it does promote comfort, feelings of security, and a sense of welcome. The following recommendations include areas to be reviewed and suggestions which may be helpful in enhancing the environment:

A. Admissions/Transfers/Discharges

1. <u>The Process</u>

   a. Review implications/impact on women veteran patients and residents.

   b. Provide patient information outlining women veterans services.

   c. Survey public and private sector health care facilities for patient treatment philosophy and admissions process/ procedures affecting women.

   d. Visit local public and private sector facilities to observe "principles-in-practice."

2. <u>Admissions Kit</u>

   a. Determine use of kits.

   b. Review contents for appropriate women veteran items.

   c. Review gender-specificity of kits.

B. Accommodations

1. Space - Review adequacy of space for inpatient and outpatient needs related to women veterans now and in the future.

2. Privacy

   a. Explore privacy issues that constitute barriers to care in the facility.

   b. Explore simple, cost effective building modifications to improve privacy.

3. Examination Rooms/Restrooms/Bathing Facilities - Review for adequacy and develop plans to correct deficiencies..

4. Interior Design - Examine perceptions of male-only environment, reviewing furniture/furnishings/fixtures, color, lighting, texture, art work, etc.

C. Patient Apparel - This issue is being reviewed in the VACO Environmental Management Service (EMS) and areas of concern should be raised to EMS Women's Issues Action Council. However, all VA medical centers should have appropriate pajamas and robes for female patients and a full range of women's sizes available.

D. Patient Assistance

1. Review policies and procedures relating to clothing, incidentals and services for patients and residents.

2. Explore enhanced use of volunteers in assisting women veteran patients and residents, especially by recruiting youth volunteers from organizations such as the Girls Scouts, Camp Fire, etc.

3. Review role of programs such as EMS Health Aids in providing additional and non-traditional bed services for women veteran patients and residents.

E. Personal Hygiene Products

1. Assure availability of dispensing/disposal units in public restroom facilities for personal hygiene products.

2. Examine methods/procedures for providing personal hygiene products, including availability through Supply, Processing and Distribution (SPD).

F. Canteen Services

1. Retail Sales

a. Examine products and services being provided to women veteran patients and residents.

b. Review product lines for variety.

c. Examine short- and long-range marketing strategies for impact on women veteran patients and residents.

2. Hair Care Services - Develop services for hair care provided to women veteran patients and residents.

3. Vending Services

a. Review services currently offered, including location, safety, hours of operation, and variety of product line.

b. Examine potential for enhanced services, including non-refreshment services.

G. Recreation/Exercise/Social Activities

1. Review all recreational and social programs specifically for women veterans.

2. Evaluate potential for "women's lounge".

3. Explore alternative programming for recreation which will provide women veteran patient and residents participation in community outreach and service activities

   a Internal - jewelry making, cosmetics lessons, magazines, movies

   b. External - socials, shopping, fashion shows, etc.

THE CULTURE IN VA FACILITIES

III. VA Culture - Attitudes and Sensitivity toward Women Veterans

In addition to addressing the physical environment found by women veterans as they enter the system, there is also a need to address the culture which they will find. This must encompass both attitudes and sensitivity toward women veterans.

The Department of Veterans Affairs is pledged to providing appropriate care and services to eligible veterans, male and female, in a sensitive, compassionate and understanding manner. It is the intention of the Veterans Health Administration that all clinical and administration personnel will strive to develop an environment conducive to making veteran patients comfortable in a way that allows for open communication between staff and patients, enhancing both the quality and appropriateness of the care and services provided and the patient's satisfaction with those services. All veterans have rights not only as individuals but by virtue of their service to our country and will be treated with the respect and courtesy which they readily deserve. The Secretary of Veterans Affairs' emphasis on courtesy and compassion has set the tone for all health care providers to follow and this is especially important in VHA's approach to women veterans.

Since, in the minds of some individuals, VA has been associated primarily with the care of men, there is the need to emphasize that "She also served" and that "Women are Veterans, Too" with clinical and administrative staff as well as patients and potential clients. Eligible women veterans shall receive appropriate quality care for both general medical problems and gender-specific diseases. This requires an environment where staff work with compassion and sensitivity. This can be accomplished through modeling of appropriate positive behavior toward women veterans, the provision of information about programs and services available, and through education.

The National Training Program on Women Veterans Health will address sensitivity, attitudes, and behaviors both directly and indirectly in both the strategic plan and all educational activities.

All VA employee orientation should include information about women veterans to reinforce "She also served" and "Women are Veterans, too." Those with direct patient contact should receive specific information on VA policy, procedures, and guidelines for providing services to women veterans.

All orientation of new clinical staff, residents, interns, and medical students should include information on VA policy, procedures, and guidelines for providing care to women veterans with reinforcement of "She also served."

Ceremonies recognizing national holidays should include recognition of women veterans in the program.

Brochures on women veterans and other issues important to women should be available in all VA facilities.

Key individuals at all managerial levels should demonstrate their commitment to VA policy toward women veterans at every opportunity.

OUTREACH

IV. Outreach

Although women constitute approximately 4% of the veteran population, they accounted for only 2.5% of all veterans discharged from VA medical centers in FY 1992 and it is estimated that less than 10% of women veterans use any VA health care facilities. This is particularly troubling in view of the findings of the 1985 Survey of Women Veterans which showed that 21% of the women surveyed had no health insurance at all, 43% had no coverage or inadequate coverage, and 47% felt that they really couldn't afford health insurance. Knowledge of VA health care benefits was limited with 40% unaware of possible entitlements for outpatient care and 53% unaware of entitlements for inpatient care. This coupled with persistent reports that many women veterans, particularly older women veterans, are not even aware that they are veterans makes it important to outreach to eligible women who could benefit from VA services. For new veterans, the Transition Assistance Program (TAP) and the Disabled Transition Program (DTAP) provides vital information about veterans benefits, including health care, to those separating from the military, both male and female.

It is important that any aggressive outreach and marketing strategies to bring women veterans into VA medical facilities be preceded by aggressive efforts to ensure that facilities are equipped to provide appropriate care for women. For example, if a woman veteran responds to outreach efforts and then finds a six month waiting list for a GYN appointment or is alienated by staff attitudes, she may never return.

In addition to outreach, it is important to "inreach" to women veterans already using the VA system but who may not be aware of other services to which they are entitled such as gender-specific preventive medicine services. Women coming to the medical center for Compensation and Pension examinations or who have applied for or are receiving other benefits should be targeted for "inreach."

Recommendations for outreach activities include the following:

> A brochure or other handout detailing local services available can be helpful for both outreach and "inreach."
>
> Local special events such as teas, luncheons, educational programs, and health fairs can be used to highlight services available at local VAMCs. Local media coverage of these activities, as well as personal stories of local women veterans during national patriotic holidays, or interviews with the women veterans

coordinator increases the potential for reaching women veterans in the community.

Collaboration with Veterans Benefits Administration (VBA) staff, particularly the Women Veterans Coordinator at the nearest Regional Office may increase opportunities for outreach. VBA lists of women who have applied for benefits could be used for VAMC outreach activities.

Collaboration with state Departments of Veterans Affairs may lead to the identification of newly separated women veterans. Some states have task forces and interaction with these task forces could be mutually beneficial.

Many women continue their military service in the Reserves or National Guard. Outreach to these groups through the distribution of pamphlets about local services and briefings are often successful in reaching women who have not used the system.

Joint efforts with local Veterans Service Organizations (VSO) may be mutually beneficial as they help spread the word about services. Joint sponsorship of teas, luncheons, health fairs and other activities have been successful at a number of VA medical centers.

ATTACHMENT TO QUESTION #22
(HONORABLE LANE EVANS)

Office of Public Affairs
News Service

Washington, D.C. 20420
(202) 535-8300

Department of Veterans Affairs

VA Fact Sheet

VA RESEARCH ON WOMEN VETERANS' HEALTH

March 1994

VA has responded to the growing number of women veterans by targeting programs and facilities to meet their unique health-care needs. Based on the 1990 Census, some 1.1 million women are veterans, or about 4 percent of the total veteran population. Currently, women make up 11 percent of the active duty military force and 13 percent of the reserve force. VA also is conducting research related to women veterans' health care.

Using National Institutes of Health criteria for identifying "women's health issues," VA research projects deal with topics such as diseases or conditions unique, more prevalent, or more serious among women or some subgroup of women. The research also may cover those diseases or conditions for which risk factors or interventions are different for women or some subgroup of women. During fiscal year 1993, VA researchers were conducting a total of 241 projects, funded by VA and other federal and private organizations.

In August 1992, VA sponsored a national conference for researchers, clinicians, and policy makers to discuss VA's research agenda related to women. Since May 1991, it has been VA policy that all applicants for VA research must consider and document the inclusion of women in their proposed study.

Women's Health Sciences Division

In January 1993, VA established a new division within the National Center for Post-Traumatic Stress Disorder devoted to studying the impact of military trauma on women veterans. The Women's Health Science Division, based at the Boston VA Medical Center, is the first of its kind in the country. The Center conducts studies designed to improve the assessment, diagnosis and treatment of PTSD in women, and provides training for professionals working with PTSD. Three recent studies are summarized below.

* Evaluation of PTSD must include a measure of the level of traumatic exposure experienced by an individual. Most combat exposure scales have been developed for male combat veterans. VA researchers at the Women's Division have developed the Women's War-Time Stressor Scale to measure levels of combat trauma. Investigators are conducting analyses to establish the validity and clinical and research applicability of this scale.

* Traumatic exposure and PTSD have been identified as predictors of physical health complaints. VA investigators asked a group of 109 female Vietnam veterans, who did not seek treatment for PTSD, to respond to a series of psychological, exposure and health questionnaires. Analyzing the results, the researchers showed that both traumatic exposure and PTSD have an effect on perceived health, with PTSD symptoms increasing the negative effects of traumatic exposure. This work supports other studies on the effects of stress on health.

* In a study of Persian Gulf War veterans, VA researchers examined how gender may be associated with psychological outcome following deployment. In a diverse sample they found that adjustment of women was significantly affected by factors such as fewer preliminary resources (i.e., educational level), serious unit incidents, and extensive exposure to dying as well as prior wartime service. More recent data suggest that sexual harassment and assault during deployment also generate symptoms.

Reproductive Health Outcomes Among Women Vietnam Veterans

Public Law 99-272 mandated an epidemiologic study of any long-term adverse health effects experienced by women veterans who served in Vietnam. This study was determined by the Office of Technology Assessment (OTA), VA and congressional staff to be not scientifically feasible. An alternative, approved by OTA and congressional staff, involved the conduct of a mortality study, which has been completed; an analysis of post-traumatic stress disorder and other psychological outcomes, still underway; and a study of reproductive outcomes. A contract recently was awarded for the reproductive study and work is beginning. Selected women Vietnam veterans will participate in a confidential telephone interview in which questions will be asked about military experiences, job history, medical and pregnancy history, and lifestyle. A request for medical records also may be made. This information will allow VA to learn more about the relationship between military service and the reproductive health of women veterans so that appropriate programs and service can be provided.

Health Services Research

VA investigators began a study to serve as a pilot phase for subsequent efforts to evaluate current primary and secondary prevention practice and rehabilitation therapy for breast cancer among women veterans in the United States, especially women veterans who are eligible for VA health care services.

Five VA medical centers are forming a consortium to pool their expertise and other resources to implement health services studies on women's health. These studies will examine organization of service, quality of and access to care, and the economic impact of providing care for women veterans. Each center will implement collaborative projects as part of the consortium as well as individual projects.

-more-

Additional Research

* Osteoporosis: A mechanism to explain the development of osteoporosis, a crippling disease of millions of post-menopausal women, was discovered by researchers at the VA Medical Center in Indianapolis. They have shown that the lack of the female hormone estrogen causes over-production of bone scavenger cells (osteoclasts) which produce pits and craters in bone, weakening its basic structure. This new information will allow for development of improved therapies.

* Breast Cancer: For the past 16 years, investigators at the VA Medical Center in Albany, N.Y., have been studying the effects of the body's natural rhythms on surgery and chemotherapy in patients with cancer, including women with breast cancer. The researchers have shown that women with breast cancer whose surgery is performed near the time of ovulation are four to five times less likely to suffer relapse and death than those who are operated on during or nearer their menstrual period. Also under investigation is the effect of daily rhythms on the administration of chemotherapeutic agents to establish maximum anticancer and minimal cytotoxic effects of the therapy.

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ATTACHMENT TO HONORABLE LANE EVANS
(MS. LYNN SMITH)

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-92-038

March 31, 1992

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Identifying and Correcting Privacy Deficiencies Adversely Affecting Women Veterans

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) Directive is to provide guidance to VAMCs (Department of Veterans Affairs medical centers) for improving privacy provisions for women veterans by identifying and correcting privacy deficiencies which interfere with their care. This directive will not be incorporated into a manual.

2. BACKGROUND: Women veterans now make up over 4 per cent of the veteran population and over 2 per cent of hospitalized veterans. In FY 1990, 241,376 women veterans were seen only as outpatients and 97 VAMCs saw over 1,000 women in their outpatient clinics. Currently, 12 per cent of the Armed Forces are women so the number of women veterans will continue to increase. It is projected that by the year 2040, 10.9 per cent of all veterans will be women. In 1991, the GAO (General Accounting Office) did an assessment of VA health care for women and concluded, as the title of the report states, "Despite Progress, Improvements Needed." Since the 1982 Report, when GAO found that VA needed to take a number of actions in the area of privacy, physical examinations for women, and facility planning, they found that VA has made significant progress toward assuring women veterans access to health care equal to that of male veterans. They cited the Women Veterans Coordinators located in every VAMC as contributing to the increased emphasis on identifying and correcting problems in the care of women veterans. However, they did identify a number of existing problems: chiefly, compliance with requirements that women veterans physical examinations included gender specific cancer screening and the identification and correction of privacy limitations affecting female patients during facility renovations. They found that some barriers to women veterans in VA facilities still exist because VA has not established adequate procedures to ensure that privacy deficiencies are identified and corrected during renovation projects. They did not feel that it was appropriate to accept women into a program but house them on a different unit because of privacy limitations. Furthermore, they cited single communal bathrooms on a ward as not providing adequate privacy for women. They recommended that VA institute a tracking mechanism for corrective actions and that the women veterans coordinator or the facility's women veterans advisory committee, if one exists, be included in the approval process for facility construction and renovation.

3. POLICY: Adequate privacy will be provided for female patients in VA medical facilities.

4. ACTION

a. VA medical facilities will survey the privacy provisions in all clinical areas and identify any deficiencies which might interfere with the appropriate treatment of women. The Women Veterans Coordinator or a member of the facility Advisory Committee on Women Veterans should participate in the survey as well as the hospital planner, the safety coordinator, and a representative from Engineering Service. Special attention should be paid to:

(1) Wards or nursing units with communal toilets and/or showers: Communal toilets and showers are allowed in renovated spaces only when space or structural barriers prohibit private or shared accommodations. However when nursing units or wards are renovated with communal toilets and/or showers, there must be both male and female facilities.

(2) Programs which must house women away from other participants because of privacy limitations;

(3) Outpatient examining rooms where the examining table cannot be shielded from the doorway;

(4) Sufficient number of one and two bed rooms (One bed rooms for domiciliaries - 8%; Nursing Home Care Units - not to exceed 10%; Medical, Surgical and Psychiatric Nursing Units - 25%);

(5) Other areas of privacy deficiency as determined by the facility staff.

b. Each facility will identify privacy deficiencies and develop a corrective action plan to bring them into compliance as soon as practical.

c. An inventory of the deficiencies and the associated corrective action plan certified by the medical center Director will be submitted through the Region (13) to the AsCMD (Associate Chief Medical Director) for Operations (13/13E) by May 1, 1992.

d. The AsCMD for Operations will establish a tracking mechanism for the corrective actions.

e. Corrective actions exceeding 1 year will be incorporated by the medical center into the FDP (Facility Development Plan) and Five Year Plan.

5. REFERENCES

a. GAO Report: "VA Health Care for Women: Despite Progress, Improvements Needed." GAO/HRD-92-23, dated January 1992.

b. Manual M-2, Part I, Change 78, Chapter 29, "Female Veterans," dated April 17, 1986.

6. FOLLOW-UP RESPONSIBILITY: Women Veterans Program (116C).

7. RESCISSION: This VHA directive will expire on March 31, 1993.

JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

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