

WOMEN VETERANS ISSUES

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SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS
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WOMEN VETERANS ISSUES

THURSDAY, JUNE 8, 2000

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

The subcommittee met, pursuant to notice, at 10:50 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Brown, and Udall.

Also Present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. The hearing will come to order.

Good morning. This Oversight and Investigations Subcommittee hearing will examine women veterans issues at the Department of Veterans Affairs. The number of women serving in our military has been steadily increasing. Women now comprise 15 percent of active-duty military service members. Therefore, it is important for the VA to recognize these changing needs to better serve the Nation's women veterans, and I would like to particularly thank Ms. Brown, the subcommittee's ranking member, for suggesting the topic of today's hearing.

Our witnesses today will be the Chair of the Women Veterans Advisory Board and representatives from the VA and veteran service organizations.

Before I recognize Ms. Brown, I would like to apologize. We had a mandatory appearance at the annual or biannual class picture taking. We didn't break any of the three cameras. That is a record, maybe.

Ms. Brown?

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman. I want to thank you for this opportunity to examine the needs of the 1.2 million American women veterans. The women who serve in the armed services often face the same risks, the same hardships, as the men they serve with, some making the ultimate sacrifice so American may be free. Our job is not only to honor their service; we must make sure they receive the same care and benefits male veterans receive. We must also ensure their special needs as women are taken care of. This is why I asked Mr. Everett to call for this hearing.

Women who serve in the military are different from men who serve. They are younger on average. They are assigned different

tasks. They end up with different health care needs. Congress created the Advisory Committee on Women Veterans in 1983. Since then, we have done a great deal to improve the treatment of women veterans. We are not here this morning, however, to congratulate ourselves. We are holding this hearing to see what still needs to be covered.

First, Dr. Linda Schwartz will testify on behalf of the Advisory Committee on Women Veterans. Then Joan Furey, Director of Center for Women Veterans, will discuss VA responses. We will hear also from the veterans' service organizations discussing their work and their observation.

I am looking forward to your testimony this morning. There is still a lot to do, and you will help us focus on the major problems.

Once again, thank you, Mr. Chairman.

Mr. EVERETT. Thank you.

I would like to welcome all witnesses testifying today. I would ask each witness to please limit your oral testimony to 5 minutes. Your complete written statement will be made part of the record. We have to be pretty strict on that. I ask that the entire panel hold its questions until each panel has testified.

At this point, I would like to recognize and welcome Dr. Linda Schwartz, Chair, Advisory Board on Women Veterans, Department of Veterans Affairs. Dr. Schwartz, welcome, and you may proceed.

STATEMENT OF LINDA SCHWARTZ, RN, MSN, DrPH, CHAIR, ADVISORY BOARD ON WOMEN VETERANS, DEPARTMENT OF VETERANS AFFAIRS

Ms. SCHWARTZ. Thank you very much, Mr. Chairman.

I am Dr. Linda Schwartz, associate research scientist at the Yale University School of Nursing, and I also have had the honor of serving as Chairman of the VA Advisory Committee on Women Veterans during the period of the report. I would like to thank you for holding these hearings and for your support of women veterans and for Congresswoman Brown's support.

I would especially like to thank Congressman Lane Evans for his continued leadership in introducing legislation which has improved VA services and programs and has significantly enhanced the quality of life for America's 1.2 million women veterans.

I would like to just address a few of the highlights of the report.

Since the problem of sexual assault and trauma in the military was first identified, VA has made a sterling effort to implement quality treatment programs through the Readjustment Counseling Service and the Veterans Healthcare Administration. Year after year, VA, veterans' service organizations, and veterans have returned to Congress to request a continuance of the present program. Surely by now this committee is aware that the need for this treatment program will persist as long as incidents of sexual assault and trauma continue to occur in the ranks of the military. This problem is not going away.

Indeed, there is no question that there is sufficient utilization of VA resources committed to treat veterans who were victimized while in the service of their country. Veterans of all ages and periods of service continue to seek assistance from VA for the physical and emotional aftermath of these traumatic events.

The burning question to this committee is: Why hasn't this become a permanent program of the VA? As more is learned about the dynamics of sexual assault and trauma in the military setting, it is unquestionably a moral and ethical responsibility of the Congress to eliminate all restriction and time limits on the VA's authority to provide care to those who are victimized while in military service.

Under the current provisions of Title 38, VA is prohibited from providing sexual trauma counsel to Reserve and Guard personnel who experience a sexual assault or trauma while on inactive duty training days because this does not qualify—satisfy the legal definition of active duty. It is important to note that incidents of sexual misconduct and victimization are not limited to active duty personnel. The very sensitive nature of these incidents often delays victims from coming forward, which complicates documentation, adequate reporting, and therapeutic intervention. This is especially true for Reserve and National Guard personnel who may experience one of these assaults during a weekend drill.

We understand that a legislative remedy is required to effect these changes. We encourage this committee to consider the situation and devise a just and fair means for providing access to VA care to Reserve and National Guard personnel injured or assaulted on non-active duty training days.

Women veterans who are homeless also have needs and problems that vary from male veterans who are homeless. It was with great enthusiasm that we welcomed the news that congressional funding had specifically been set aside for programs for women veterans who are homeless. As we eagerly awaited the initiation of this process that would bring these vital programs on line, we witness yet another cruel reality of the "One VA."

The announcement that VA will be able to fund 11 projects for women veterans this year is a hollow victory. I say hollow because there is only one year of funding guaranteed for these programs. There is no question that VA's Mental Health Strategic Health Care Group and the Homeless Provider Grant and Per Diem Program have achieved significant progress in meeting the needs of America's veterans who are homeless. However, like other special programs authorized and funded by Congress, the importance placed on these initiatives is lost in the maze of funding mechanisms that characterizes the bureaucracy of the "One VA."

When VA's Internal Policy Board ruled that money authorized for the Homeless Grant and Per Diem Program had to be spent in fiscal year 2000 or it would revert back to the general fund, the legislation passed by Congress to assist veterans who are homeless was vetoed de facto. It has come to our attention that although sites for the funding are identified, VISN Directors are hedging their bets by using the money for temporary positions with no guarantees of employment for more than 12 months. Mr. Chairman, this is not the program we envisioned. I don't think it was the program Congress intended. However, this is the program as it now stands.

In the past, money for special programs was fenced to assure that programs authorized and funded by Congress would be used for that purpose only. Funding streams at VA appear to have been

reduced to the level of a shell game. Now you see it, now you don't. We ask that this committee take measures to protect this funding, preserve these valuable programs, and in essence protect veterans with special needs.

Mr. Chairman, you weren't here but I remember 15 years ago when I first came into this hearing room. The major topic that day for women veterans was cosmetics in the VA canteens. Now we have progressed to inquiry into compensation and care of women veterans who are homeless and mastectomies. It has taken a great deal of effort on the part of Congress, veterans' service organizations, and to increase the quality of benefit and health care delivery to women veterans. While it is important to note the many improvements that have occurred in the last 20 years, there is also evidence that there is still much work for us to do.

I was particularly disappointed to read VA's responses to the recommendations made by the Women's Advisory Committee. For example, to our recommendation that all studies and surveys funded or conducted by VA must include gender-specific information, VA's response was a statement that "women can be expected to benefit from a much wider range of VA research studies. This seems to be a reasonable assumption given that many biological processes are common to both men and women." This seems quite enlightening given the status of science in the 21st century.

I was also disappointed that VA would report as a response the fact that we were looking at privacy for women veterans in their facilities, that they reported that two-thirds, not 100 percent, of the VA medical centers responded as either having or in the process of developing programs and policies addressing patient privacy issues. It was also very disappointing given the fact that for the past 20 years protecting patient privacy has been the main thrust of our efforts and concern for women veterans in VA health care settings.

These responses, coupled with the observations made by our Committee on site visits to specific facilities, indicated that services and programs for women veterans are eroding. There is no doubt that there is a pervasive and disingenuous attitude that programs for women veterans are window dressing, trivial, or optional. We have encountered these sentiments at every echelon at the Department of Veterans Affairs. I would just call your attention to VA's response to our recommendation that women veterans be considered for appointed positions within VA has yielded the most disturbing statistic that only 2.5 percent—2.5 percent—of the women in appointed positions—appointed positions—at VA are women veterans. We can only speculate that that includes the women veterans on the Advisory Committee and the Director and Deputy Director of the Center of Women Veterans.

I know that this committee has already acted to assure that our biannual reports of the VA Advisory Committee will continue to be forwarded by the Secretary of Veterans Affairs to the Committee. I believe that the stewardship of the responsibilities charged to the members of the Advisory Committee has been well served in the year since it was authorized. These successes are due in large part to the tireless efforts——

Mr. EVERETT. Dr. Schwartz, could you please summarize? I would appreciate it.

Ms. SCHWARTZ. Yes. These successes are due in large part to the tireless efforts of Joan Furey, the director of the center, and her staff. I also hope that the proceedings of today's hearings are not only informative to you, but also provocative enough to warrant your attention and action.

Mr. Chairman, that concludes my testimony. I am available for any questions you may have.

[The prepared statement of Ms. Schwartz appears on p. 29.]

Mr. EVERETT. Thank you very much.

Does the Advisory Committee have updated information after the 1997 women's patient privacy survey?

Ms. SCHWARTZ. I don't have it.

Mr. EVERETT. Currently, how many VA facilities have not developed programs and policies addressing patient privacy?

Ms. SCHWARTZ. Well, from the response that we got from VA to our recommendation, it said two-thirds of the VA facilities were working on programs or developing programs. I believe probably Ms. Furey could help you more with that specific statistic. But that is the response that we have.

Mr. EVERETT. You mentioned 15 years ago when you arrived. Neither myself nor Ms. Brown was here 15 years ago. Isn't that how long the VA has been working on this?

Ms. SCHWARTZ. Well, it started a little before that, I was here because at that time I was a disabled, I still am a disabled women veteran, and I was talking about the care that the VA had provided me. And, yes, we have been working on it.

Mr. EVERETT. Quite a while.

Ms. SCHWARTZ. Yes, sir.

Mr. EVERETT. To what extent do women veterans utilize VA health care in proportion to their numbers? And to what extent do women veterans use the VA health care system for service-connected disabilities?

Ms. SCHWARTZ. I can't really give you the real numbers on that, but I can tell you one thing. They are the fastest-growing group of people coming to the VA for service. They are choosing VA in greater numbers than ever before.

Mr. EVERETT. Finally, what kind of VA health care services do women currently use most often?

Ms. SCHWARTZ. I would have to say probably the gynecological services we have, and also because VA has instituted primary care, this is a new and very comprehensive way to approach the problem. But I believe that Carole Turner could probably give you more factual data on that.

Mr. EVERETT. Are they readily available?

Ms. SCHWARTZ. She is going to be—she is here.

Mr. EVERETT. I apologize for asking you to sum up, but if we don't stick to that kind of schedule with as many witnesses as we have, we never—

Ms. SCHWARTZ. Well, you can appreciate, sir, that we practice this, but when you get up here, your tongue doesn't work as fast as it does when you are practicing.

Mr. EVERETT. I understand. Well, we appreciate it.

Ms. Brown?

Ms. BROWN. Thank you, Mr. Chairman.

First of all, I would like a little bit more in-depth discussion about homeless women veterans and what we need to do in that area, because most of the time when a woman is homeless, it means families. And can you expound upon that a little bit more?

Ms. SCHWARTZ. Yes, ma'am, I can.

I myself for several years did have a program which provided shelter for homeless veterans, and one of the things, the outstanding things, of course, is women with children. They don't seem to fit in—they did not seem to fit into VA programs because those are just mainly to assist men or single adults.

So we did try very hard and Congress did respond quite well to starting a pilot project so that we could not only do outreach but see what the needs of women veterans were and be able to institute through VA's Grant and Per Diem Program for the Homeless programs specifically for women.

I would just like to expound a little bit and let you understand my concern. The concern was that when Congress appropriated that money, we were all very happy, \$2.3 million. But when the VA Policy Board was asked if this money could go from one fiscal year to another, which would give adequate time to do a comprehensive response for the proposals, to do a good looking at the different people who had responded, they said no. They said, no, if you do not spend this money by the end of this fiscal year, you don't have it.

And so then VISN Directors—yes, listen, VISN Directors were asked, if you get this money to help women veterans, you have to agree to keep this program going for 3 years. Now, we know the story of the fishes and the loaves. But having a VISN Director be required to commit to 3 years of operation on one year of funding, that is why right now we understand that they are not hiring people on a permanent basis for these programs, and we are very concerned at how this will play out.

Ms. BROWN. We need to follow up on that. In reading your testimony, I was disturbed with what has been termed the dismantling of services to women veterans in the VA system. I am disturbed, as you are. Please discuss this and tell me any conversations that you have had with Secretary West on this topic.

Ms. SCHWARTZ. You may not know that once a year the Women's Advisory Committee does choose to make site visits to actual facilities to see how the services are being provided and if there are any needs, and if there is anything that is really good going on.

One of our visits was to Seattle, and I would just use this, because I said at every echelon and I mean that. I mean that no one could possibly have a handle on pulling this all together and identifying the culprit because it is pervasive.

For example, this was a decision by a chief of staff. Seattle has one of the finest women's programs. They have utilization of 2,000 to 3,000 women veterans, they report, use their facility a year. So we are not talking about skimping, but they decided, the chief of staff decided when the position of gynecologist was vacated that he would not fill it.

The other thing that we found was that there are certain programs in VA that are funded for residencies in women's health. This is a competition throughout the United States. In that par-

ticular VISN, there were two in one hospital funded. However, that hospital did not even have a women's clinic.

We found in Los Angeles that they had one of the finest mammogram suites I had ever seen, but the thing was that because of the way the administration had scheduled it, only one afternoon a week was for the women's clinic. And certainly, I am sure you probably know that Los Angeles has one of the highest women veteran populations in America.

Mr. EVERETT. This hearing is particularly important to the subcommittee, and Ms. Brown has a good interest in it, so we are going to have a second round of questioning to accommodate Ms. Brown.

Ms. BROWN. When you met with Secretary West, you discussed H.R. 3998, Mr. Everett's and Ms. Berkley's legislation to provide special monthly compensation of \$76 a month to women veterans who received mastectomies for service-connected conditions. Can you tell me about those discussions?

Ms. SCHWARTZ. Secretary West did visit the Advisory Committee recently, and at that time he said that he did support—he didn't know what the problem was about the mastectomies, but indeed we know what it is—there was both a readout from the general counsel and a readout from VBA that this would require a legislative remedy in order to be able to extend the Special K compensation to victims, both men and women, who have had radical or simple mastectomies. So he was in favor—I mean, he said that to us in an open meeting.

I didn't answer your question, and I am sorry, Congresswoman Brown, my discussion with Secretary West was about the erosion of services to women veterans, and he was quite concerned. At that time we discussed our visit to Seattle and some of the things that we found there. And he was very supportive.

Ms. BROWN. He was supportive?

Ms. SCHWARTZ. Yes. He was as concerned as I was. However, I—

Ms. BROWN. I think you said that the problem is up and down the spectrum.

Ms. SCHWARTZ. I think it is, and I think that that is what makes it so difficult because this is—as you pointed out in your opening statement, women are joining the military in greater numbers. On my way to this hearing, I was taking the train in from Baltimore, and next to me was a young woman who was coming home on leave from Baumholder. And I silently said to myself, as we talked: I hope that we have made it better for you when you become a woman veteran; I hope that we have done the work that we need to do to make sure that you are given the best care in the VA.

Ms. BROWN. Part of your beginning discussion was on sexual trauma. Congress extended VA's authority to offer sexual trauma counseling, but did not make it a permanent part of the VA services. VA says some 13 to 20 percent of women veterans reported having experienced some sexual trauma on active duty, and you mentioned women that are not on active duty but temporary duties not being able to receive counseling or treatment from VA.

Ms. SCHWARTZ. Yes.

Ms. BROWN. Do you think that is an example of where VA and DOD need to work closely together?

Ms. SCHWARTZ. Yes, ma'am. I have the honor to serve both on active duty and as a reservist. I was injured as a reservist, but I happened to be on active duty at the time. And I can tell you that injuries do happen to our Reserve and National Guard when they are on non-active duty training days.

I do believe that this is just semantics. It is not reality, because training is as essential to the defense of our Nation as any part of active duty. And I can assure you, as a reservist I was required to maintain my readiness and training to the level of my active duty counterparts.

It seems that there is a moral responsibility, again, for this Congress to be sure that when someone is in the service of this Nation, wearing the uniform, that they will have the knowledge of knowing that they will be cared for. And I can tell you truthfully, even though I was a reservist when I was injured, my insurance company would not take care of me, would not pay for me. Do you know why? Because an insurance company considers any military training, any military active duty to be an act of war.

Ms. BROWN. Is there any other last thing that you would like to share with us that wasn't covered in the 1998 report from the Women's Advisory Committee?

Ms. SCHWARTZ. We understand that this committee is considering legislation to compensate the children of women veterans who served in Vietnam. My research was in this area, and I can tell you that I am elated at the idea that we would be able to extend to these women and these innocent victims, their children, of the Vietnam War. But I would be remiss if I did not say at the same time I am concerned about how many studies have been done on the men and haven't really been adequate research studies to look at the outcomes of their offspring and their children.

And so I would say that it would be important for you as you pass the legislation—and I believe—we do support that—that we not forget the men and their children.

Ms. BROWN. Thank you. Thank you very much for your testimony.

Mr. EVERETT. Well, thank you very much for your testimony. The panel may have additional questions that we would ask you to respond to in writing. Thank you.

Ms. SCHWARTZ. Thank you, Mr. Chairman.

Mr. EVERETT. I would now like to welcome and recognize Ms. Jacqueline Garrick, Healthcare, National Veterans Affairs and Rehabilitation Commission, The American Legion; Ms. Joy Ilem, Association National Legislative Director, Disabled Veterans; and Ms. Marsha Four, Chair, Women Veterans Committee, Vietnam Veterans of America. If they would please come up, we will begin your testimony.

Ladies, I would again ask you to hold your remarks to 5 minutes, and I can assure that your entire testimony will be put into the record. I apologize for having to keep a strict eye on the clock, but, otherwise, we end up in the afternoon, and we do have other committee hearings to go to.

Why don't we start on my right, on the left side of the table down there, and if you will, you may proceed.

STATEMENTS OF JACQUELINE GARRICK, DEPUTY DIRECTOR, HEALTH CARE, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; JOY J. ILEM, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND MARSHA TANSEY FOUR, CHAIR, WOMEN VETERANS COMMITTEE, VIETNAM VETERANS OF AMERICA

STATEMENT OF JACQUELINE GARRICK

Ms. GARRICK. Good morning, Mr. Chairman and members of the subcommittee. The American Legion appreciates the opportunity to participate in today's hearing.

Since its inception in 1919, women legionnaires have served in positions of leadership at all levels. Women legionnaires could vote or run for any office, including National Commander, before they could vote for President of the United States.

Recently, in response to the needs of its female legionnaires, the American Legion conducted a special review of the services and benefits available to women veterans as well as through its ongoing VALUE, VA Local User Evaluation, oversight methodology.

The American Legion developed a guide for women veterans identifying risks, services, and prevention, which is a compendium of women veterans' issues, availability of benefits and services, and tips for assistance.

The American Legion developed the guide in conjunction with VA's Psychosocial Rehab's desire to outreach to formerly incarcerated female veterans. Women veterans do not always identify themselves as such, nor do agencies or systems providing services inform of their earned benefits. The American Legion hopes that the guide will fill that gap. A copy of the guide is attached to the written statement and submitted for the record.

The Center for Women Veterans, directed by Joan Furey, and the Advisory Committee for Women Veterans, chaired by Linda Schwartz, are commended for their dedication and contributions to improving the quality of health care and other services available for women veterans. It is through these efforts that we have come a long way in ensuring recognition and appropriate access for the special needs of America's 1.2 million veterans, which is a group that is making up more and more of the VA population.

In the wake of eligibility reform, VA developed its uniform benefits packages to include a myriad of services for women veterans.

The Advisory Committee on Women Veterans made 42 recommendations, however, and five of those recommendations are pertinent to Congress. They are: to require the federally funded research to capture data about military service and war zone history for comparative analysis of veterans and civilian population and publish findings by gender; authorize selected reservists and National Guard personnel who experience sexual assault, trauma, or harassment while on active duty to have VA access; remove all constraints on VA services and treatment programs for survivors of sexual assault and trauma; the Sexual Trauma Counseling Pro-

gram must be made a permanent part of VA's uniform benefits package; require all federally funded social service agencies or programs to identify the veteran population they serve to VA on an annual basis; and the lack recommendation was the enactment of Medicare subvention.

The American Legion views each of these legislative initiatives with merit and supports their enactment.

The American Legion has several of its own recommendations it would like to make to this subcommittee. First, provide veterans' dependents with access to quality health care, as outlined in the GI Bill of Health. This measure would benefit women veterans in two ways.

First, it would expand access to spouses, thereby creating a greater demand for gynecological care. This increased utilization and influx of resources would facilitate improvements in access point and specialization for women veterans as well.

Second, with the increase in single-parent families, women must have a health care plan that includes their children and be provided a more comprehensive continuum of care through access to a well-baby program. It is a disincentive to a parent or spouse to use VA when they cannot enroll their entire family. DOD recognized this obligation, and it is time for VA to follow suit.

The next recommendation from the Legion is to expand the homeless veterans grant and per diem program to be a 3-year instead of a 1-year program. The current side effect of a 1-year operating budget acts as a disincentive to the networks to want to establish these programs. And, again, this becomes harmful to women veterans, leaving an unmet community-based women's housing shortage. And I think Ms. Schwartz expanded on that quite well.

As Congress monitors VA to ensure it is maintaining capacity, the special needs of women veterans should be given careful consideration to the unique needs of women in regard to privacy, specialization, equipment and prosthetics sizes, and educational services.

In addition, although not noted in its written statement, the American Legion would like to take this opportunity to voice its support for H.R. 3998, the Veterans' Special Monthly Compensation Gender Equity Act, which grants service connection for radical mastectomy, and for H.R. 4488, which provides benefits for the children of female Vietnam veterans who suffer from certain types of birth defects.

Finally, the American Legion looks forward to the Summit on Women Veterans to be held in just a few weeks and views this as an additional opportunity to identify the unmet needs of this population.

Women are veterans, too, but they first must know it and feel it.

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

[The prepared statement of Ms. Garrick, with attachment, appears on p. 37.]

Mr. EVERETT. Thank you very much.

Ms. Ilem, if you will?

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to discuss Department of Veterans Affairs programs and services for women veterans. We acknowledge that VA has made significant progress in its effort to address the unique physical, mental, and social needs of women veterans. Many VA facilities have developed special programs and services to meet these needs. However, women veterans continue to use their benefits at lower rates than their male counterparts, and some women veterans still experience obstacles in accessing quality health care services that are tailored to their needs.

Since the restructuring of the Veterans Health Administration and implementation of a primary care model through the system, we have seen the discontinuation of several dedicated women's health clinics. The DAV is seriously concerned about the incidental impact of the primary care model on the quality of health care delivered by VHA to some women veterans. Information from a January 2000 VA conference report noted that women veterans comprise less than 5 percent of VA's total population, and as a result, VA clinicians are generally less familiar with women's health issues and less skilled in routine gender-specific care. With the advent of primary care in VA, clinicians are seeing a reduced ratio of women; therefore, it is unlikely that they will gain the clinical exposure necessary to develop and maintain expertise in women's health.

Women's health clinics should be maintained to ensure women veterans are not subjected to lower standards of clinical expertise in their health care, and VA women veterans' health programs must be adequately funded to avoid decline in services.

Another topic for discussion of the January 2000 VA conference was the outcome of VA's Women's Health Project. Findings from that study revealed there are significantly increased rates of sexual trauma reported by women who served or are serving in the military. In light of these and other findings, we believe the authority for the VA's Sexual Trauma Counseling Program should be made permanent, and that a legislative amendment be approved to make reservists and members of the National Guard who experience sexual trauma during any official military duty period eligible for VA sexual trauma counseling and care.

Other areas of concern to the DAV are the effectiveness of VA programs for women veterans who are homeless, the availability of the quality of inpatient mental health services for women veterans, and the issues of privacy and safety at VA medical facilities.

The VA has a comprehensive program to help male veterans who experience homelessness, but until recently, it has not focused on providing the same level of services to homeless women veterans. Program workers often face obstacles in providing transitional housing to women veterans because of child care issues and/or safety concerns. We are pleased that Congress last year earmarked approximately \$3 million to support demonstration projects for women veterans who are homeless.

Increasing numbers of women are seeking mental health treatment programs for post-traumatic stress disorder as a result of sexual trauma. However, very few VA facilities have dedicated inpa-

tient mental health clinics specifically designed to meet the needs of these women.

Women veterans may be disadvantaged in terms of the quality of mental health care they receive if clinicians are unfamiliar with the unique manifestation of PTSD symptoms in women who have experienced sexual trauma and the added impact of an assault that occurred during military service.

We suggest that in VA facilities where numbers of women are too low to be cost-effective to maintain an inpatient psychiatric unit or provide appropriate care, contracted care at a nearby facility should be secured.

Women veterans continue to express concern about privacy and safety issues at some VA facilities. It is not uncommon during an inpatient hospitalization or domiciliary stay for a single woman veteran to be placed in a ward with 30 men. Privacy and safety protocols for women veterans should be consistent and strictly adhered to at every VA facility.

Although privacy and safety issues remain a concern, women veteran coordinators have helped to eliminate deficiencies and ensure that services to women veterans are maintained. However, we are concerned that there is a lack of continuity in the services provided by women veteran coordinators throughout the system. Some VA employees complain that their duties as women veteran coordinators are often secondary to their assigned responsibilities. Hospital and regional office directors should fully support women veterans so that they can successfully manage their caseload and have adequate time to complete necessary tasks and projects associated with that position. This successful program should not be jeopardized by VA reorganization or budget cuts.

Equally important is the function of the VA Advisory Committee for women veterans. Recommendations made by the committee provide an honest look at the accomplishments and deficiencies in the VA system concerning women veterans and will help to ensure consistency of quality services to women veterans throughout the country.

More women are serving in the armed forces, and this means more women veterans will likely be seeking VA benefits and health care services in the future. Therefore, VA should increase outreach to women veterans and ensure they receive benefits and health care services on par with male veterans.

It must also work hard to identify and eliminate the barriers experienced by women when accessing VA benefits and programs.

Mr. Chairman, that completes my presentation, and if you have any questions, I will be happy to answer them. Thank you.

[The prepared statement of Ms. Ilem appears on p. 57.]

Mr. EVERETT. Thank you very much. Ms. Four.

STATEMENT OF MARSHA TANSEY FOUR

Ms. FOUR. Good morning, Mr. Chairman and distinguished members of this committee. This is the first time I have had the opportunity to address this committee, and I appreciate the opportunity to do so.

My name is Marsha Four. I served in the United States Army Nurse Corps with duty in Vietnam, and I am the Chair of the

Women's Veterans' Committee for Vietnam Veterans of America (VVA).

VVA recognizes the positive steps the VA has taken over time to increase care and services and equitable treatment for women veterans within their system. Today, though, I would like to address several specific issues of priority from our Women Veterans Committee.

The enactment of Public Law 102-585, the Veterans Health Care Act of 1992 was a landmark victory, including care for the aftermath of sexual trauma associated with military service. The issues of sexual harassment, abuse, and trauma, however, continue.

According to the VA, in 1999, 50 percent of all women assaulted in the military developed signs of PTSD, and 60 percent of all women in the military have said that they have experienced at least one instance of sexual harassment or assault while on active duty.

Today we ask the attention and the assistance of this subcommittee in recognizing that this issue is not, nor will not, disappear. VVA seeks legislation that will make sexual trauma counseling a permanent part of the VA programs and services and not have to be readdressed year after year.

Approximately 3 to 4 percent of the 275,000 homeless veterans across this country are women. Homeless women veterans present many different problems from men, specifically for gender-related care, treatment of physical and sexual trauma, and dependent children. Because of these compounding issues, few programs dedicated to them are available. It was very heartening to see that added dollars were put into the VA budget and \$2.3 million was set aside for homeless women programs. Eleven programs were and will be put up on line through contract in the VA.

The Department of Veteran Affairs Policy Board determined that this money for homeless women programs would only be available through fiscal year 2000, and the subsequent 2 years would be allocated by the VA out of the general medical fund. Continued funding would be dependent upon VERA allocation to the VISN within which these programs are located. VVA realizes the workload information that drives VERA and its attached VISN funding level is at least 2 years behind its translation of data into actual dollars.

Mr. Chairman, special needs programs take time to develop and thrive. This time is vital in the acquisition of outcome data that will be used to fully justify the future existence of these programs. VVA believes Congress needs to protect money allocated for special programs and extend to 3 years, by legislation, the time frame that these programs may prove their functionality. We ask Congress to consider this issue and bring stability and security to special veteran programs by initiating legislation that would bring a resolution to this dilemma.

The addition of the diagnosis of simple and radical mastectomies, to those eligible for VA Special Monthly Compensation, "Special K Award," is presently under consideration. Vietnam Veterans of America supports the recommendation of the VA Advisory Committee on Women Veterans regarding this issue. VVA has been given to understand that VA General Counsel has determined they have not the statutory authority to make this ruling. VVA stands firmly

behind the belief that this consideration move forward with legislative reality possibly through H.R. 3998.

Our Women Veterans Committee attention to this issue led to a review of the overall compensation and rating schedules for mastectomies. VVA became concerned about the existence and possible inadequacies with this scheduling. Compensation should reflect the amount of disability to include all components of a diagnosis, including the impact on day-to-day living for veterans with mastectomies. Managing care, psychological devastation, and coping with this disfigurement that strikes at the very core of one's sexual identity is a trauma which must be renegotiated every day of one's life.

VVA feels this psychological aspect should not be separated or dissected from the diagnosis and must be included as part of the whole and overall picture that is included at the start of the rating process for mastectomies. We look forward to working with VA on the revision of this present rating schedule, for a more adequate reflection of the appropriate level of disability rating.

Military training is an essential part of mission readiness, and it is vital to the overall defense of this country. At this time in our Nation's history, the contribution of the Reserve and National Guard, both here and abroad, is immeasurable. An issue emerges related to care and treatment of these men and women who experience sexual trauma or assault while on training days. Although physical injury incurred while on training days is included for care, sexual assault and trauma are not. We feel this is an issue of semantics rather than reality. VVA feels the stressor for this personal infringement should be considered an injury, a psychological injury.

While we wait for the outcome of the VA-DOD task force to consider this very issue, these victims sense a lack of empathy and they, too, await the outcome with screaming pain. Someone surely must be hearing them.

VVA requests consideration by this committee in drafting legislation which would bring a just equality and quick resolution to this issue.

Interest has been given to the statistics from the Klemm Report relating to the birth defects of children born to women who served in Vietnam. This has resulted in an initiative by the Secretary of Veteran Affairs to provide compensation and benefits for these children. VVA looks forward to the positive outcome of H.R. 4488. If we are not a parent of a child who lives daily with a defect, no one of us can truly, truly understand so deeply, or ache so desperately, or know so profoundly the strength that it demands to bear the lifetime of heartache this presents. The financial burden is overwhelming, and to think that this was the result of service in our military, VVA believes it is right and just to assist and provide compensation for these children. However, we do feel that further investigation into statistical information needs to be gathered to look at the men who fathered children with birth defect. We believe that a study should be requested by Congress to determine if there is evidence to include these children of the men who served in Vietnam into this arena. To deny them equitable consideration on this issue is less than honorable.

VVA Women's Committee has outlined, during this testimony, several issues of concern. We are proud to have been a moving force in the establishment of the VA Advisory Committee on Women Veterans and the Center for Women Veterans at the VA. The biannual report delivered to Congress by the VA Advisory Committee on Women Veterans has been and continues to be a tool of advocacy for women veterans. It is VVA's hope that Congress will continue to require the Secretary of Veterans Affairs to deliver this report to Congress.

With the increased number of women in the military, the needs of women veterans are emerging, unfolding, and rapidly changing. VVA applauds and thanks this committee for taking the initiative to schedule these hearings. In the past, these hearings were held annually. Vietnam Veterans of America senses the importance of this practice and urges for its continuance.

Thank you for providing me the opportunity to be here today at these hearings. Mr. Chairman, this concludes the testimony of Vietnam Veterans of America.

[The prepared statement of Ms. Four appears on p. 64.]

Mr. EVERETT. Thank you very much.

Let me digress a minute on sexual harassment, for instance. This committee has taken the forefront in investigating sexual harassment in the VA, and I don't know that we ever see what we should see toward our women veterans when VA itself has its own sexual harassment problems. We have had a situation in the past of at least 12 hospital directors who were either given \$25,000 buyouts or allowed to retire without any charges being brought against them after they had committed obvious sexual harassment, either physically or verbally.

We had one case of a director, and we had five women, that he had either physically or verbally sexually harassed, who were before this subcommittee under oath, and the VA had actually signed an agreement that they would bring no charges against the director if he would agree to a move. It just so happened he agreed to a move where he already had his retirement home. He got an increase in pay and \$75,000 or \$80,000 to move from the Carolinas down to Florida.

So the VA seems to have a real problem in dealing with sexual harassment, which resulted in some legislation I wrote that would hopefully improve that and not make the hospital director also the EEOC officer.

But I have just a couple very simple questions, and each of you, if you would, give the VA an A to F grade on dealing with women veterans' health care issues.

Ms. GARRICK. Mr. Chairman, the American Legion has its own evaluation system, and I would like to sort of go back to that.

Mr. EVERETT. I would just like, if you don't mind—we don't have a lot of time. Just give me an A to F evaluation.

Ms. GARRICK. Well, based on what we have done in the past, then, we have given VA grades for excellence in quality—

Mr. EVERETT. If you will, just one grade.

Ms. GARRICK. I am trying to add it up. I would say that they have done pretty—they have done good, in the middle.

Mr. EVERETT. Okay. That is good.

Ms. Ilem?

Ms. ILEM. Probably, yes, a C, in the middle. More could be done to improve.

Mr. EVERETT. Okay.

Ms. FOUR. Several years ago the answer to that question certainly would be much different than today. The VA has moved forward in a progressive manner, and so I would say, in the middle—

Mr. EVERETT. The grade you would give them today, please?

Ms. FOUR (continuing). And it is attempting to rise.

Mr. EVERETT. Okay. Thank you.

Next, what is the single most important thing, the one single most important thing that needs improvement in your estimation at the VA?

Ms. GARRICK. Well, from the American Legion's perspective, it is our GI Bill of Health. If we can expand access, if we can increase the influx of users, we would just have a better health care system for women regardless of whether or not they were veterans or not. We need those dependent spouses coming into the system through insurance and bringing in those resources to help create a better, more comprehensive program for women veterans and reduce that adverse select down spiral that VA is currently in.

Mr. EVERETT. Ms. Ilem?

Ms. ILEM. Probably health care issues, just to ensure that systemwide everywhere that quality health care is provided for women veterans and tailored to their needs. That primary and gender specific care that they need is consistent.

Mr. EVERETT. Ms. Four?

Ms. FOUR. I think to recognize that women's care is, in fact, and in many respects, different from the care for male veterans, that it be given an equal level of importance within the system, that the outreach and women veteran coordinators do not lack in their availability to reach out into the community and to provide a constant vigilance, we need to have a constant vigilance on the oversight that they are providing within the VA through the Women's Health Center and through the Advisory Committee.

Mr. EVERETT. Thank you, ma'am.

Ms. Brown?

Ms. BROWN. Thank you.

First of all, Ms. Marsha Four, I want you to know there is nothing in your testimony that would let me know that this is your first time coming here. You are absolutely pro.

But let me commend all three of you on your testimony, and if we could, just briefly summarize the important things that you think that we should be doing. Let me know whether I am correct. One, we need to make sure that sexual trauma counseling is permanent.

Ms. GARRICK. Correct.

Ms. BROWN. Everybody is agreeing with that. Secondly, the homeless program should be—we need to talk with VA. It needs to be the 3-year program we intended and not one year of funding and hoping the next 2 years by some magic the money will be there.

Ms. GARRICK. Yes, ma'am.

Ms. FOUR. Correct.

Ms. BROWN. That would be the sum of your testimony.

Ms. GARRICK. Yes, ma'am.

Ms. BROWN. And I like what you said about, you know, whether or not the VA—whether they get an A or an F, but I've got to tell you a little story here. I have been on this committee, this is my 8th year, and there have been times when we have discussed women veterans' issues. And I will never forget the first time they whipped out the chart and were talking about how much it costs. Well, we don't talk about how much it costs when we are talking about men veterans. So we have got to make sure that cost is not a factor when we are dealing with women veterans even in Congress.

I yield back the balance of my time.

Mr. EVERETT. Thank you, Ms. Brown. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman, and I thank the panel for being here today.

According to a 1998 VA study, women veterans who served in Vietnam are more likely to give birth to children with severe birth defects than their counterparts who served elsewhere. Mr. Evans, our ranking member here, has a bill, H.R. 4488, which would provide compensation, health care, and rehabilitative services to these children in a manner similar to what is provided for Vietnam veterans era children with spina bifida.

Do your organizations support this idea? Do you have an opinion on this?

Ms. GARRICK. Yes. I know it is not in our written statement. I did have it in my verbal statement that the American Legion has been very involved with the issues of Agent Orange for years and years and years through our—especially through the activities of our Executive Director John Sommer. And we have supported that legislation.

Ms. ILEM. The DAV does not have a resolution in support of that issue. We do recognize the devastating and far-reaching effects of Agent Orange on these children of women Vietnam veterans, and we believe that the Government should compensate them. However, we do have some concerns about the authority being provided under Title 38. We would like or prefer it to be under the Social Security Administration or another more appropriate Government agency. But we certainly don't oppose the legislation, and we certainly believe that these children need to be compensated.

Mr. UDALL. What are those concerns under Title 38?

Ms. ILEM. That this is getting outside the scope of the VA's mission, specifically, you know, in providing this care—you know, this benefit, compensation rather than for service-connected disabled veterans to their dependents. But certainly we don't oppose this in any way and believe that certainly compensation is due to these children and they need to be compensated, just perhaps not under Title 38.

Ms. FOUR. Vietnam Veterans of America does support this legislation. We feel, though, that it is a positive movement forward, then takes this look to another level in possibly addressing a study that would provide statistical information in regard to birth defects of children of the men who served in Vietnam. But Vietnam Veterans is in favor of this legislation.

Mr. UDALL. Thank you very much, and I would yield back the balance of my time.

Mr. EVERETT. Ladies, thank you very much. We have great respect for the VSOs you represent and for the testimony that you have given here today. It is always extremely helpful, and I again thank you very much.

Ms. GARRICK. Thank you.

Ms. FOUR. Thank you.

Ms. ILEM. Thank you.

Mr. EVERETT. Now I would like to recognize the next panel: Ms. Joan Furey, Director, Center for Women Veterans, Department of Veterans Affairs, and Ms. Furey is accompanied by Ms. Carole Turner, Director of Women Veterans Health Program, Veterans Health Administration; and Mr. Robert Epley, Director of Compensation and Pension Service, Veterans Benefits Administration.

Ms. Furey, if you would begin your testimony, and, again, I ask you to please hold it to 5 minutes, and your complete testimony will be made a part of the record.

STATEMENT OF JOAN FUREY, DIRECTOR, CENTER FOR WOMEN VETERANS, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CAROLE TURNER, DIRECTOR, WOMEN VETERANS HEALTH PROGRAM, VETERANS HEALTH ADMINISTRATION, AND ROBERT EPLEY, DIRECTOR COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION

Ms. FUREY. Yes, sir. Thank you.

Mr. Chairman and distinguished members of the subcommittee, I am pleased to testify today on behalf of the Department of Veterans Affairs on services in the VA for women veterans. As the chairman said, I am accompanied today by Ms. Carole Turner, director of the Women Veterans Health Program, and Mr. Robert Epley, director of VA's Compensation and Pension Service.

As you are aware and as the prior witnesses have testified, the role of women in the military has changed dramatically over the last 99 years. As women have taken on more responsibility in the service and demonstrated their competence in performing a wide array of duties, more and more military occupational specialties are open to them. As a result of these changes, today's women comprise a significantly larger percentage of the active duty force than ever before in our history, and this change will ultimately be reflected in the veteran population.

The 1998 report of the Advisory Committee on Women Veterans, including VA's response to the recommendations contained therein, was submitted to Congress in May of 1999. The report included 42 recommendations. VA concurred with or supported the intent of 36 of the recommendations and did not concur with 6. The rationale for VA's nonconcurrence is included in the Department's formal response to the Advisory Committee, a copy of which is attached to my formal statement.

The primary concerns of the Advisory Committee, as reflected in the 1998 report, were:

One, the future of VA programs for women. Current enrollment figures indicate that approximately 5 percent of enrolled veterans

are women. This disparate ratio of men to women in VA facilities presents specific problems for the women veteran population utilizing VA. But the development of specialized in-house women's services is not seen as an optimal method to provide cost-effective quality health care in every facility.

With VA's shift from disease-oriented specialty care to holistically oriented primary care and with their shift from hospital-based care to community-based care, the trend has been to mainstream some specialties, including women's health, into primary care clinics or teams. And I would like to underscore here that that does not mean that services will not be provided, just that they will be provided perhaps in a setting that is different from what has evolved over the last 15 years.

Recognizing that women's health care delivery in VA does require further evaluation as the system changes the manner in which it delivers care, the VHA, in collaboration with the Center, has established a task force to assess the current status of women's services in VA and provide recommendations to assist management in developing cost-effective programs that will be responsive to the needs of the women veteran population.

Number two, the elimination of the sunset provision from VA's Sexual Trauma Counseling Program. This was addressed, I believe, in Public Law 106-117, the Millennium Health Care and Benefits Act, which extended the authority for VA to provide this counseling through December 31, 2004.

The enactment of legislation authorizing VA to provide sexual trauma counseling services to National Guard personnel and reservists who encountered such experiences while on active duty for training. As you are all aware, Title 38 does not include reservists on active duty for training in the definition of veteran. However, again, in Public Law 106-117, the Congress asked VA to establish a task force in collaboration with DOD to assess the extent to which members of the Reserve and National Guard experienced sexual trauma while on active duty for training and the extent to which these services would be needed. We anticipate the findings of that task force will be reported in March of 2001.

Four, the amendment to authorize special monthly compensation for women veterans who have undergone mastectomy. We are aware of the legislative initiative that has been put forward in the House and the Senate, and the administration has testified in prior hearings and is in support of that legislation.

Services for women veterans who are homeless. As you have heard from the other witnesses, during this fiscal year VA allocated \$3 million to support the development of demonstration programs designed to meet the treatment and support service needs of women veterans who are homeless. Eleven VA facilities have been selected to receive funds in support of their proposed program, and to address the concerns that have been expressed by other members, we have worked with VHA and with the homeless programs, and in keeping with the intent of GAO, all of those programs will be funded for a minimum of 18 months, and we have developed a task force to look at the outcomes and the efficacy of the interventions that are incorporated into the programs to determine the best use of money to continue those programs for the full 3-year period.

As I have indicated, most of the issues identified by the Advisory Committee in the 1998 report have been addressed and in some cases resulted in subsequent programmatic or statutory amendments. Later this month, the Center for Women Veterans, in collaboration with the Disabled American Veterans and the White House Office on Women's Outreach and Initiatives, is sponsoring a national summit on women veterans' issues. The summit is designed to provide representatives from the women veterans' community and other interested individuals with a forum to discuss their current initiatives for women veterans, identify the concerns of the women veterans' community, and share ideas on how to improve services to women veterans.

I am pleased that staff members from both the House and Senate Veterans' Affairs Committees have agreed to participate in a panel presentation during the summit, and we truly appreciate their support.

In conclusion, let me say that VA is grateful for the work of the Advisory Committee on Women Veterans. Its activities and reports play a vital role in helping the Department assess and address the needs of this deserving population.

Mr. Chairman, this concludes my formal testimony, and my colleagues and I will be pleased to answer any questions you or any member of the committee may have. Thank you.

[The prepared statement of Ms. Furey, with attachment, appears on p. 70.]

Mr. EVERETT. Well, Ms. Furey, thank you very much for appearing today and for your testimony. According to the 1999 Women's Patient Privacy Survey, 25 percent of VA medical centers apparently do not have or are not in the process of developing programs and policies addressing patient privacy issues. If you will, please explain. Is that as bad as it sounds to me?

Ms. FUREY. Well, what you say is true, sir. The 1999 survey did address that. I guess the good news is that in the 1997 report that number was about 66 percent. So we have certainly seen some significant improvement in a short time.

I can also tell you that in the 1999 survey the facilities were asked for their plans, and the projection is that those deficiencies will all be addressed by the end of fiscal year 2001.

However, I can assure that the Center will continue to monitor the progress of that and that in October we will do a follow-up to be sure that, in fact, progress is being made to decrease these deficiencies and that the 2001 target date will be met.

Mr. EVERETT. Let's go a little further on that. For the record, please provide the subcommittee with a list of the VA medical centers that make up that 25 percent.

Ms. FUREY. Yes, we would be glad to.

Mr. EVERETT. Do you agree with Dr. Schwartz's testimony that services and programs for women veterans are eroding?

Ms. FUREY. I think that is a difficult question to respond to. I think there is no question that VA services for women veterans are changing in the way that they have been delivered following many of the changes that started in the mid-1980s, the development of women's clinics and primary care teams.

As I think the members of this committee are aware, there has been a dramatic reorganization of Veterans Health Administration that has resulted in an increase in community-based outpatient clinics and a move away from hospital-based care, away from, as I said in my testimony, disease-oriented care to primary care.

As a result, some facilities—certainly not all facilities—have chosen to try to mainstream women's health into the primary care. Now, there is no question that there is a debate about how well that is working and whether or not that is the best way to do that.

In response to that, my office has worked with VHA and with Ms. Turner's office in developing a task force to really look at this issue. What is the best way to do this in the new system that will both address the needs of the women veterans, their concerns about safety and privacy, the issues about the skill level of the clinicians, and at the same time, help us to move forward with the reorganization and move to community-based care.

Mr. EVERETT. Thank you very much. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

First of all, let me say that I am disturbed about VA's dismantling of services to women veterans. You said the development of specialized in-house women's services is not seen as a method to provide cost-effective quality care in every facility. You also say that it is a difference of opinion between providers and consumers about what you call the impact of mainstreaming women's health into primary care.

This is a difference of opinion between VA officials and the veterans. I think you know which side Congress is on.

Women's health was mainstreamed 15 years ago, before I got here, and it did not serve the basic needs of women veterans. I am concerned about that mainstreaming again may be a way to get women veterans out of VA by sending them to contract providers.

Women veterans deserve the care they need to be available in VA's facilities. It does not matter that there are fewer women veterans than men. They need the care they need, the way veterans with brain injuries or spinal injuries, who are also few in number, deserve specialized care. I expect to follow the work of VHA task force on women's services very closely.

With that, I have a few questions. I think you spoke at the beginning of your testimony on mainstreaming in some of those facilities. How many?

Ms. FUREY. I am going to ask Ms. Turner from VHA to respond to that.

Ms. TURNER. Yes, good morning. As far as a number, unfortunately, I am not able to give you that this morning. However, we will take a look at that and provide that information for you.

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

In FY 1997, there were 97 separate women veterans' clinics or teams that provided primary care. In FY 1998, there were 92.

Source: FY 1998 Women Veterans Health Service Survey.

Ms. TURNER. With regards to mainstreaming, I think what we are looking at is not necessarily contracting services out in total. What we are talking about when we refer to mainstreaming is shifting the emphasis of care, as we are in other specialty clinics

as well, into the general internal medicine type of milieu. So when we talk about mainstreaming, we are, in fact, providing services for women, however, in a different milieu within the Veterans Administration.

Very often, in this mainstreaming, many of the primary care clinics that are now delivering services to women veterans have gone forward with designing special accommodations by way of separate waiting areas for women or even designating special days within the week that women veterans will receive services so that they feel that their privacy and security issues environmentally are being met. And we have also looked at incorporating into the primary care teams specialists in the area of women's health to serve as consultants as well as deliverers of care to women veterans.

So we are not necessarily mainstreaming outside of the system or contracting. What we are doing is mainstreaming with regards to the delivery of primary care in the direction that the VA as a whole is going.

Ms. BROWN. I hope—maybe we need a better word than “mainstreaming.”

Ms. TURNER. Okay.

Ms. BROWN. I am very aware of what has been going on in the past in the different facilities because I have physically gone in there. I have gone into facilities where women didn't have the privacy for an exam or didn't have needed facilities. So, you know, I have seen VA come a distance, but we need to go further. Maybe the right word is not “mainstreaming,” when you indicated that some facilities have certain days for women for services, certain specialized service. So I would like to see more integration in making sure that women are served.

Why don't I just yield now? Maybe I can come back for another round.

Mr. EVERETT. Certainly.

Lane Evans, our ranking member on the full committee.

**OPENING STATEMENT OF HON. LANE EVANS, RANKING
DEMOCRATIC MEMBER, COMMITTEE ON VETERANS' AFFAIRS**

Mr. EVANS. Thank you, Mr. Chairman. I would like, if you agree, to have my full statement entered into the record.

Mr. EVERETT. Without objection.

[The prepared statement of Congressman Evans appears on p. 27.]

Mr. EVANS. I just want to say a few words about the tireless advocate for women veterans who is leaving us, and that is Linda Schwartz. I came to the Congress and Linda came to the larger veterans' movement at about the same time, and, of course, even then, we had troubles about the women veterans, according to surveys of women veterans, having problems identifying themselves as veterans. They didn't think they were entitled to that status. I think because of Linda Schwartz and all she has done, we have moved beyond that and helped a lot of people with the problems that they face.

When I first came to Congress, we didn't have hearings on women veterans, so that alone, I think, is an indication of how hard she has worked. I salute her. We never quite let one go, and

we are going to draw on your expertise in the future. I just want to congratulate you for the nearly 20 years that you have been fighting for women veterans.

Thank you.

Mr. EVERETT. Thank you, Mr. Evans.

Ms. BROWN, do you have additional questions?

Ms. BROWN. Well, I think you heard of a summary before, and you spoke about some things in your testimony, for example, homeless veterans. You said something about 18 months. I know that several Members of Congress sent a letter to you all asking that you extend this to 3 years. I guess if we can't get it through administration, then we have to try legislation, because the intent was that we would run these programs for 3 years to see how the program was working.

Do you want to respond to that?

Ms. FUREY. Yes, I can respond to that, Madam Congresswoman. The initial proposal which we originated did recommend a 3-year pilot. I think you are probably aware that—and I don't know the exact date—but not too long ago, the GAO put out a report that was critical of VA homeless programs because of their failure to have outcome measures and study the effectiveness of the programs, whether they are really doing anything.

I think with our program, the proposal that we have done with women—and I am very proud of it, that we are funding it, because it is a little unique. And as you mentioned in your earlier statement, we do have an issue with women veterans that is more common than with male veterans who are homeless, which is the child care issue. And because VA is, you know, prohibited from using appropriated funds to fund any kind of programs for children, we really wanted to design our demonstration projects in a way that women who did have dependent children might be able to receive some assistance from VA.

So the 11 demonstration projects will all have a community component with community agencies that have experience and a track record in providing care for women and for women with children, and that will work with us in using their community-based funding to support the children of women veterans who are homeless and with children. So they will not be excluded from this program, and that is a very important point that I wanted to make.

In any event, to get back to the GAO testimony, when we met with VHA to discuss our wishes for the 3-year pilot, they did point out that they did need to have some idea of whether or not the money was being used to achieve good results. So we have worked with the network office. We have set up a joint task force which has people from VHA, from my office, and from the network, as well as some outside consultants with expertise on the homeless. We are going to be setting up criteria by which to measure at the end of 18 months how successful these programs have been. Have they identified the women? Have they brought them into the programs? Have the women made some kind of successful transition within an appropriate time frame? And do the programs actually seem to be working and doing what we anticipate them to be doing?

We have had assurances that if there is an indication that that is happening, those programs will continue to be supported for the full 3 years. And our hope is, in fact, that the demonstration projects will be successful and then, in fact, will be replicated in other areas to actually increase services for women veterans who are homeless even more so.

Ms. BROWN. I thought you said in your testimony it was 18 months. I know a year is definitely not enough.

Ms. FUREY. No, no. What we have negotiated is different from what some of the initial concerns that Dr. Schwartz and some of the other witnesses testified to. We have entered into an agreement now with VHA, and they have agreed to fund these programs for 18 months.

Ms. BROWN. Okay.

Ms. FUREY. At the end of 18 months, we will evaluate each project, and if the program has met all the criteria, they will be funded for the remaining 18 months.

Ms. BROWN. For the remaining 12 months, or an additional 18 months.

Ms. FUREY. Right, exactly. So it comes to 3—actually, I think if they continue to work, they'll be funded indefinitely. I think that is really what—

Ms. BROWN. And I just have one other quick comment. You noted with that comment that last year Congress extended VA's authority to provide sexual trauma counseling through 2004. Why does VA keep considering sexual trauma counseling as something it will do only if Congress requires it? I think that is part of the problem that we have in VA, the culture of not understanding that this should be a particular of the services that are provided to women and in some cases to men.

Ms. FUREY. Yes, I think it is not so much that VA requires Congress' authority to provide the counseling. If I am not mistaken, what Public Law 102-585 did was give VA the authority to not use the normal criteria for eligibility to access counseling. So that, in essence, any woman veteran who states she was assaulted while on active duty automatically can receive the counseling, regardless of the length of time she served on active duty, regardless of her service-connected status, regardless if she can prove the allegations. And that is what the legislation allows us to do. It gives us much broader authority. Without the legislation, we would still provide the counseling, but, again, we would have to look at the eligibility status, the category, and fall back into the normal thing which says if you did not serve—I think it is 240 days or—that you would not be eligible.

So that is really what the issue is with what Congress has authorized.

Ms. BROWN. Thank you. And, in closing, Mr. Chairman, I think that this is an area—we haven't had a hearing since 1994. I think we should have yearly hearings as far as the progress of women veterans is concerned.

Thank you, Mr. Chairman, for scheduling this hearing.

Mr. EVERETT. And I thank you for your input. I want to thank all our witnesses today for giving the subcommittee the benefit of their testimony.

Overall, I am encouraged by the VA's attention to the needs of women veterans in both benefits and health care services. However, the pace of improvement can reasonably be expected to be faster, and the VA apparently has some stragglers among the medical centers that didn't get the message, or in many cases that we found out, simply ignored messages.

Congress expects the VA to provide, directly or by contract, the same level of services for women veterans that it does for male veterans and to budget its resources accordingly.

This hearing is adjourned.

[Whereupon, at 12:09 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, COMMITTEE ON VETERANS AFFAIRS

Thank you, Mr. Everett and Ms. Brown, for holding this hearing today. From our Nation's beginning to the present, women have answered the call to duty without hesitation, though their service was never required and often not wanted. Like their male counterparts, they put their lives, their goals, and their dreams on hold to preserve their Nation.

Women's participation in the military dates back as early as the Revolutionary War. In June of 1778 at Monmouth Courthouse a woman known as "Molly Pitcher" came to the aid of General Washington's weary troops. Moving across the battlefield binding wounds and dispensing water, she took over a silent gun position and fired its cannon until relieved by artillerymen.

As many as 400 women are believed to have served during the Civil War, disguised as men or acting as spies. Dr. Mary Walker signed up as a nurse because she was excluded as a doctor. She became a prisoner of war before being allowed to practice as she was trained to do, and was ultimately accorded the Medal of Honor.

During World War I 34,000 women served as nurses in the armed forces. Three received the Distinguished Service Cross in combat. Another 23 received the Distinguished Service Medal, the highest non-combat award. Some 38 women gave their lives and were buried overseas in U.S. cemeteries.

In World War II, Congress passed laws establishing the Women's Army Auxiliary Corps, the Navy Women's Reserve, the Marine Corps Women's Reserve, and the Coast Guard Women's Reserve. Roughly 350,000 women served in the armed forces in virtually every occupation outside of direct combat.

The record of women's service to the Armed Forces does not stop with these early wars. Women served in every branch of the Armed Forces during the Korean War. Some 265,000 women served during the Vietnam War and approximately 35,000 women served during the Persian Gulf War. They shared two things—they all volunteered and they had a desire to serve their Nation.

None of us who have served in our country's armed forces will ever doubt the importance of the service of women in the military. Accounting for an increasing percentage of those in uniform today, women now hold positions of leadership and achievement few would have predicted as recently as World War II. The brave women who have served, and who continue to serve this Nation, deserve our respect and gratitude. Equally, women veterans are increasing among the ranks of all veterans. The debt we owe them for their individual and collective contributions to our Nation is significant. I am eager to learn how we can continue to be of service in meeting their needs.

I would particularly like to commend and welcome Dr. Linda Spoonster Schwartz, Chair of the Department of Veterans Affairs Advisory Committee on Women Veterans. Congress adopted legislation in 1983 forming the Advisory Committee because it was clear that VA was not meeting the needs of women veterans.

For the most part, the alliance of Congress, the Advisory Committee and the VA has made significant strides to transform the delivery of health care, in particular, and benefits so that the equality and the great service of women veterans can be honored. Last fall, for instance, in the Veterans Millennium Health Care and Benefits Act, Congress extended the VA's authority to provide sexual trauma counseling through December 31, 2004. This program needs permanent status.

We have more to do. The Advisory Committee's 1998 report made 42 specific recommendations for improving VA's delivery of services to America's 1.2 million women veterans. By my count, VA concurred with only 21 of them, and "non-concurred"—disagreed—with another six. Today we will explore these recommendations

and VA's responses to them, as well as issues that have come into focus since the 1998 Report was issued. I am also concerned about reports that VA is dismantling services for women veterans that have taken a long time to create, with no indication that they are unneeded.

The House Committee on Veterans' Affairs needs to review both the substance and the status of the Advisory Committee's recommendations periodically. The last time the Committee held a hearing on the needs of women veterans was when I chaired the Subcommittee on Oversight and Investigations, back in 1994. I commend Ms. Brown for pressing for this hearing, and I thank Chairman Everett for agreeing to hold it. I hope we will hold another hearing on women veterans next year, as soon as we have VA's responses to the Advisory Committee recommendations that will be written this summer.

TESTIMONY PRESENTED

By

Linda Spoonster Schwartz RN, MSN, DrPH

Associate Research Scientist

Yale University School of Nursing

Chair VA Advisory Committee on Women Veterans

Before

**Subcommittee on Oversight and Investigations
Committee on Veterans Benefits**

June 8, 2000

Linda Spoonster Schwartz RN, MSN, DrPH

Subcommittee on Oversight
And Investigations
June 8, 2000

Good Morning Mr. Chairman, I am Dr. Linda Spoonster Schwartz, Associate Research Scientist at Yale University School of Nursing. I also have the honor of serving as Chairman of the VA Advisory Committee on Women Veterans during the period of the 1998 Report. I would like to thank you for holding these hearings and for your support of women veterans. I would especially like to thank Congressman Lane Evans for his continued leadership in introducing legislation, which has improved VA services and programs and significantly enhanced the quality of life for America's 1.2 million women veterans. It is my understanding that the focus of today's hearing is the 1998 VA Advisory Committee on Women Veterans Report. It is indeed a pleasure to be able to address the specific recommendations made by the members of the Committee and VA's responses to those proposals.

As you know, the Advisory Committee was authorized by Congress in 1983 to assess the needs of women veterans with respect to compensation, health care, rehabilitation, outreach and other benefits and health care programs administered by the Department of Veterans Affairs. Additionally, the Committee was empowered to make recommendations for change and entrusted with the responsibility to evaluate these activities and report progress to the Congress in a biennial report. From that time to this, Committee members and advisors from all walks of life and all parts of this Nation have collaborated to improve the status of services and programs and assure that women veterans receive quality and gender specific care in a safe and secure environment.

It has been more than 15 years since I first came to this Hearing Room to voice the concerns of women veteran to this Committee. In that time we have seen great change. We have graduated from a time we did not know the exact numbers of women veterans in America to a time when women constitute the fastest growing population of VA eligible veterans. An increase which is also reflected in the increased numbers of women, who are using the VA today.

Outreach

No doubt you have noticed that a common theme that runs through a majority of the recommendations in the Report has to do with the continued need for outreach and educating women about their eligibility for VA services and programs available to them as veterans. While many good efforts have been made on the local and national level to identify women veterans, the truth is that after 15 years outreach remains the number one priority for our Committee. We feel that new approaches need to be instituted to assure that women veterans are not lost in the system and that they receive the benefits that Congress, in the name of the American people, has authorized for them.

We have suggested that an orientation to VA programs and services be incorporated in basic military training. As a disabled veteran with 16 years Active Duty and Reserve military service, I can tell you I had no idea what the VA could do for me. At the time of my injuries, I was so impaired, I could neither think nor act on my own behalf. Everyone told me the "Air Force takes care of its' own "but no one told me what happens when you have to leave the service for medical reasons. We believe that it is important for all military members, from day one of their service, to know and understand how to access their VA benefits.

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Additionally, we have suggested that it is important that DOD Healthcare Providers be oriented to the VA Compensation and Pension Programs. We believe that instructing DOD Healthcare Professionals about the criteria for care and process of compensating military veterans will lay a foundation for a better understanding of the continuum of care for disabled veterans. We see that this will ultimately improve the quality of the documentation of injuries and illness incurred while on Active Duty and assist VA in making accurate and valid compensation decisions.

Additionally, we recommended that VA use the medium of professional medical nursing, social work and psychiatric journals to inform healthcare providers in the public sector about the availability of VA benefits and programs. This is especially important for women veterans, who still are unaware that their military service qualifies them for VA health care. With the increasing numbers of women entering the military, the restructuring of America's welfare system and VA eligibility criteria that can change from one year to the next, it makes sense to educate health care professionals in private practice about the array of services and benefits available to veterans and the criteria for eligibility for these programs. As VA looks for more local venues to provide health care to veterans, it is important that non-VA professionals understand the unique needs and experiences of the men and women who have served in the military. The articles we suggested would be informational and will also assist health care professionals in the public sector to identify veterans and make appropriate referrals to VA.

In that same vein, the Committee has suggested that asking questions about veteran status on intake forms for federally funded social service programs and research projects would help identify veterans and their utilization of public support systems. This very procedure has been suggested by providers of services to homeless veterans to assist with outreach, allocation of resources and the development of community based programs. Instituting this process in a wider spectrum will not only facilitate needs assessments and delivery of services; the information can be used by VA for strategic and health care planning and policy.

Members of the Selected Reserve and National Guard

Today, members of the Armed Forces Selected Reserve and National Guard are an integral part of the defense of this nation. The demand on Reserve and National Guard units is great and not likely to decline in the near future. The issues, needs and concerns encountered by these "Citizen Soldiers" after incurring an injury or illness in the line of duty or while mobilized and/or deployed are difficult to address because of the precarious status of these individuals in relation to the military and VA eligibility.

The Committee put forth several recommendations regarding the benefits and informational needs of members of the Selected Reserves and National Guard. It is important that Congress assess the utilization of these troops in the defense of our nation and initiate measures which will protect these individuals when they are deployed, when they are injured in the line of duty and when they are injured while on in active duty for military training. We are very much aware of VA's position that veteran status depends on the number of continuous Active Duty days.

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As a Retired Air Force Nurse and Reservist, I can tell you that I had to meet the same training requirements as my Active Duty counterparts. There was no compromise of mission readiness in my unit because we were not on Active Duty. I can tell you something else, Reservists on inactive duty training are injured, they bleed and they have to deal with returning to a civilian job that often has no sympathy. I can tell you that Insurance Companies will not take care of them because their injury was sustained under provisions, which consider all military service to be "an act of war".

In my travels as Chair of the VA Advisory Committee on Women Veterans, I have listened to Reservists pose these very same concerns in several meetings. For them the issue of health care while they are in uniform and for their families when they are deployed is a major concern. Military Training is an integral part of the defense of this nation. It can be as dangerous as a combat mission. That is why it is imperative that the men and women serving in the Reserve and National Guard and their Commanders need to be educated about the process required to establish VA eligibility and access to care for disabilities sustained in the line of duty.

This issue of VA eligibility emerged as our Committee reviewed the eligibility for Reserve and members of the National Guard who are victims of sexual assault while on In-Active Duty status. As we learned more about the problem, we realized that this state of affairs is not only a women veteran issue nor is it solely a veteran issue. We believe that adequate health care for members of the Reserve and Guard components of America's Armed Forces injured while on military duty is an issue of national security of sufficient importance to warrant the attention of Congress.

Sexual Trauma Counseling

Since the problem of sexual assault and trauma in the military was first identified, VA has made a sterling effort to implement quality treatment programs through the Readjustment Counseling Service (RCS) and Veterans Healthcare Administration (VHA). Year after year, VA, Veteran Service Organizations, and veterans have returned to Congress to request a continuance for the present program. Surely by now, this Committee is aware that the need for this treatment program will persist as long as incidents of sexual assault and trauma continue to occur in the ranks of our military. For all practical purposes, this problem is not going away.

Indeed, there is no question that there is sufficient utilization of VA resources committed to treat veterans who were victimized while in the service of their country. Women of all ages and periods of service continue to seek assistance from VA for the physical and emotional aftermath of these traumatic events. The burning question to this Committee is why hasn't this become a permanent program of the VA? As more is learned about the dynamics of sexual assault and trauma in a military setting, it is unquestionably a moral and ethical responsibility of the Congress to eliminate all restrictions and time limits on the VA's authority to provide care to those who are victimized while in military service.

As noted earlier, under the current provisions of Title 38, VA is prohibited from providing sexual trauma counseling to Reserve and Guard personnel, who experience a sexual assault or trauma while on inactive duty training days because this does not satisfy the legal definition of Active

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Duty. It is important to note that incidents of sexual misconduct and victimization are not limited to Active Duty Personnel. The very sensitive nature of these incidents often delay victims from coming forward which complicates documentation, adequate reporting and therapeutic interventions. This is especially true for Reservists and National Guard personnel who may experience one of these assaults during a weekend drill. We understand that a legislative remedy is required to effect these changes. We encourage this Committee to consider this situation and devise a just and fair means of providing access to VA care to Reserve and National Guard personnel injured or assaulted on non Active Duty training days.

Mastectomy

I would like to thank Congressman Lane Evans and Congresswoman Shelley Berkley for taking the initiative to introduce this legislation, to amend Title 38 of the US Code Section (USC) 114 (k) and 38 Code of Federal Regulations (CFR) Section 3.350 (a) to include a Special Monthly Compensation K-award for veterans who have survived radical or modified radical mastectomy of one or more breast. The Committee felt this recommendation was in keeping with the spirit and intent of the existing law, which also authorizes an additional compensation for, the loss of both buttocks, loss of sense of smell as well as the loss of or loss of use of one or more extremities. The tenor of the present language to the law is one of compassion and concern for a veteran who has sustained an anatomical loss or loss of one of the vital senses.

In this case, the Veterans Benefits Administration of the VA did not concur with the recommendation on mastectomies. This is not the first nor will it be the last time advocates for women veterans will encounter policies, regulations, or legal barriers, which constrain VA ability to respond to women veterans. We appreciate that some of the laws and regulations for compensation were codified long before women were an integral part of our Armed Forces.

It is the Committee's belief that radical and modified radical mastectomies involve a loss comparable to those presently covered by Title 38 and should qualify for the "Special Monthly Compensation K Award". For women, the outcome of these procedures frequently results in severe physical disfigurement which necessitates major reconstructive surgery and/or the use of prosthetics. In addition to the loss of physical integrity, the loss of a breast to a woman is the loss of an identifying feature, a secondary sex characteristic and a part of her persona as a female.

Mastectomy and the post-operative treatment for cancer can also precipitate premature menopause and infertility. Especially striking is the American Cancer Society report that one out of 3,000 American women who are pregnant report a diagnosis of breast cancer. VA Reports note that there is an increased number of eligible women veterans of childbearing age using health care services. Thus, we see that these dynamics pose real questions about the loss of a breast in the reproductive/creative process.

In addition to the question of breast-feeding and the ability to nurture a newborn, several factors may place a woman at higher risk for sexual problems following a mastectomy. There is the question of the loss of body image that comes with the loss of a breast and how that affects the ways in which a woman views herself and her body- her self-esteem, her hopes and fears and her

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place in society. There is the question of sexuality and how she will relate to her partner and express love physically and emotionally.

Psychological responses to the losses that mastectomies pose for women may persist long after the surgical procedure and physiologic recovery. Presently VA does have provisions for the care and treatment of psychological problems following mastectomy. However there is no additional increase in percent of disability of compensation. There is a need for VBA to review the present Schedule, which grants the same compensation for mastectomy to a man and a woman. The degree of loss is not equal. This is another challenge for the VA system to begin to officially acknowledge that the physiology of a woman does differ from that of a man and needs to be considered from a holistic perspective.

Children of Women Veterans Who Served in Vietnam

The recently completed and published VA study on the Reproductive Outcomes and Birth Defects of Children born to women veterans who served in Vietnam has evoked great interest in the Congress. We again thank Mr. Evans for his leadership on introducing legislation to compensate and care for children severely impaired by birth defects. We welcome these legislative initiatives and look forward to the day this program will begin to help the innocent casualties of the Vietnam War. However, I would be remiss if I did not say that in all fairness, our attention must now turn to investigating the problems of children with birth defects that were fathered by male Vietnam veterans. It is abundantly clear that the often cited Air Force Health Study, better known as the Ranch Hand Study, is should only be used to gauge the health of that particular group of Vietnam veterans. It is not an accurate reflection of the health status of the health and reproductive outcomes experienced by the majority of the men who served in Vietnam. For all practical purposes, there is no study of birth defects in children born to the men who served in Vietnam. In view of the pending legislation regarding women who served in Vietnam, this Committee must consider a comparable study of the birth outcomes of children of the men who served there.

One cost effective option that should be considered in revisiting the National Vietnam Veterans Readjustment Study (NVVRS). The strength of the study was the three comparison groups: Vietnam veterans with Era veterans and civilians. Congress used this study to estimate the needs of Vietnam veterans 11 years ago. We have suggested that returning to the NVVRS study subjects now would be extremely informative and valuable as a longitudinal look at how this generation of veterans has experienced the 25 years since the end of the war.

Women Veterans Who Are Homeless

Women veterans who are homeless also have needs and problems that vary from those of male veterans who are homeless. These challenges range from privacy and childcare to treatment for physical and sexual abuse and prenatal care. It was with great enthusiasm that we welcomed the news that Congressional funding had specifically been set aside for programs for women veterans who are homeless. As we eagerly awaited the initiation of the process that would bring these vital programs on line, we witnessed yet another cruel reality of the "One VA".

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The announcement that VA will be able to fund 11 projects for women veterans this year is a hollow victory. I say hollow because there is only one year of funding guaranteed for these programs. There is no question that VA's Mental Health Strategic Health Care Group and the Homeless Provider Grant and Per Diem Program have achieved significant progress in meeting the needs of veterans who are homeless. However like several other "Special Programs" authorized and funded by Congress, the importance placed on these initiatives is lost in the maze of funding mechanisms that characterizes the bureaucracy of the "One VA".

When VA's Internal Policy Board ruled that money authorized for the Homeless Grant and Per Diem Program had to be spent in FY 2000 or it would revert back to the General Fund, the legislation passed by Congress to assist women veterans who are homeless was vetoed de facto. As a part of the RFP, VISN Directors were required to make a statement that if funded, they would commit, despite the availability of one year of funding, to keeping the program operational for 3 years. It is not difficult to see why some would be reluctant to make that guarantee. It has come to our attention that although sites for the funding are identified, VISN Directors are hedging their bet by using the money for temporary positions with no guarantees of employment for more than 12 months. Mr. Chairman, this is not the program we envisioned. I don't think it was the program Congress intended. However this is the program as it stands now.

In the past, money for special programs were "fenced" to assure that programs authorized and funded by Congress would be used for that purpose only. Funding streams at VA have been reduced to the level of a "shell game". Now you see it, now you don't. Where did it go? Is it in the new furniture for the Directors office? Is it in a slush fund for discretionary project? Did it pay for someone to go to a Conference? We ask this Committee to take measures to protect this funding, preserve these valuable programs and in essence protect veterans with special needs.

Invisible Veterans

I remember my first Hearing on the VA in this room. The major topic that day was cosmetics in the VA Canteens. Now we have progressed to inquiry into the compensation for women veterans who are homeless and mastectomies. It has taken a great deal of effort on the part of Congress, Veteran Service Organizations and VA to increase the quality of benefit and health care delivery to women veterans. While it is important to note the many improvements that have occurred in the last 20 years, there is also evidence that there is still much work to do.

I was particularly disappointed as I read VA's responses to the recommendations made by the Women Veteran Advisory Committee. For example the response to our recommendation that "**all studies and surveys funded or conducted by VA must include gender specific information**" was answered with a statement that "**women can be expected to benefit from a much wider range of VA research studies. This seems to be a reasonable assumption given that many biological processes are common to both men and women**" seems quite enlightened given the state of science in the 21st Century. That VA would state for the record that "**In the 1997 Women Patient Privacy Survey.... two thirds of the VA medical Centers responded as either having or in the process of developing programs/policies addressing**

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patient privacy issues" is also disappointing given the fact that for the past 20 years protecting patient privacy has been the main thrust of our efforts and concern for women veterans in VA health care settings.

These responses coupled with observations made by the Committee on our site visits to specific facilities and VISIN's, indicated that services and programs for women veterans are eroding. There is no doubt that there is a pervasive and disingenuous attitude that programs for women veterans are "window dressing" trivial or optional. We have encountered these sentiments at every echelon of the Department of Veteran Affairs. It is amazing how much the decision by a Chief of Staff, not to fill the position of a Gynecologist in a facility that served over 3,000 women veterans a year, can effect the overall functioning and efficacy of a successful program. We have also noted the funding of two Residencies in Women's Health in a facility that does not even have a Woman's Clinic. These are decisions that are not always made at the "Top". However they do illustrate that many only pay lip service to providing quality care for the women who have served in the Armed Forces of this Nation.

I know that this Committee has already acted to assure that the biannual reports of the VA Advisory Committee on Women Veterans will continue to be forwarded by the Secretary of Veterans Affairs to the Congress. I believe that the stewardship of the responsibilities charged to the members of the Advisory Committee have been well served in the years since it was authorized. I also hope that the proceedings of today's Hearing are not only informative but also provocative enough to warrant your attention and action.

Mr. Chairman, this concludes my testimony. I will be happy to answer any of the Committee's questions.

STATEMENT OF
JACQUELINE GARRICK, ACSW, CSW, CTS
DEPUTY DIRECTOR, HEALTH CARE
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

VA SERVICES FOR WOMEN VETERANS

JUNE 8, 2000

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to participate in today's hearing. Since The American Legion's inception in 1919, women veterans continue to service in positions of leadership at the community, state and national levels of the organization. Women veterans could vote or run for National Commander of The American Legion before they were eligible to vote for President of the United States!

The American Legion Guide: Women Veterans – Identifying Risks, Services and Prevention

Recently, The American Legion conducted a review of the services and benefits available to women veterans. ***The American Legion Guide: Women Veterans – Identifying Risks, Services and Prevention*** is a 16-page publication, is a compendium of women veterans' issues; availability of benefits and services; and tips in accessing assistance. This new guide is the first one-of-its-kind for women veterans gives meaning to the slogan, "Women are veterans too."

The American Legion developed this guide in response to VA's Psychosocial Rehabilitation's desire to conduct outreach to formerly incarcerated female veterans. The American Legion immediately recognized that incarceration was not the only risk women veterans might face. Other issues related to employment, education, child-care, housing and homelessness, harassment, domestic assault, rape, substance abuse, cancer, AIDS, environmental hazards and other illnesses are all issues affecting women service members and veterans. Women veterans do not always identify themselves as veterans, nor do agencies or systems providing services inform them of their earned

benefits and rights. The American Legion hopes that its guide will reach all women veterans to provide information of services available.

Center for Women Veterans

According to the Center for Women Veterans, there are approximately 1.2 million female veterans, and approximately 15 percent of the active duty forces are females. The number of female servicemembers is expected to grow upwards of 20 percent over the next several years. More and more women are seeking services from VA. The demographic make-up of women veterans and their demands for services vary from their male counterparts. Women veterans enrolling in VA today tend to be younger, better educated and less likely to be married. VA is primarily structured to meet the healthcare and benefits demands of an older, sicker male population. Therefore, women veterans are elbowing their way into the institutional consciousness of VA through the advocacy of The American Legion and other sister veterans service organizations. The culmination of this joint advocacy effort resulted in the passage of Public Law 98-160, which authorized the Advisory Committee on Women Veterans and the establishment of the Center for Women Veterans through Public Law 103-446.

The Center for Women Veterans, directed by Joan Furey, and the Advisory Committee for Women Veterans, chaired by Linda Spoonster Schwartz are to be commended for their dedication and contributions to improve the quality of healthcare and other services available for women veterans. It is through these efforts that we have come a long way in ensuring recognition and appropriate access for the special needs of women veterans.

In the wake of eligibility reform, VA developed its Uniform Benefits Package to include:

- gynecological care;
- mammography;
- osteoporosis screening and bone density treatment;
- menopausal care and Hormone Replacement Therapy (HRT);
- infertility services;
- tubal ligation;
- oral contraceptives; and
- maternity care, including labor and delivery (usually on a contract with a VA affiliated hospital.)

Mental health care includes counseling for sexual trauma. VA still does not cover abortion or new baby care. Women veterans can access this care through 130 women's clinics, Women Veterans' Coordinators, Vet Centers, and an expanse of VA Community Based Outpatient Clinics (CBOC) across the country. Yet, there are still areas of consideration that need to be addressed.

Advisory Committee on Women Veterans Legislative Recommendations

In its 1998 Report, the Advisory Committee on Women Veterans made 42 recommendations, five of those recommendations are pertinent to Congress:

- Require federally funded research to capture specific data about military service and war zone history for comparative analysis of the veteran and civilian population and publish outcomes and findings by gender.
- Authorize Selected Reservists and National Guard personnel who experience sexual assault, trauma, or harassment, while on active duty, to have access to VA counseling and treatment programs.
- Remove all time constraints and limitations on VA services and treatment programs for survivors of sexual assault and trauma. The Sexual Trauma Counseling Program must be made a permanent part of VA's Uniform Benefits Package.
- Require all federally funded social service agencies and other community based programs and organizations identify the veteran population that they serve to VA on an annual basis.
- Enact Medicare Subvention.

The American Legion views each of these legislative initiatives with merit and supports their enactment. These are necessary steps to ensuring that not only women veterans, but all veterans have appropriate access to information, services and care whenever they need it. The other recommendations made by the Committee pertain to VA, Department of Defense, Department of Labor, and other agencies.

The American Legion Legislative Recommendations

As an organization that has taken a leadership role in defending and protecting the rights of women veterans, The American Legion feels there are several other recommendations to be made to this Subcommittee:

- **Provide dependents with access to quality health care, as outlined in the GI Bill of Health.** This measure would benefit women veterans in two ways. First, it would expand access to spouses, thereby creating a greater demand within VA for gynecological care. This increased utilization and influx of resources would facilitate improvements in access points and specialization. It is a simple medical philosophy that teaches that the more patients treated the better at treating patients a provider gets. Secondly, women are usually the healthcare decision-makers in most households and with the increase in single parent families, women must have a health care plan that includes their children. It would also provide for a more comprehensive continuum of care, if after the birth of a child, a woman could easily access a well-baby program through the same management source. It is a disincentive to a parent or spouse to use VA when they cannot enroll their entire family. DoD recognizes this obligation and it is time for VA to follow suit.

- **Expand the homeless veterans grant and per diem program to be a three-year instead of a one-year program.** The current side effect of a one-year operating budget is that it acts as a disincentive to Veterans Integrated Service Networks (VISN) Directors to want to establish these programs in their networks. This becomes especially harmful to programs that would benefit women veterans, since there is a community-based need for women's housing.
- As Congress monitors VA to ensure it is maintaining capacity, the special needs of women veterans should be given careful consideration as well. Are the special programs giving due consideration to the unique needs of women in regard to privacy, specialization, equipment and prosthetics sizes, and educational services? The American Legion encourages capacity reporting include women veterans.

Mr. Chairman and Members of the Subcommittee, The American Legion greatly appreciates the opportunity to participate in today's hearing. The American Legion hopes that as the Center for Women Veterans and the Advisory Committee on Women Veterans move forward in their work, The American Legion will all be able to join forces to improve the knowledge and availability of services to this nation's women veterans. *The American Legion Guide: Women Veterans – Identifying Risks, Services and Prevention* is designed to contribute to the efforts being made to advance the cause of women veterans and get them to the services and benefits they earned.

The American Legion looks forward to the Summit on Women Veterans to be held in just a few weeks in Washington, DC. It views this as an additional opportunity to identify the unmet needs of this population.

Women are veterans too, but they must first know it and feel it.

Mr. Chairman that concludes this statement.

attachment

The American Legion Guide:

Women Veterans

Identifying Risks, Services, and Prevention

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"From the storm lashed decks of the Mayflower...to the present hour, women has stood like a rock for the welfare and the glory of the history of the country, and one might well add...unwritten, unrewarded, and almost unrecognized."

Clara Barton, February 1911



Women in the Military

American women have been great patriots, warriors, and healers for this Nation's military efforts from the Revolution to those in uniform today. Images of Molly Pitcher loading a cannon and the quill of the slave Phillis Wheatley are part of American history, just as the Yomenette of WWI, the WWII Women's Army Corps (WACS), the Vietnam nurse, and today's female pilots. American Women have answered the call to serve with the same honor and integrity as their male counterparts, but often do not identify themselves as veterans. However, these women *are* veterans too.

According to the VA Center for Women Veterans, there were approximately 1.2 million women veterans in America in 1999, and they made up approximately 15 percent of the active duty forces. This number is expected to grow upwards of 20-25% in the next few years. In a VA study on the health status of women veterans, Women using the VA were younger than the men (52 vs. 62 years of age), better educated, and less likely to be married.

In recent years, in part due to the public awareness raised through the Vietnam Women's Memorial and the Women In Military Service For

America (WIMSA) Memorial, women veterans are getting the recognition and attention they deserve. For too long, women were allowed to think that they were not veterans. If asked if she was a veteran, a woman would say, "No." But, if asked if she had ever served in the armed forces, she would say, "Yes." So, very often women were not properly identified as veterans, and were overlooked for benefits and services. The message to female veterans is getting out, but there is still much to be

There are approximately 1.2 million women veterans in America.

done in getting these veterans the services and treatment they need and deserve.



Transitioning from Active Duty

There are many reasons why women choose to join the military. Most join for the educational and health care benefits, and career opportunities. Very often, young people join the military seeking a better quality of life. They leave home filled with the hope that the military will provide them with the atmosphere they need to succeed. When these individuals separate from service or retire, they may lose the support, direction, and discipline the military provided. When they transition, it is often at the place of their last assignment, where they do not have the social or family supports they had before entering the military or while on active duty.

Many women, like their male counterparts, make the transition from active service back into their communities without faltering. The experiences they had while in the military go a long way to assist them in their careers and life goals as an advantage. However, for other men and women the transition is not as easy depending upon their experiences and community support systems. Although most people leave active duty feeling good about the decision to "get out," transitioning off of active duty can be a difficult time. Women veterans face unique challenges and conditions once

they transition from active duty back into the community.

There are many unforeseen challenges when leaving active duty. It is a major life event that requires planning. Retiring or transitioning can be a very exciting time, but if not properly planned can lead to complicated obstacles and difficulties in coping. Active duty should attend a Transition Assistance Program (TAP) class before leaving the military.

The American Legion recommends that women veterans consider the following issues and resources.



Women Veterans' Benefits Issues:



Women veterans are entitled to the same VA and DoD benefits as their male counterparts based on their service eligibility. Women veterans can file a claim with the VA for pension or compensation, as well as home loan guaranties, and educational benefits. Any veteran who needs VA assistance should contact an American Legion Department Service Officer in their state to file a claim. (See page 15.) There are several issues women veterans may need to consider as they transition from active duty, or if they seek VA benefits.

• Compensation and Pension

Any veteran with an other than dishonorable discharge who becomes ill or is injured while on active duty can file a claim for VA monetary compensation. VA rates service-connected disabilities from zero to 100% and is paid monthly. Dependents can be included in the monthly allotment. These benefits are non-taxable.

Pension is awarded to veterans who have low incomes, have had 90 days or more of active service with one day during a period of war, and have other than dishonorable discharges.

• Child-care

Without DoD medicine or **Tricare**, providing health care for children becomes a primary concern for parents. When retiring from active duty, it may be best to enroll in Tricare's family plan for \$460.00 a year, unless a job with benefits is already available. VA can only care for veterans, and is not currently authorized to care for dependent children (or spouses) of veterans.

• Homelessness & Housing

Among the homeless population in America today, approximately a third are veterans. In general, women are 15 percent of the homeless population. There are also more families being reported as homeless. Women veterans can be at risk for homelessness because of the lack of support they may encounter as they transition from active duty. Women are more likely to be primary care providers to children, and when they have trouble securing housing, not only are they at risk for homelessness, but so are their children. Women seeking shelter from abusive relationships are also at risk for becoming homeless.

There are VA Home Loan Programs and

Residential Treatment Programs that can assist veterans with their housing needs. (See section on VA Home Loan Guaranties and Psychosocial Rehabilitation.)

When buying a home, it is important for veterans to check on their state and county property tax laws, since in some states, disabled veterans and their surviving spouses are exempt from property tax.

• Employment

For all veterans who serve in a Military Occupational Specialty (MOS) that does not translate into the civilian marketplace, the ability to find an appropriate job can become difficult. Women who have served often face the difficulties of finding a job that matches the pay they had while on active duty. Data on salaries shows disparity still exists in the job market between pay for men and women. Women must consider their earning potential in the private sector as they leave active duty.

On the other hand, military service and training can go a long way in preparing a woman for the job market, and can be impressive to



prospective employers and supervisors. There are 105 professions that the military trains in that do convert to a civilian occupation. Therefore, women should always include their military service on their resume, (avoiding military jargon) and in filing out job applications.

The Department of Labor offers job-search assistance that is specialized for veterans. VA operates a Vocational Rehabilitation program for disabled veterans who want to return to the workplace. Federal civil service jobs will give "veterans' preference points." Any honorably

discharged veteran (grades Major and below) who has campaign medals or awards can be given a five point preference for hiring. Veterans who are service-connected at 30 percent or greater can be rated with a 10 point hiring preference. In some states, veterans' preference points are granted for state jobs, but it varies between the states. Women veterans should explore these options when seeking employment.

Special Note:

If a veteran was an Army medic or Navy Corpsman, she can use military training as a qualification for Emergency Medical Technician (EMT) employment. Military training records, a DD2586 file can be used to get an EMT certificate.



Keep copies of your DD214 in a safe place!

• Education



There are similar obstacles to finding a good job, as there are difficulties in obtaining the education and training necessary to get a good job. Often military training does not correlate to the requirements of a job in the private sector. So, even though a veteran may have performed the same job function while in the service, they are not qualified to perform that job in the civilian market. They may need to be re-trained or credentialed to meet industry, state, or federal standards that may be different from DoD standards.

However, military training, in some cases, can also be used to waive credit requirements with some universities or vocational schools. Proper documentation from the military will be required. Most schools have a veteran counselor who can offer guidance on these issues. An appointment should be made with one of these counselors before enrolling in any courses.

VA offers a variety of educational benefits depending upon when a veteran was on active duty.

Based on dates of service, veterans can participate in the Montgomery GI Bill, Vietnam Era GI Bill, or the Veterans' Educational Assistance Program.

Contact an American Legion Department Service Officer for more information on VA educational benefits and eligibility.



VA Education Programs:

- *Montgomery GI Bill*
- *Vietnam Era GI Bill*
- *Veteran's Educational Assistance Program (VEAP)*
- *Vocational Rehabilitation*

• Incarceration



According to the US Department of Justice (DoJ), in 1998, there were 84,427 women sentenced to state or federal prisons. Since 1990, the number of women incarcerated has almost doubled. In a 2000 DoJ report, the number of incarcerated veterans was about 225,700. The number of female veterans is about 1 percent of the total incarcerated veteran population.

Substance abuse and a history of violence place many women on the path to incarceration because the risks they take may also be illegal. Women tend to commit crimes (take risks) related to their survival. They are trying to cope, and often trying to provide for themselves and their children. Women, who have been

(Continued on page 6)

(Continued from page 5)

victimized in the past, are at risk for prostitution and other crimes to satisfy a partner (i.e. selling drugs, check forgery, robbery.)

Incarcerated veterans or their dependents may apply for the same compensation, Dependency and Indemnity Compensation (DIC), and pension benefits. However, there are restrictions if a veteran is incarcerated. If a veteran is convicted of a felony then she can generally only collect ten percent or less. Incarcerated dependents receiving DIC can only collect half the amount paid to a veteran receiving compensation for a ten percent rating.

Disabled veterans collecting VA compensation, who are incarcerated may not receive the same VA benefits as they did prior to being incarcerated. The veteran's dependents, however, may receive a portion of such benefits. If a veteran's family can show financial need then they may be able to collect an apportionment of the veterans benefit. An American Legion Service Officer can assist a family in filing a claim.

There is a 60-day grace period after a veteran is incarcerated when a veteran or their dependents can still collect full payments. Failure to notify VA of a veteran's incarceration will cause the loss of all financial benefits until any overpayment is recovered.

Once a veteran is released from a correctional facility, she should notify VA since she can resume collecting previous benefits.

80 percent of women veterans involved with the criminal justice system have children, even if they are the non-custodial parent. Efforts to return these women back into their communities as healthy productive members must include planning for their children.



Incarcerated veterans can still collect a portion of their benefits for their family. Notify VA when incarcerated, and upon release.

Women Veterans' Health Issues:

Once discharged from the military, veterans lose their health care coverage, but can enroll in VA. However, since women are often the primary caregivers of their children, they may need to seek other health care coverage that includes children. There are several important health issues that women veterans should be aware of and have checked periodically. The following medical conditions should be of major concerns for all women in America and veterans in particular.

• Heart Disease:

Heart Disease is the number one cause of death in American women today, but is the least discussed. One in two women or 44.4 percent will die of heart disease and stroke, compared with one in 27 who will die of breast cancer. This rate increases among African American women. Forty-two percent of women compared to 24 percent of men will die within a year of a heart attack. Post-menopausal women are more likely to have a heart attack.

Heart disease – or cardiovascular disease develops when the blood vessels or arteries that supply blood to the heart and brain become clogged from a buildup of cells, fat and cholesterol. This can lead to a heart attack or stroke.



RISK FACTORS FOR CARDIOVASCULAR DISEASE IN WOMEN VETERANS:

- **Age** – advanced age increases risk.
- **Hereditary** – including genetics and race. African American women are more prone to severe hypertension.
- **Cigarette and tobacco smoke** – smokers have twice the risk for heart attack and death than non-smokers. Second-hand smoke is also a risk factor.
- **High Blood Cholesterol Levels** – increased cholesterol levels are influenced by age, gender, hereditary, and diet.
- **High Blood Pressure** – causes the heart to work harder, thereby weakening it over time leading to stroke, heart attack or failure, or kidney failure. Risk increases in women who smoke, are overweight or have diabetes or elevated cholesterol levels.
- **Physical Inactivity** – lack of exercise increases risk. Any physical activity done regularly can help lower risk.
- **Overweight** – excess weight adds to the strain on the heart. It causes other diseases like diabetes. Being overweight by 10 or 20 pounds can make a difference in a woman's risk for heart disease.
- **Diabetes** – diagnosis increases risk for heart disease and stroke. Once diagnosed it is critical to control and monitor.
- **Stress** – Women veterans experience a variety of stresses ranging from daily living stresses and traumatic stress brought on by rape, domestic violence or war zone experiences. (See section on PTSD.)

• Sexually Transmitted Diseases:



Women who have been raped, have had unprotected sex, or are intravenous drug users are susceptible to being diagnosed with a Sexually Transmitted Disease (STD), or HIV/AIDS. VA operates an HIV/AIDS program that can help female veterans manage and control their disease.

• Environmental Health Hazards:

Women who served in a combat zone (Vietnam or the Persian Gulf) may develop illnesses related to environmental exposures, such as Agent Orange. The VA has conducted specialized studies on female Vietnam and Gulf War veterans and exposures, especially related to birth defects. Female veterans who fit into either of these categories should get an Agent Orange or Persian Gulf Registry exam at their local VA hospital.



• Cancers:

Women should be aware of their family history for certain conditions that can increase their risk for cancer. There are other factors that increase with age or lifestyle habits such as diet, drinking and smoking. Women should discuss these risks with their health care provider, and seek additional information for these diseases.

The cancers that most often effect women are **breast, lung, colorectal, endometrial, and ovarian and cervical cancer.** Breast

cancer is the primary cause of cancer-related death among American women. Early diagnosis and treatment can save lives. The VA offers screening for all types of cancers, including mammography and Pap tests. All women should have an annual gynecological exam each year, including a **Pap test.** Women over age 40 should get regular **mammograms,**



and yearly after the age of 50. Breast self-examination should be done monthly, so that any changes can be recognized early. (See breast self-examination guide on page 9.)

• Substance Abuse

Alcohol and/or drugs become a coping mechanism when stress, depression, and anxiety build. Women tend to become addicted to substances through the significant others in their lives. Individuals who grow up in an addictive environment are predisposed to becoming addicted themselves. In spite of new awareness in the military, it is still an environment that encourages drinking as a means of being a "team player." In a male dominated culture, there is also pressure to be "one of the guys" and have a few drinks. Unfortunately, these drinking episodes, which are seen as opportunities to enhance unit camaraderie can also lead to date violence and assault when things get out of control.

According to the Center on Women Veterans, women veterans are less at risk for substance abuse disorders than their male counterparts. VA does have inpatient and outpatient substance abuse treatment programs that are available for women. There is a Women's Addictive Disorder Unit at the VA Medical Center in Cleveland, OH that any female veterans can be referred. Tricare offers 8 sessions a year for addiction counseling with a \$10 -\$25 co-payment.

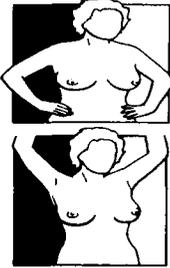
BREAST CANCER SELF-EXAM GUIDE

At the same time each month, check for any changes in the normal look or feel of your breasts. Look for a lump, hard knot, or skin that thickens or dimples. Report any changes to your doctor or nurse. **Go for regular breast exams and Pap tests. Ask about a mammogram.**

Check your breasts using these steps:



Lying down: Place a pillow under your right shoulder. Put your right hand under your head. Check your entire breast area with the finger pads of your left hand. Use small circles and follow an up-and-down pattern. Use light, medium, and firm pressure over each area of your breast. Gently squeeze the nipple for any discharge. Repeat these steps on your left breast.



Before a mirror: Check for any changes in the shape or look of your breasts. Note any skin or nipple changes such as dimpling or nipple discharge. Inspect your breasts in four steps: arms at side, arms overhead, hands on hips pressing firmly to flex chest muscles, and bending forward.



In the shower: Raise your right arm. With soapy hands and fingers flat, check your right breast. Use the same small circles and up-and-down pattern described in "Lying Down." Repeat on your left breast.



Courtesy: The Susan G. Komen Breast Cancer Foundation

Sexism and Sexual Harassment

Sexual harassment is defined as unwanted, offensive, and uses coercion for sexual attention, and is made job-related. The harassment is primarily verbal, but can include some touching. In a 1996 study conducted by the Department of Defense (DoD), 64 percent of the women on active duty experienced some form of sexual harassment within a 12-month time period. In various VA studies, 55 to 90 percent of women veterans reported experiencing sexual harassment while on active duty. The unfortunate reality is that women face sexist attitudes and harassment in our society, especially when competing for positions and resource that have been traditionally seen as male professions. Women in the military have had to deal with a dominant male culture while on active duty, and sometimes face sexist practices and even harassment. Many women leave the military prematurely when they feel they are not being treated fairly by their male counterparts or by the culture of the armed forces. This treatment causes undo stress for women that can lead to emotional and physical health problems, such as depression anxiety, sleep difficulties, headaches, sexual dysfunction, and stomach problems. Tricare and VA offer a variety of mental health treatment programs, which can help women veterans overcome the stress caused by sexual harassment.

Sexual Trauma

In studies conducted by VA, approximately 13-20 percent of the women veterans reported being assaulted or raped while on active duty. Some women reported multiple attacks. Sexual assault is defined as unwanted sexual contact (not limited to penetration) with the threat, or use of force.

When women remain under-valued, and

unwanted by their commands, it can lead to an atmosphere where abuses and assaults can occur. In spite of the fact that DoD has attempted to improve its treatment of women, many female veterans are still reporting being assaulted. In a 1996 study, 4 percent of the active duty women reported a rape or an attempted rape. Eight percent of the women who served in the Gulf War reported being raped. Women are often attacked by the men they serve with, or under their command. Since rape is not a crime of passion, but power, the women are usually younger and have less rank causing most of them to not want to report the crime. There are many other complicating factors effecting military women, who have been raped, which differ from other women. Military women are faced with issues of betrayal, role identification (Soldier/Victim) and loyalty to their service after being assaulted. All too often, when they do report the crime, they are the ones who are medically boarded or given bad discharges from the military, thereby effecting their careers, financial stability, and their future. The American Legion Department Service Officer can assist women veterans with other than honorable discharges who want to try to upgrade those discharges.

These traumatic experiences can lead to the development of **Post-traumatic Stress Disorder (PTSD)**.



PTSD Symptoms include:

- > Nightmares
- > Flashbacks
- > Intrusive thoughts
- > Sleep disturbances
- > Safety sensitive
- > Memory impairment
- > Depression
- > Anger
- > Numbing
- > Guilt and shame
- > Limited sense of future
- > Isolation

VA specializes in treating PTSD and there are programs throughout the United States for women veterans.

Women who have been raped may also suffer from chronic pelvic pain and stomach problems, low self-esteem, sleep difficulties, eating disorders, hypertension, respiratory-related problems, apprehension to becoming pregnant, sexual dysfunction, and other relationship problems. Research has shown that women who have been victimized are more likely to experience abuse or maltreatment again in their lives.

• **Domestic Violence**

As for any woman, the problems of domestic violence

are paramount, and safety is the primary issue. For women who have been in the military, the isolation that they may have experienced in changing stations, or being in an unknown community may have heightened the potential to be in an abusive relationship. Women who have been previously abused are at greater risk to be harmed by a partner. Domestic violence, or rape, like any other assaults on women is about power and control, not love.

Military women are reluctant to report being assaulted by their partner because of the isolation, lack of social supports, and fear that reporting the attack will harm their careers.

However, the Department of Defense (DOD) operates a **Family Advocacy Program (FAP)**.

Women still on active duty should report the crime to FAP!

Women veterans should not feel trapped in an abuse relationship. There is help available. They should contact the Women Veterans Coordinator at the local VA hospital for further assistance and guidance. (See page14.)

As with sexual harassment and trauma, domestic violence

survivors are also prone to develop PTSD symptoms and other emotional and physical conditions, which can be treated by VA.



• **War Zone Stress**

More and more women are being exposed to war zone actions, humanitarian missions, peacekeeping forces, and disaster relief. Women in the military transport and treat the wounded, police dangerous areas, and fly into hostile territory. They are not only at risk for personal assault, but face some of the same combat threats as their male counterparts. In spite of the job satisfaction that comes with these missions, the risks are just as great for women as they are for the men in a war zone.

Women veterans can develop PTSD from these situations, and can file a VA claim.

Service Connection for Women Veterans Suffering from PTSD:

Women veterans who have been in a war zone, or disaster area, have survived sexual harassment, sexual assault, rape, domestic violence, stalking, or a hate crime while on active duty and have been diagnosed with PTSD or other related conditions, can file a VA claim for service-connection disability.

Evidence that can be used to support a claim includes:

- Military records and awards
- Private civilian records
- Treatment records for a physical injury for the assault, but not reported
- Civilian police reports
- Reports from Crisis Centers
- Testimonial statements from friends (civilian and military), family, co-workers, clergy
- Personal diary or journal
- Request for changes in military assignment
- Increase in sick call or leave slips
- Change in military performance evaluations
- Increased use of prescription and over-the-counter medications
- Substance abuse and/or other compulsive behavior
- Request for a pregnancy test
- Request for HIV test or counseling for sexually transmitted diseases
- Counseling statements in personnel file
- Breakup of marriage or relationship
- Reports to Child Protective Services (in cases of domestic violence)

To file a claim: Contact an American Legion Department Service Officer in your state.

Services Available for Women Veterans:***Department of Veteran's Affairs (VA):***

Women veterans make up less than five percent of the VA population, but this number continues to rise. Currently, there are approximately 164,000 women users of VA as oppose to almost three million men. However VA is sensitive to this ratio, and there are several programs specifically designed to meet the needs of women veterans. In recent years, VA has tried to be more in tune to issues of privacy, pajamas, and services and equipment that women veterans need.

Women veterans should enroll at their local VA hospital using the form at the end of this guide.

- **Psychosocial Rehabilitation Programs**

The VA's Psychosocial Rehabilitation (PSR) Programs consists of over 250 work based programs nationally that are made up of **Compensated Work Therapy (CWT)**, **Incentive Therapy (IT)**, **Therapeutic Printing Plants (TPP)**, and **Vocational Rehabilitation Therapy (VRT)**.

The **Residential Rehabilitation** components consist of 48 CWT/Transitional Residences (CWT/TR). An additional 875 **Psychosocial Residential Rehabilitation (PRRTP)** beds were established in FY 98. The mission of VA's Psychosocial Rehabilitation Programs is to provide a supportive, stable, structured program utilizing work based individualized rehabilitation treatment that allows the veteran to strengthen vocational identity and maximizes her potential based on skill, ability, and rehabilitation needs. The program assists all veterans in improving the quality of their lives.

Transitional Residence enables individuals to function effectively at home, work, and in the community. Transitional Residence programs place special emphasis on meeting the special needs of women, and veterans with addiction, homeless, and/or PTSD. Each

veteran is referred by a physician for assistance in developing an individualized plan to return to work. As such, participants in the programs are considered *employees of a company*, but are also participants in a VA program. Veteran's earnings come directly from companies and government agencies. No government entitlements subsidize the veteran's earnings in CWT.

A variety of assessments are made, and some participants begin with a situational assessment in a workshop setting in which work is brought in to VA from supporting companies. The next step is supported employment where veterans work on a transitional basis at local companies, or for a federal agency, including VA. These supported employment sites provide an opportunity for veterans to learn new skills while under the direct supervision of the companies' management.

CWT continues to grow as a result of the support local companies and government agencies provide. CWT resembles private sector rehabilitation in many ways: providing evaluation, work experience, and job placement activities via the use of sheltered workshops and/or placement in work assignments.

It may also include

participation in non-pay activities: job seeking skill seminars, resume writing, vocational groups, etc.

PRRTPs served nearly 21,000 veterans in programs for Serious Mental Illness, PTSD, Addictive Disorders, and Homelessness. These residential programs function as alternatives to acute hospitalization and enhances VA's continuum of psychiatric care. Since 1996, nearly 2000 residential rehabilitation beds have been established, providing rehabilitative services to over 33,000 veterans.

Job placement services are performed by VA Vocational Counselors who operate local Job Banks and work closely with the local Department of Employment and Department of Labor, and local skills training centers, Veterans Programs, state vocational rehabilitation agencies, and VA Benefits. Psychosocial rehabilitation addresses such issues as returning veterans to community living, community housing options, transportation, money management, recreation, community resource utilization, family re-unification, and legal advocacy.



- **VA Women Veteran Residences**

In several areas, VA operates community-based domiciliarys for post-discharge homeless female veterans. These residences operate as transitional housing for women who have been homeless or have had substance abuse or mental health problems.

- **Home Loan Guaranties**



Loan guaranties are made to servicemenbers, veterans, reservists, and unremarried surviving spouses. VA

Guaranties can be used to: purchase a home, condominium or trailer, build a home, repair, alter or improve a home, or refinance a loan for a primary residence. A VA loan guaranty will allow a veteran to borrow up to \$204,000 with no money down. A veteran can obtain a home loan guaranty certificate from a VA Regional Office or with assistance from an American Legion Department Service Officer.

- **VA Hospital Women Veterans Coordinators**

Each VA hospital has a representative responsible for coordinating the care of fe-

male veterans. It is their job to ensure that these veterans are receiving the proper care and necessary referrals.

- **VA Hospital Gynecological Services**

There are 130 women's clinics in the VA system, and eight Women Veterans' Comprehensive Health Care Centers. Women veterans can find out more about the services available to them by contacting their local VA hospital Women Veteran Coordinator.

VA's Uniform Benefits Package covers osteoporosis screening and bone density treatment, menopausal care and hormone replacement therapy, infertility services, tubal ligation, birth control pills, maternity care, including labor and delivery (usually on a contract with a VA affiliated facility.) VA does not cover abortion or new born care.

- **VA Center for Women Veterans**

In 1994, Congress passed Public Law 103-446 requiring VA to create the Center to oversee all of its programs that effected women, with the Director reporting directly to the VA Secretary. The purpose of the Center is to ensure women veterans have access to VA benefits and services, and that VA is responsive to the specific needs of women. The



Center conducts outreach and education, reviews policies and programs, coordinates women veteran services with county, state, and other federal providers, and monitors VA research relating to women. The Center provides information to women veterans through its internet home page <http://www.va.gov/womenvet/index.htm> or by phone at 202-273-6193.

- **Advisory Committee on Women Veterans**

Established in 1983, by Public Law 98-160, Congress authorized the Committee to assess the benefits and health care needs of women veterans, review VA programs, make recommendations and follow-up. The Committee convenes three times a year, and visits at least one VA facility to conduct a site visit. The Committee issues reports on the status of women veterans, which can be obtained by contacting the VA Center for Women Veterans.

Department of Labor:

There is a Women's Bureau within the Department of Labor (DoL) that can help women looking for jobs. In addition, there are **Disabled Veterans Outreach Program Specialists (DVOPS)** and **Local Veterans Employment Representatives (LEVR)** who can help veterans find jobs. Each local office of the Department of Labor should have a DVOP or LVER counselor. When applying for unemployment benefits, a women veteran should identify herself as a veteran.

**The American Legion:**

- **Membership**

Since its inception in 1919, women have always been eligible to join The American Legion, as long as they meet the timetable requirements for membership. Female Legionnaires have participated in all of the Legion programs, and have held office and chaired committees at the post, department, and national levels. The American Legion offers a variety of membership benefits, including Life Insurance, Health Care Supplemental Coverage, Prescription Discounts, an Eye Care Plan,

travel discounts, scholarships, and MBNA bank financial options. The American Legion operates a **National Emergency Fund** for Legionnaires effected by natural disasters, and a **Temporary Financial Assistance Program** for other types of family crisis that have resulted in financial hardship.

Contact The American Legion Post nearest you listed in the telephone book to join.

- **Department Service Officers (DSO)**

There are American Legion Department Service Officers (DSO) in each state who can assist in filing a claim for benefits or accessing VA health care that have been

American Legion Eligibility Dates:

Aug. 2, 1990 -
Dec. 20, 1989 - Jan. 31, 1990
Aug. 24, 1982 - July 31, 1984
Feb. 28, 1961 - May 7, 1975
June 25, 1950 - Jan. 31, 1955
Dec. 7, 1941 - Dec. 31, 1946
April 6, 1917 - Nov. 11, 1918

described in this guide. DSO's are specially trained to recognize and handle benefits issues, claims and discharge upgrades for women veterans. DSO's can be found on the Internet at <http://www.legion.org> or by calling 800-433-3318.

- **Hire Quality**

The American Legion

sponsors the Hire Quality Employment and Networking Services to specialize in helping veterans transition from military service to new civilian careers. Hire Quality maintains a job database that matches a veteran's skills to a job description, screens candidates for potential employment, and arranges interviews. There is no charge for this service. Contact Hire Quality at 800-414-4733 or on the Internet at <http://www.hire-quality.com>.

- **Persian Gulf Task Force**

The American Legion operates a special unit that deals with the issues of gulf war veteran's claims and health care access. Temporary Financial Assistance (TFA) is also available through this program and is designed to help Gulf War veterans and their families in times of crisis or disability. For more information on the Persian Gulf Task Force or other environmental hazards, call 202-861-2700.





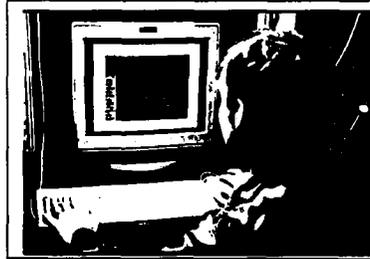
• **The American Legion Auxiliary**

A female veteran can be a dual member of the Auxiliary based on her own membership in The American Legion. The membership of the Auxiliary is all female, and mirrors the structure of The American Legion. Most Legion Posts have a corresponding Auxiliary Unit attached to it. Auxiliary members are eligible for many of the same benefits as Legionnaires. There is an **Auxiliary Emergency Fund** for members that provides financial support in the event of a family crisis, and offers assistance to "**displaced homemakers**" who need job training because of divorce, illness, or death of a spouse.

Contact an American Legion Post nearest you, listed in the telephone book, to join an Auxiliary Unit.

Resources :

- Alcoholics Anonymous 202-966-9115
- Al-Anon 800-356-9996
- American Cancer Society 800-ACS-2345
- The American Heart Association 800-242-8721
- **The American Legion 800-433-3318**
- **The American Legion Auxiliary 317-955-3845**
- American Red Cross 800-301-3535
- Assoc. Traumatic Stress Specialists (ATSS) 803-781-0017
- Child Abuse Hotline 800-633-5155
- Cocaine Hotline 800-262-2463
- DOD – Family Advocacy Program 202-433-5032
- Domestic Violence Hotline 800-799-7233
- Drug Abuse Hotline 800-662-HELP
- Hire Quality 800-414-4733
- Mental Health/Substance Abuse 888-910-9378
- National Alliance for the Mentally Ill – Veterans Committee 800-461-5453
- National Alliance of Breast Cancer Organizations 800-719-9154
- National Org. of Victims Assistance 888-777-4443
- National Women's Health Center, US Public Health Services, Dept. HHS 800-994-WOMAN
- Social Security 800-772-1213
- Susan Komen Breast Cancer Foundation 888-782-7607
- Medicare 888-887-4111
- VA (General Information) 800-827-1000
- VA Center for Women Veterans 202-273-6193
- VA Compensated Work Therapy 800-355-8262
- VA Mammography Help Line 888-4927844



**STATEMENT OF
JOY J. ILEM
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
June 8, 2000**

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I appreciate the opportunity to discuss Department of Veterans Affairs (VA) programs and services for women veterans.

Throughout history, women have served their country with pride, patriotism, and honor equal to their male counterparts. It was not until the beginning of the 20th century, however, that women were finally permitted to officially serve in the Armed Forces, making them veterans after military service.

According to the VA, there are currently 1.2 million women veterans, representing 4.8% of the total veteran population. In contrast to the overall declining veteran population, the female veterans population of the United States and Puerto Rico is projected to increase by 6% between 2000 and 2020, from 1.24 million to 1.3 million. The number of women serving in the military has continued to increase over time and so has their range of opportunities. Today, 90 percent of military occupations are open to women—all non-combatant fields and most combat-support positions. During the Persian Gulf War, some 33,000 women served honorably in Southwest Asia performing combat and combat support functions.

Unfortunately, women veterans use their earned benefits at lower rates than their male counterparts. We acknowledge that the VA has made an effort over the last seven seven years to address the unique needs of this population; however, some women veterans still experience obstacles when trying to obtain health care services and other benefits they need from the VA. The VA must work aggressively toward further effective and positive change through advocacy, outreach, and direct service to women veterans. In doing so, VA will reflect that we truly honor the contributions and sacrifices made by women veterans in service to this nation.

In this vein, our discussion will encompass the following issues: VA health care services for women veterans, including access to counseling and treatment for sexual trauma and inpatient mental health care services; privacy and safety concerns of women veterans utilizing VA facilities; initiatives for women veterans who are homeless; the effectiveness of the VA Advisory Committee for Women Veterans, the VA 2000 National Summit on Women Veterans Issues, and Women Veterans Coordinators; and outreach and benefit awareness among women veterans.

VA HEALTH CARE SERVICES FOR WOMEN VETERANS

In the past, it was difficult, if not impossible, for women to get gender-specific care at VA medical facilities. For many years, VA focused on the numerically dominant male veterans. With the Congressional mandate for VA to establish a Women Veterans Advisory Committee the beginning of a national effort to identify women veterans and improve VA services to them started in November 1983. In 1993, then Secretary of Veterans Affairs Jesse Brown took the initiative and made a serious attempt to improve and expand services for women veterans by creating a Women Veterans Program Office. He was determined to sensitize the VA to the contributions women have made in the military and address their unique problems as they returned to civilian life as veterans. In 1995, Congress passed Public Law 104-446, establishing the Center for Women Veterans (CWV) and the Center for Minority Veterans.

Over the past seven years, VA has made significant progress in its effort to address the unique physical, mental, and social needs of women veterans. The Women Veterans Program

Office and the VA Center for Women Veterans (CWV), both under the direction of Ms. Joan Furey, have been instrumental in helping develop proper programs and services to meet these needs. The DAV commends Ms. Furey for her efforts and dedication to women veterans and advocacy in helping to assure VA policies, practices, and programs are responsive to the needs of women veterans.

Many VA medical facilities have developed special programs and services to meet the specific health care needs of women veterans, including eight women's comprehensive health centers located in, Boston, Massachusetts; Philadelphia, Pennsylvania; Durham, North Carolina; Tampa, Florida; Chicago, Illinois; Minneapolis, Minnesota; San Francisco, California; and West Los Angeles, California. However, since the restructuring of the Veterans Health Administration (VHA) and implementation of a primary care model throughout the system, we have seen the discontinuation of several dedicated women's health clinics. The number of women veterans' clinics and primary care teams has decreased significantly, from 121 in 1994 to 96 in 1998. The DAV is seriously concerned about the incidental impact of the primary care model on the quality of health care delivered by VHA to some women veterans.

The following excerpt is from the January 19, 2000, VA conference report on *The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services*. The report stated:

VA women's clinics were established because, unlike the private sector, where women make up 50 to 60 percent of a primary care practitioner's clientele, women veterans comprise less than 5 percent of VA's total population. As a result, VA clinicians are generally less familiar with women's health issues, less skilled in routine gender specific care, and often hesitant to perform exams essential to assessing a woman's complete health status. With the advent of primary care in VA, many women's clinics are being dismantled and women veterans are assigned to the remaining primary care teams on a rotating basis. This practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

The VA is obligated to provide health care services to women veterans equal to those provided to male veterans. Services must be available to eligible women veterans regardless of the relatively low number of women in comparison to their male veteran counterparts. Additionally, VA must ensure women veterans are not subjected to lower standards of clinical expertise in their health care because of restructuring of VHA and the advent of the primary care model. VA needs to increase the priority given to women veterans' programs to ensure that quality health care is provided and that services are maintained.

While the VA has been working hard to improve health care services for women veterans, Congress and the Administration may be eroding programs with restrictive fiscal policies. The VA Women Veterans Health Programs must be adequately funded to avoid a decline in services. Initially, funding was earmarked by Congress specifically for women veteran's health initiatives. Regrettably, Congress has not continued to dedicate funding for these programs. Insufficient funding threatens the progress that has been made in improving and enhancing services and jeopardizes women veterans' access to quality care in the future. We emphatically agree with comments provided in the 1998 Report of the VA Advisory Committee on Women Veterans, "Funding of gender specific services for women veterans is an investment in the future which needs to be protected regardless of the current cost cutting climate [in Congress]."

COUNSELING AND TREATMENT FOR SEXUAL ASSAULT

Another topic for discussion at the January 2000, VA conference was the outcome of the VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services. Findings from that study revealed there is a high prevalence of sexual assault and harassment experiences reported among women veterans accessing VA services and that active duty military personnel report rates of sexual assault higher than comparable civilian samples. "The data also suggested it is essential that VA staff recognize the importance of the environment in which care is delivered to women veterans, and that VA

clinicians possess the knowledge, skill and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault.”

Findings from the VA study revealed that: 1) women who reported experiencing sexual assault while in the military scored lower on all scales measuring physical and mental health status and social functioning in comparison to women veterans who reported no experience of sexual assault during active military service; 2) the consequences of sexual assault include decreased physical and psychological functioning which may persist for an extended period and that women who have experienced sexual trauma are more likely to be high utilizers of healthcare; 3) chronic conditions such as arthritis, obesity and diabetes, and higher rates of numerous medical problems such as irritable bowel syndrome, back and headache pain, eating disorders, poor reproductive outcomes, and digestive problems were reported more frequently by women who experienced sexual trauma in comparison to women reporting no such history; and 4) the psychological effects of sexual trauma may be more severe than those of other traumatic events, including exposure to combat.

Findings from the study also suggest that resources needed to care for women veterans who experienced sexual trauma may be different from those used to care for men. Additionally, the study indicated that women veterans would benefit from a specialized comprehensive health care approach and possibly more intensive mental health care.

VA must not fail to meet these identified needs of women veterans who have experienced sexual trauma during military service. It must seriously consider and address the barriers to care women veterans face and issues that negatively impact on a woman veteran’s decision to seek health care from VA.

Public Law 102-585, the Veterans Health Care Act of 1992, authorized VA to provide counseling services for women veterans who experienced sexual trauma during active military service. This law was amended by Public Law 103-452, the Veterans Health Programs Extension Act of 1994, to authorize VA to provide counseling to both men and women. Currently, the law mandates VA shall operate a program which provides outreach, counseling, and appropriate care and services to veterans who VA determines require such counseling care and services to overcome the effects of sexual trauma. The law extends counseling and treatment services through December 31, 2004. Given the significantly increased rates of sexual trauma reported by women who served or are serving in the military, we urge the Subcommittee to consider legislation to make the VA Sexual Trauma Counseling Program permanent.

Public Law 106-117, section 115 includes provisions that require: 1) VA to conduct a study and submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives reports on its study of expanding eligibility for counseling and treatment to members of the reserve components of the Armed Forces who experienced sexual assault while serving on *active duty for training*. (Emphasis added.) 2) VA to enter into a collaborative effort with the Department of Defense (DoD) to ensure that members of the Armed Forces, upon separation from active service, are provided appropriate and current information about the VA counseling and treatment program for sexual trauma, including information about eligibility requirements and procedures for applying for these services.

In recent years, DoD has relied more frequently on our military reserve components to meet the National Security missions of our country. The DAV believes it is wholly unfair to exclude certain National Guard and Reserve members who experienced sexual trauma from receiving VA sexual trauma counseling and treatment because they were on “active or inactive duty for training” status vs. “active duty” at the time of the sexual assault. General Counsel Opinion (VAOPGCADV 17-97) dated July 1, 1997, held in part that reservists and members of the National Guard serving on active duty for training when disabled as a result of sexual trauma are not eligible for sexual trauma counseling and care because Section 1720D of title 38, United States Code, requires that the covered trauma occurred while the veteran was on active duty; and the law excludes *active duty for training* from the definition of “active duty.” (Emphasis added.) Counseling and treatment should be available to reservists and members of the National Guard who experience a sexual assault while performing active or inactive duty for training or any other period of official military service.

We request that the Subcommittee consider a legislative amendment to Section 1720D of title 38, United States Code, to make reservists and members of the National Guard who experience sexual trauma during any official military duty period eligible for VA sexual trauma counseling and care. This legislative remedy would make moot the necessity for the VA to carry out provisions in Public Law 106-117, requiring the Secretary to indicate the additional resources that would be required to meet the projected needs of reservists and members of the National Guard needing sexual trauma counseling and treatment. Reservists and members of the National Guard should be entitled to quality health care services for the after effects of sexual assault that occur while serving in an official military capacity that are equal to those entitlements provided to other veterans.

HOMELESSNESS; INPATIENT MENTAL HEALTH CARE; PRIVACY

Three areas of specific concern to DAV are the effectiveness of VA programs for women veterans who are homeless, the availability of quality inpatient mental health services for women veterans, and the issue of privacy and safety at VA medical facilities. The VA has been deficient in providing outreach and services to women veterans who are homeless, and some VA facilities' inpatient mental health services for women are inadequate. Additionally, although VA has made notable progress in levels of privacy and safety afforded to women veterans, improvement is necessary at some VA health care facilities.

The VA has a comprehensive program to help male veterans who experience homelessness, but, until recently, it has not focused on providing the same level of services to homeless women veterans. Women veterans often have different concerns and needs than male veterans who are homeless. They are routinely concerned about issues such as privacy, personal safety, childcare, and treatment programs for the after effects of sexual abuse and assault. VA must address these unique issues in order to develop effective treatment programs and services for homeless women veterans.

The VA Health Care for Homeless Veterans Program (HCHV) is successful largely because of outreach with a focus on reducing homelessness through necessary treatment and rehabilitative services. Outreach workers target areas where homeless persons congregate; however, women generally frequent different areas than their male counterparts. Therefore, many women veterans who may benefit from these services are missed. Transitional housing is a key component in helping the homeless to successfully reintegrate into communities. Program workers often face obstacles in providing transitional housing to women veterans because of childcare issues and or safety concerns. For example, transitional housing is often shared among 3-4 persons. Placing a woman in a house with 3 men may compromise her physical safety. Additionally, housing contracts are generally authorized for the veteran but not her children. If a women veteran is the sole custodian of her children, it is unlikely she will choose a housing situation where her children are unable to remain with her.

We are pleased that Congress last year earmarked approximately \$3 million to support demonstration projects for women veterans who are homeless. With continued resources, we are confident VA will develop and maintain programs and services to meet the needs of women veterans who are homeless, including access to transitional housing on par with male veterans.

Many women veterans seek VA counseling and treatment for post traumatic stress disorder (PTSD) and need inpatient mental health services for psychiatric conditions that developed as a result of sexual assault that occurred during military service. The special needs of women utilizing an inpatient mental health program must be carefully considered to avoid having women drop out of inpatient programs or suffer even further set backs in treatment of their service-related conditions. Some VA facilities have closed their women veterans' inpatient psychiatric units, complaining that low utilization rates do not make them cost effective. Currently, there are only a few VA facilities with inpatient psychiatric units specifically designed to meet the special needs of women veterans.

Women veterans admitted to inpatient psychiatric treatment programs for PTSD frequently report they are the only female in the group and often feel too intimidated to discuss gender-specific issues. Male and female veterans suffering from PTSD may have very different core issues surrounding their traumatic event, i.e., combat-related vs. sexual abuse or trauma. This could potentially lead to complications for the clinician trying to provide group therapy.

Women veterans may be disadvantaged in terms of care if a clinician is unfamiliar with the unique manifestation of PTSD symptoms in women who have experienced sexual trauma and the added impact of an assault that occurred during military service.

As the number of women veterans eligible for VA benefits increases, their utilization of VA mental health programs and services is also likely to increase. Women veterans must be provided quality inpatient mental health care services. They should not be disadvantaged in terms of the quality of care they receive and are entitled to because they are seen in lower numbers in comparison to their male counterparts. We suggest that, in VA facilities where numbers of women are too low to be cost effective to maintain an inpatient psychiatric unit or provide appropriate care, contracted care at a nearby facility should be secured.

Women veterans continue to express concern about privacy and safety issues at some VA facilities. It is the VA's responsibility to ensure and maintain a woman veteran's right to privacy at all times. It is not uncommon during an inpatient hospitalization or domiciliary stay, for a single woman veteran to be placed in a ward with 30 men. It is understandable in this situation that a woman might feel threatened or that her safety might be endangered. Privacy and safety protocols for women veterans should be consistent and strictly adhered to at every VA facility. Patient treatment rooms should be well marked with "please knock before entering" and hospital curtains installed to ensure privacy. If possible, women veterans should be placed near the nurses station during inpatient hospital stays. Special locks can be installed on doors allowing the patient to easily exit the room, but requiring authorized staff to use a key to enter the room. Women Veterans Coordinators (WVC) should be contacted immediately and informed when a woman veteran is admitted as an inpatient. These are just a few precautions that can be taken to ensure a safe and private environment at VA facilities for women veterans.

Additionally, some women veterans indicate they feel uncomfortable sitting in a waiting room mainly comprised of men. All VA facilities should provide a safe, private and comfortable environment for women veterans. Ideally, women veterans should be provided a private waiting area when possible.

VA WOMEN VETERANS COORDINATORS

Every VA medical center and regional office should have a designated WVC to assist women veterans in accessing VA services and benefits. VA WVCs are a valuable resource for providing outreach, assuring quality health care, and keeping VA informed about the unique needs of women veterans. Many WVCs have been able to successfully guide women veterans through the VA system and raise awareness among VA staff and within communities about the contributions of women veterans. However, we are concerned that there is a lack of continuity of services provided by WVCs throughout the system.

Nurses, doctors, social workers, and benefits and administrative personnel work as WVCs throughout VHA and the Veterans Benefits Administration. We recognize that these women have many responsibilities, including advocacy for women veterans in their communities. The amount of time WVCs have to spend on women veterans' issues depends on a number of factors, including job description, case load, the number of women veterans in the area, and management priorities at their facilities. Coordinators who have the support of the hospital or regional director and or management are likely to be more able to successfully manage their case load and have adequate time to perform duties related to their WVC position. Their duties as WVCs should not be "secondary" to their overall responsibilities, but approached with appropriately approved managed time to complete necessary tasks and projects. For medical centers in areas where there are statistically sufficient numbers of women utilizing the system, and where it is proven to be cost effective, the WVC position should be mandated as full time. Sufficient resources should be designated to support WVCs and the Center for Women Veterans, including an adequate number of staff to accomplish their mission.

VA ADVISORY COMMITTEE FOR WOMEN VETERANS

The VA Advisory Committee for Women Veterans, established in 1983 by Public Law 98-60, authorizes committee members to assess the needs of women veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and health care programs administered by the VA. Since its inception, the committee has worked hard to address the

needs of women veterans and improve VA services to them. In 1989, the committee began conducting site visits at VA medical facilities, regional offices, and vet centers throughout the nation. It has also conducted open forums for women veterans to express concerns and talk about the status of VA programs for women veterans in their location.

The advisory committee submits a report biennially to the Secretary on the activities of the VA pertaining to women, together with assessments of needs and recommendations for future action and, until recently, VA was required to convey the report to Congress. However, Public Law 104-66 removed this requirement. The DAV shares the concerns of the committee and believes the submission of the report to Congress plays an important role in maintaining services and programs for women veterans and helps to bring to the forefront important issues and concerns that need to be addressed. We observe that H.R. 4268, recently passed by the House, would reinstate the requirements for the biennial report to Congress. We appreciate the House action.

Oversight of women veterans' programs is key to their ultimate success. Our representation on the VA Advisory Committee for Women Veterans affords DAV an excellent opportunity to gain perspective about the concerns of women in the veterans' community and to make recommendations to fully address the needs of women veterans.

The DAV appreciates the efforts of the advisory committee and fully supports its continuation. We believe recommendations made by the committee provide an honest look at the accomplishments and deficiencies in the VA system concerning women veterans and will help to ensure consistency of quality services to women veterans throughout the country.

VA 2000 NATIONAL SUMMIT ON WOMEN VETERANS ISSUES

The DAV fully supports the upcoming VA 2000 National Summit on Women Veterans Issues. Recognizing that more needs to be done to address the needs of the women veteran community, DAV agreed to cosponsor this event. It provides an excellent opportunity for women veterans, veterans' advocates, and government policymakers to come together to openly discuss problems and seek solutions. Summit 2000 is an ideal forum in the continuing efforts to effect policy changes within the VA to ensure appropriate medical services and accommodation for hospitalized women veterans, to provide necessary outreach programs and services to women veterans who are homeless, and to assure the availability of treatment for gender-specific conditions, appropriate gynecological care and treatment and counseling for PTSD and other conditions related to their military service.

OUTREACH

It is possible that women veterans utilize their benefit entitlements less than their male counterparts in part because of the strong cultural perception associated with the word veteran. Women veterans will often check "no" on a questionnaire when asked if they are veterans, but then indicate that they have served in the military. Many women believe they do not meet the basic definition of a "veteran"—perceived to be a male who served in combat. A VA commissioned survey published in 1985 found that 57% of women did not know they were eligible for VA services and programs.

Outreach is key to help identify women veterans throughout the country. The VA Center for Women Veterans reported they hold approximately 30 outreach events each year and that the Veterans Health Administration and Veterans Benefits Administration WVCs conduct on average at least two outreach events each year in their local communities. We appreciate the VA's efforts to maintain an effective outreach program for women veterans; however, more needs to be done.

Women veterans often "disappear" back into their local communities following active service; therefore, we believe it is necessary to ensure they are clear about their status as "veterans" and are properly informed about benefits and services prior to leaving active military service. The Transition Assistance Program (TAP) provides crucial information to separating servicemembers about programs and benefits available to assist them during their transition and to help them to search for post-service employment. The DAV participates in TAP, providing

information about veterans' benefits and services, as well as comprehensive reviews of service medical records. But we cannot stop here.

Separating servicemembers are often anxious to return to civilian life, new careers, or educational opportunities, and they are not focused on these important issues at the time of separation. Often, it is only when a veteran is in need of help or a particular service or benefit that he or she is open to receiving information. For this reason, it is imperative that VA as well as veterans service organizations make it a priority to increase outreach to women veterans.

The DAV recognizes the lack of benefit awareness among women veterans; therefore, we are redoubling our efforts to reach women who have served in the Armed Forces. Our National Service Officers (NSOs) provide outreach to the veterans' community by conducting Veteran Information Seminars designed to educate disabled veterans and their families about veterans' benefits and programs. Our most recent outreach initiative involves the implementation of the DAV Mobile Service Office Program for the purpose of providing free assistance to veterans, with special attention to those residing in rural areas and localities throughout America, which are not in proximity to VA facilities. Although these outreach initiatives do not directly target women veterans, we are hopeful that these efforts will help them to receive the benefits and services they are entitled to.

The DAV also has its own Women's Veteran Advisory Committee, made up of women veterans from DAV's membership, who meet annually at DAV National Conventions. The Committee works to increase awareness among women veterans about available benefits, services, and programs, and advises the DAV National Headquarters about the concerns of women veterans. The committee encourages women veterans to play an active role in our organization.

The DAV also recognizes the unique problems disabled women veterans face, including job discrimination, both as women and disabled women veterans; therefore, we have made a concerted effort to build employment and enhance our NSO corps with eligible and qualified disabled women veterans.

CONCLUSION

We owe a debt of gratitude to women veterans who have proudly and honorably served our nation. More women are serving in the Armed Forces, and this means more women veterans will likely be seeking VA benefits and health care services in the future. The VA must increase outreach to women veterans to ensure they are informed about their benefits and entitlements. VA must also work hard to identify and eliminate barriers experienced by women when accessing VA benefits and programs. We can demonstrate our appreciation, dedication, and commitment to women veterans by ensuring they receive benefits and health care services on par with male veterans.



Vietnam Veterans of America

8605 Cameron Street, Suite 400 • Silver Spring, MD 20910
Telephone (301) 585-4000 • Fax Main (301) 585-0519
World Wide Web: <http://www.vva.org>

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Statement of

Vietnam Veterans of America

Submitted by

**Marsha Tansey Four, RN,
Chair
Women Veterans Committee**

Before the

**Subcommittee on Oversight and Investigations
Committee on Veterans Affairs**

Regarding

**Department of Veterans Affairs Service for
Women Veterans**

June 8, 2000

Vietnam Veterans of America

Subcommittee on Oversight
and Investigations
June 8, 2000

Good morning Mr. Chairman and other distinguished members of the subcommittee. My name is Marsha Four I served in the United States Army Nurse Corps with duty in Vietnam between 1969 and 1970 with the 18th Surgical Hospital. I am Chair of the Women Veterans Committee, Vietnam Veterans of America.

Presently I am employed as the Program Director for Homeless Veterans Services with The Philadelphia Veterans Multi-Service & Education Center, Inc., a non-profit agency, serving veterans in Southeastern Pennsylvania.

On behalf of Vietnam Veterans of America, I would like to thank you for holding these hearings and for your continued interest in the welfare of America's veterans. As you know, Vietnam Veterans of America has been a leader in moving the agenda of Women Veterans and has taken a proactive approach in advocating for quality services and programs for Women Veterans regardless of time or place of service. The Women Veterans Committee began as the Women Veterans Project in the spring of 1979 and is a Standing Committee at all levels of our organization.

The Women Veterans Committee, as a representative body, is the voice of those who seek strength and support in resolving problems and addressing concerns related to all women veterans. The Committee identifies issues and needs specific to Women Veterans and develops strategies to address and resolve them. Annually, we develop specific priorities of concern to Women Veterans.

Today I would like to address a five of those specific issues:

Sexual Trauma:

Vietnam Veterans of America's Women Veterans Committee presented testimony and assisted in the drafting of legislation, which resulted in Public Law 102-585, The Veterans Health Care Act of 1992. The enactment of this law was a landmark victory in the long struggle by Women Veterans to assure continued recognition and support for their specific health care programs and broaden the context of Post Traumatic Stress Disorder to include care for the aftermath of sexual trauma associated with military duty. Despite the open televised hearings over eight years ago, which resulted in the original legislation, the issues of sexual harassment, abuse and trauma continues.

According to the VA in 1999, 50% of all women assaulted in the military developed signs of PTSD. Additionally, it was reported 60% of all women in the military have experience at least one instance of sexual harassment or assault while on active duty.

The aftermath of these demeaning experiences cannot be justly denied. Clearly, these alarming statistics indicate the justification of, and need for, continued sexual trauma treatment programs. Year after year we strategize and return with a request for Congressional intervention to retain a treatment program that is clearly needed. In the past VVA has asked for two or three or four year renewal of sexual treatment programs. Today VVA seeks legislation that will make sexual trauma counseling a permanent part of VA programs and services.

Vietnam Veterans of America

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and Investigations
June 8, 2000**Homeless Women Veterans:**

Approximately 3 to 4% of the 275,00 homeless veterans across this county are women. For the past three years I have been the Program Director of a homeless veterans program in Coatesville, Pennsylvania. We are one of the few facilities that accommodate veterans, both men and women, who are homeless, however even we have our limitations in meeting the needs of our women veterans. Homeless women veterans present different needs with reference to privacy, gender related care, treatment for physical and sexual trauma, and care for dependent children. Due to these compounding issues very few programs are available to serve and appropriately meet the needs of this particular homeless population.

This deficiency in available programs was recognized by Congress, when in FY2000, approximately \$2.3 million dollars of the additional \$50 million of those funds allocated to VA Homeless Programs were designated and fenced for homeless women veteran projects. Ten Homeless Women Veteran Projects have been selected.

The Department of Veterans Affairs Policy Board determined that this money for homeless women veterans programs would be available and protected, only for FY2000, despite the numerous requests of clinicians and VSO's for a reconsideration of this policy. We are given to believe that, as it presently stands, money to continue these special and unique homeless women veteran programs for the next two years would be allocated by the VA out of the general medical care fund. Continued funding would be dependent upon the VERA allocation to the VISN's within which these programs are located. This places the continuance of these high visibility and desperately needed programs in a rather tenuous position. Their very existence is reliant upon a decision made at the VISN level without guarded assurance of continued funding. It is important to note that the work load information that drives VERA and its attached VISN funding level is at least two years behind in the transposition of this data into actual dollars. There is no promise that funding for this type of program will be committed in the future.

Mr. Chairman, the effort involved to establish the criteria of programs, to issue requests for funding, to review proposals, and to award grants, is a time consuming process. In light of this it is difficult to understand that the VA Policy Board did not realize the accomplishment of the goal, as intended by Congress for this appropriation, would never be attained in one fiscal year. Sadly, needed women veteran specific, homeless programs may never see the light of day because continued funding is in jeopardy. Special Needs Programs take time to develop and thrive. This time is vital in the acquisition of outcome data that will be used to further justify their future existence.

The time and effort of legislators, veteran service organizations, veteran advocates, and Congressional staff, spent identifying issues and developing legislation to address special needs, should not be squandered. Vietnam Veterans of America believes that Congress needs to protect money allocated for specific veteran programs. It seems necessary to extend by legislation, the time frame for the protected money of special need programs to three years. Without this extension, an injustice is done to the special program developers, the veterans that are served, and to Congress, whose intention was to make special care and treatment a reality. Without protecting the allocated and appropriated funding for three years, the future of all special needs

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programs are in jeopardy as displayed in the Policy Board decision of the homeless women veteran projects. We ask congress to consider this issue and bring stability and security to special veteran programs by initiating legislation to resolve this dilemma.

Benefits for Service Connected Mastectomies:

The number of veterans rated for service-connected mastectomies may not be great. However, this has never been the determinant for fair and just compensation of a service-connected disability? The addition of the diagnosis for simple and radical mastectomies to those eligible for the Special Monthly Compensation Award, as found in Title 38 U.S.C. Section 1114 (K), known as the "Special K Award", is presently under consideration by this committee. Vietnam Veterans of America supports the recommendation of the VA Advisory Committee on Women Veterans regarding this very issue.

Vietnam Veterans of America petitioned the VA for a ruling on the inclusion of service connected mastectomies on the list for those identified to receive the Special K Award. Although no official response has been issued to VVA, we have been given to believe that VA General Council has determined that they do not have the statutory authority to make this addition of the Special Monthly Compensation. VVA stands firmly behind the belief that this consideration move forward into legislative reality. We thank this subcommittee for its interest and attention to this issue and look forward to a timely positive resolve.

When the Women's' Committee of Vietnam Veterans of America first began discussion about this legislation, we thought that the issue of mastectomies was only relative to women veterans. However, we quickly became aware that men are also rated for this disability. This in turn led to a review of the rating and compensation schedules for mastectomies. In our review of the scheduling, VVA became concerned about the existence of possible inadequacies in the current schedule.

Compensation should reflect the amount of disability to include the psychiatric and emotional impact of the day-to-day living of veterans with mastectomies. Managing the care, the psychological devastation, and coping with the disfigurement that strikes at the very core of one's sexual identity is a trauma which has to be re-negotiated every day of the woman veterans life. Most importantly, the loss of a breast for a woman, is not merely the loss of a body part, it is the loss of an intimate aspect of her persona.

Our members have reported that psychological problems associated with their mastectomies are not adequately reflected in VA's rating of their condition. We have been told that they are given a psychiatric diagnosis, but no increase in compensation or rating is given to them. There is evidence that, though the psychological effect of mastectomies is recognized by the VA, and treatment can be accessed, there is a lack of standardization for inclusion of this mental health element in the rating of these individuals.

We look forward to working with the VA on the revision of the present rating schedule to more adequately reflect the appropriate level of disability and improve the quality of life of these veterans.

Reserve and National Guard Benefits:

Since the beginning of the "All Volunteer Force" this nation has come to rely heavily on the Reserve and National Guard components of our Armed Forces. Training is an essential part of mission readiness. It is vital to the overall defense of our country. At this time in our nation's history, the contribution of these forces, both here and abroad, is immeasurable. If they are expected to lay down their lives in defense of this country, then they should be afforded the same standard and quality of care for injuries incurred while training for this mission as if the incident occurred on active duty.

This issue that emerges is one related to care and treatment for those men and women of the Selective Reserve and National Guard who experience sexual trauma or assault while on training days. Although physical injury incurred while on training days in the Selective Reserves and National Guard is addressed by VA, sexual assault or trauma are not. We feel this is an issue of semantics rather than reality.

The impact of sexual trauma with the manifestation of residuals can last a lifetime. The resultant Post Traumatic Stress disorder, which accompanies such a personal violation, cannot be denied. The stressor for this personal infringement should be considered an injury...a psychological injury.

Vietnam Veterans of America is aware, that as a result of the Millennium Health Care Act, the VA has set up task force with the Department of Defense to look at this very issue and make recommendations.

While we await the outcome of this task force as it ponders the relevance and appropriateness of providing assistance for sexual abuse and trauma suffered by men and women in the Selected Reserves and the National Guard, victims sense a lack empathy and they too await the outcome with a silent screaming pain.

VVA sees the necessity to extend these benefits to those men and women of the Selective Reserve and National Guard to include sexual trauma and assault, incurred while on training days. We understand that granting these entitlements to the Selective Reserve and National Guard would require a change in the law. VVA requests consideration by this Committee in drafting legislation which would bring a just equality and a quick resolution to the pain and mental suffering of those who serve this country.

Compensation and Benefits to Children:

With the completion and reporting of the VA Study on the Reproductive Outcome of Women Vietnam Veterans, often referred to as the Klemm Report, great interest has been given to the statistics related to the number of children with birth defects born to women who served in Vietnam. This has resulted in an initiative by the Secretary of Veterans Affairs to provide compensation and benefits to these children in a yet to be determined manner.

Vietnam Veterans of America

Subcommittee on Oversight
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VVA understands this may include, not only care, but also vocational rehabilitation. Any of us who have children can understand the heartache of a parent who cares for a child who lives with a birth defect. We can't imagine bearing the pain of this reality when we look into the eyes of our own children. But if we are not a parent of a child who lives daily with a birth defect, no one of us can truly understand so deeply or ache so desperately or know so profoundly the strength it demands to bear the life time of heartache. The financial burden, coupled with the desperate concern for the unknown future of these children is a crippling situation.

That there is a link, as suggested in the Klemm Report, between the effect of military service in Vietnam and birth defects, VVA believes it is right and just to provide assistance and compensation to the children with birth defects of women who served in Vietnam.

The Women Veterans Committee of VVA does feel that in order to truly address the justice of this issue, there needs to be further investigation into the effects of Vietnam on the statistical information related to those men who have fathered children with birth defects. We believe that a study should be requested by Congress to determine if satisfactory evidence exists to include the children with birth defects of, not only the women who served in Vietnam, but also the men. Many of us As women, we served side by side with the men in Vietnam. We supported each other from the very beginning. To deny them equitable consideration on this issue would be less than honorable.

Summary:

The Women Veterans Committee of Vietnam Veterans of America has outlined during this testimony five issues which are of great concern. VVA is proud to have been a moving force in the establishment of the VA Advisory Committee on Women Veterans and the Center for Women Veterans within the VA. The bi-annual report delivered to Congress by the VA Advisory Committee on Women Veterans has been, and continues to be, a tool of advocacy for women veterans. It is Vietnam Veterans of America's hope that Congress will continue to require the Secretary of Veterans Affairs to deliver this report to Congress.

With the increased number of women in the military, the needs of women veterans are emerging, unfolding and rapidly changing. Maintaining effective, quality programs, services and benefits requires the constant oversight and attention of Congress. VVA applauds this committee for taking the initiative to schedule these hearings. In the past these hearings were held annually. Vietnam Veterans of America senses the importance that this practice be continued in the future.

Thank you for providing me the opportunity to participate in these hearings. Mr. Chairman, this concludes the testimony of Vietnam Veterans of America.

**STATEMENT BY
JOAN FUREY
DIRECTOR
CENTER FOR WOMEN VETERANS
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

June 8, 2000

Mr. Chairman and Members of the Subcommittee, I am pleased to testify today on behalf of the Department of Veterans Affairs on services in the VA for women veterans. I am accompanied by Carole Turner, RN, MN, CNAA, Director, Women Veterans Health Program, Veterans Health Administration (VHA) , and Mr. Robert Epley, Director, Compensation and Pension Service, Veterans Benefits Administration (VBA).

Women have officially served in the United States military forces since 1901 when the Army Nurse Corps was established. As early as 1938, an article in the American Journal of Nursing stated that the Veterans Administration had 287 hospital beds and 45 domiciliary beds for women beneficiaries. At that time, there were 3,511 women receiving disability compensation as a result of their military service.

Many women have served during the wars of the 20th Century: 34,000 women served during World War I; 400,000 during World War II; approximately 3,000 served in country in Korea, over 7,000 served in Vietnam; and 49,950 were deployed in the Gulf War. In reviewing the history of women in the military, it is important to remember that, until 1973, the number of women serving on active duty was limited by law to 2% of the active duty force, and the roles in which they served were limited. However, following the dissolution of the draft, that cap was removed and more military occupational specialties were opened to women. As a result, women today comprise 15% of the active-duty force and, with the exception of the Marine Corps, 20% of new recruits. Additionally, all military occupational specialties, with the exception of the combat arms and submarine service, are open to women.

Despite this long history of military service, the 1980 census was the first ever to ask American women if they had served in the military, and it was something of a surprise to find that there were over 1.1 million living women veterans at that time. According to the 1990 Census, women veterans comprise 4% of the total veteran population, and statistical projections indicate that, by the year 2010, that number will increase to 10%. This will be a dramatic change in the demographics of the veteran population and will have significant implications for VA.

In 1982, the General Accounting Office (GAO) reviewed VA's efforts to serve this growing number of women veterans and found that action was needed to assure equitable services for men and women. Subsequently, a number of dramatic actions occurred to improve services to women veterans. One of the most important was Congress' establishment of the Advisory Committee on Women Veterans, in 1983. That Committee has been an invaluable asset to the Department and the women who served our country. The Committee's most recent report will be discussed later in my testimony.

In February 1984, following the establishment of the Advisory Committee, VA implemented an outreach program for women veterans and assigned Women Veterans Coordinators at each of VBA's regional offices. These positions continue today. Locally developed outreach programs have been very effective in identifying individual women veterans, as well as service organizations, with predominately women membership. A recent example of this outreach includes a special VBA Fact Sheet entitled "Disability Compensation for Sexual Trauma," which is distributed nationally during Transitional Assistance Program (TAP) briefings for active duty personnel within 180 days of separation from the military. During FY 1999, VBA military services coordinators briefed over 217,000 active duty personnel and their families on VA benefits and services.

The Compensation and Pension Service Women Veterans Advisory Group was created in the early 1990's to review policy and procedures regarding

benefits delivery to women veterans. The advisory group has conducted several case reviews of issues generally considered to be associated with women veterans' claims, such as gynecological diseases - - including disorders of the breast and PTSD secondary to sexual/personal trauma. As a result, field-training tools have been developed. These include satellite broadcasts and a "Guide to Developing Personal Trauma Claims." The Women Veteran Coordinator Intranet Site provides materials to assist VBA coordinators in outreach and claims-processing activities. VBA and VHA also worked collaboratively to develop and present, via satellite broadcast, a three-part training series on "Women's Health Issues."

A number of other steps have also been taken by VHA to improve services. In 1986, Women Veterans Coordinators were appointed at all VA Medical Centers to be advocates for women seeking care and to promote the provision of high-quality care in an appropriate setting. The availability of gynecology and other gender-specific services was also markedly improved. In 1992, Congress enacted the "Veterans Health Care Act of 1992" (Pub. L. No. 102-585), which authorized counseling for sexual trauma. The Act also authorized certain women veterans' health services. Since then, thousands of women have received counseling and related services. During that same year, VA established the first four Comprehensive Women Veterans Health Centers (expanded to eight the following year) and established Women Veterans Stress Treatment Teams at four VA medical centers. The VA National Center for Post

Traumatic Stress Disorder established a Women's Division in 1993. Under the reorganization of health care in VHA, known as "The Vision for Change," the Women Veterans Health Program was designated as a special program and a full-time director was appointed in Central Office in 1997.

In December 1993, the Department established the Women Veterans Program Office to assure all VA programs, policies and practices were responsive to the needs of women veterans. In 1994, at the urging of the Advisory Committee, Congress enacted the "Persian Gulf War Veterans' Benefits Act" (Pub. L. No. 103-446), which established the Center for Women Veterans in VA. At that time, the Women Veterans Program Office was reorganized to meet the requirements of that law. The Director of the Center serves as chief consultant to the Secretary of Veterans Affairs on all issues related to women veterans and also as the Executive Secretary of the Advisory Committee.

As women make up a larger proportion of the Armed Forces, they will make up an increasingly larger proportion of the veteran population. VA is committed to meeting the needs of women veterans in all its programs. The Advisory Committee continues as a valuable partner in these efforts, and I am pleased to appear before you to discuss their latest report.

The 1998 report of the Advisory Committee on Women Veterans, including VA's response to recommendations contained therein, was submitted to

Congress in May 1999. The report included 42 recommendations covering 11 areas:

- Outreach
- Health Care
- Benefits Entitlement
- Women Veteran who are Homeless
- Minority Women Veterans
- Women Veteran Coordinators
- Research
- The Future of Women Veterans
- Selected Reserve and National Guard Benefits
- National Cemetery System
- Employment of Veterans within VA

VA concurred with, or supported, the intent of 36 of the recommendations

but did not concur with 6, including the following:

- Recommendation 3: Require by legislation, all federally-funded social service agencies, community programs and organizations to identify, within their served population, veteran clients and annually report these statistics to VA.
- Recommendation 4: Develop and produce a video to address issues affecting women veterans, such as VA eligibility criteria, benefit and health care services, and the contributions of women to the United States Military. Distribute this video for use in TAP briefings, local media presentations and Public Service Announcements (PSAs).
- Recommendation 6: Place VA benefit and health care information in professional medical, nursing, social work and psychiatric publications to alert community caregivers to the existence and availability of VA benefits and programs. Articles should routinely solicit assistance of the community and address the difficulties experienced by VA in identifying women veterans.
- Recommendation 10: Develop VA outreach initiatives to inform Selected Reserves and National Guard commanders of the current exclusion of reservists and guard members for VA sexual trauma health care treatment and counseling. Ensure that alternative services can be provided to assist these troops should they experience a sexual assault, trauma or harassment during their military assignments.

- Recommendation 16: Submit a formal legislative request to amend 38 U.S.C. § 1114(k) to include a Special Monthly Compensation ("k" award) for women veterans who have undergone a simple or a radical mastectomy.
- Recommendation 30: Require, through legislation, that all federally funded research programs and studies include a schedule of questions to solicit information related to military background and combat exposure for every study subject.

Rationales for VA's non-concurrence in these recommendations were included in the Department's formal response to the Advisory Committee. A copy of that response was provided to Members of this Committee in May 1999 and is included as an attachment for the Record. I will be glad to answer specific questions regarding these recommendations.

The primary concerns of the Advisory Committee, as reflected in the 1998 report were:

1. The future of VA programs for women, particularly women's clinics and other gender-specific services. Although there has been a significant increase in the number of women using VA since 1992 (+64%), they remain a small percentage of the population of veterans accessing VA services. According to VHA, current enrollment figures indicate that approximately 5% of enrolled veterans are women. While it is true that the disparate ratio of men to women in VA facilities presents specific problems for the women veteran population in VA, the development of specialized, in-house women's services is not seen as an optimal method to provide cost-effective quality health care in every facility.

VHA currently operates approximately 500 community-based outpatient clinics (CBOC's) to provide access to health care services closer to veterans' homes, to reduce congestion and travel times and to improve patient satisfaction with VA health care. Coupled with the emphasis on primary care, in some locations specialty clinics are being streamlined as a result of expanding CBOC capabilities. Some VA medical centers originally designed Women's Health Clinics to provide gender-specific specialty care; e.g., gynecology exams, Pap, general reproductive and breast care, and sexual trauma screening for women veterans, as well as comprehensive primary care. Others established Women's Clinics, which were, in fact, gynecology clinics, or infrequently scheduled clinics providing only preventive services. With VHA's shift from disease-oriented specialty care to holistically-oriented primary care, the trend has been to mainstream women's health, as well as all other specialties, into primary care clinics/teams. There is a difference of opinion between providers and consumers about the impact of mainstreaming women's health into primary care. Advocates of this approach believe that the individual needs of these women are being met in clinics of another name/type. Others believe that this practice does not address the concern that VA primary care providers may be less attuned to women's health issues and less skilled in gender-specific care because of the small number of women patients seen in VA. An effective compromise between these two positions has evolved in some facilities where one primary care team has

been designated as the women's team. These teams are designed to provide comprehensive primary care to women, including gender-specific health care, and are consistent with the direction the VA health care delivery system is moving. In all VHA facilities, referral to gynecologists or other specialists is available to all enrolled women veterans, as clinically indicated.

Recognizing that women's health care delivery in VA is evolving and requires further evaluation, VHA, in collaboration with the Center for Women Veterans, has established a task force to assess the current status of women's services in VA and provide recommendations to assist management in developing innovative, creative and cost-effective programs that are responsive to the needs of the women veteran population. The task force is comprised of representatives from the National Leadership Board, Women Veterans Comprehensive Centers and the Women Veterans Coordinators. The Director, Center for Women Veterans, is a consultant to this group.

2. The elimination of the sunset provision from VA's Sexual Trauma Counseling Program (STC). At the time the Advisory Committee report was completed, the authority to provide sexual trauma counseling under Pub. L. No. 102-585, was due to expire on December 31, 1998. The "Veterans Program Enhancement Act of 1998" (Pub. L. No. 105-368), signed into law November 11, 1998, extended VA's authority to provide sexual trauma counseling through December 31, 2001, and the "Millennium Health Care and Benefits

Act" (Pub. L. No. 106-117), further extended this authority through December 31, 2004.

3. The enactment of legislation authorizing VA to provide sexual trauma counseling services to National Guard personnel and Reservists who encountered such experiences while on active duty for training. Pub. L. No. 106-117 mandates that the Secretary of Veterans Affairs, in consultation with the Secretary of Defense, conduct a study to determine the extent to which former members of the Reserve components of the Armed Forces experienced sexual trauma while serving on active duty for training, and to determine the extent to which sexual trauma counseling services are utilized. This task force has been established under the direction of Ms. Carole Turner, Director, VHA's Women Veterans Health Program, and the final study will be reported to the Committees on Veterans' Affairs of the Senate and House of Representatives in March 2001.

4. The amendment of 38 U.S.C. § 1114(k) to include the authorization of special monthly compensation for women veterans who have undergone a simple or radical mastectomy. The Administration has stated its support for legislation to effect this change.

5. Services for women veterans who are homeless. Since 1990, the number of women veterans provided residential treatment through VA's Domiciliary Care

for Homeless Veterans Program (DCHV) increased from 2.7% to 3.5%, and although these programs have worked very hard to develop interventions responsive to the needs of women veterans, their ability to be effective with this population is hindered by the disparate ratio of men to women that exists in the veteran population. In response to this, VA has developed a special initiative for homeless women veterans with and without children. During this fiscal year, \$3 million dollars has been allocated to support the development of demonstration programs designed to meet the treatment and support service needs of women veterans who are homeless. I am pleased to announce that, following a competitive RFP process, 11 VA facilities have been selected to receive funds in support of their proposed program. These facilities are located in Atlanta, GA; Brooklyn, NY; Tampa, FL; Cleveland, OH; Cincinnati, OH; Dallas, TX; Houston, TX; Los Angeles, CA; San Francisco, CA; and Seattle, WA.

As I have indicated, most of the issues identified by the Advisory Committee in the 1998 report have been addressed, and in some cases, resulted in subsequent programmatic or statutory amendments.

The Center for Women Veterans will continue to monitor the status of their 1998 recommendations and will work closely with VA staff to assure that those recommendations with which VA concurred are implemented.

Finally, the Center for Women Veterans is hosting "Summit 2000: A National Summit on Women Veterans Issues," June 23 - 25, 2000, at the Omni Shoreham Hotel, Washington D.C. The summit is being co-sponsored by the Disabled American Veterans and the White House Office on Women's Initiatives and Outreach. The summit is designed to provide representatives from the women veterans' community, veterans' service organizations, veterans' service providers, Federal agency representatives and other interested individuals with a forum in which to:

- discuss current initiatives for women veterans,
- identify issues of concern to the women veterans' community, and
- share ideas on how to improve services to women veterans through programmatic, outreach or other initiatives that address the identified concerns.

I am pleased that staff members from both the House and Senate Veterans' Affairs Committees have agreed to participate in a panel presentation at the summit. We appreciate their support.

The Center for Women Veterans will publish proceedings of the summit, which will include the issues and initiatives suggested by the summit working groups. This document will be distributed to Federal and State agencies,

Congress, veterans' service organizations, and veterans' service providers for consideration in organizational strategic planning activities.

VA is grateful for the work of the Advisory Committee on Women Veterans. Its activities and reports play a vital role in helping the Department assess and address the needs of women veterans.

This concludes my formal testimony. My colleagues and I will be pleased to answer any questions.

DEPARTMENT OF VETERANS AFFAIRS**RESPONSE TO RECOMMENDATIONS OF
THE VA ADVISORY COMMITTEE ON
WOMEN VETERANS
1998 REPORT****A. RECOMMENDATIONS: OUTREACH****1. VA continue to monitor and improve outreach programs and initiatives for women veterans with special emphasis on minority populations.**

Concur: VA agrees that outreach is an essential component of its efforts to inform women veterans of the benefits and services to which they are entitled. Department outreach efforts have increased by establishing the Center for Women Veterans (CWV), and encouraging local facilities to develop outreach programs for their local women Veterans' community. CWV reaches the women veteran population in many ways, including: hosting community meetings and town forums across the country, including Native American Reservations, and providing information seminars at local, regional and national veteran group meetings. Annually, CWV conducts an average of 25 open forums for women veterans. In addition, information seminars are conducted at most of the National Veterans' Service Organizations' annual conventions.

In January of 1998, CWV established an interactive web site on the Internet that provides information about the CWV, VA benefits and healthcare services, as well as VA programs specifically designed for women veterans. Accessible through VA's Home Page, it is linked to a wide variety of other veteran-focused web sites. The CWV site is designed so readers may communicate through direct e-mail with the CWV.

This past year, the Center for Women Veterans has worked closely with the Center for Minority Veterans to assure women's issues are incorporated into their outreach agenda. Additionally, Center staff has presented information seminars on VA programs for women at minority veteran conferences and outreach programs particularly focused on the minority veteran community.

The Department of Labor's Women's Bureau is sponsoring a poster contest in 1999 that will honor women veterans. The winning poster will be placed in local employment offices throughout the United States to ensure that women who have served in the armed forces are aware of special services provided to veterans in state employment offices and to encourage employers to hire women.

2. Increase outreach efforts to assist community-based agencies. Site visits and providing information about the availability of VA healthcare and benefits coupled with the maintenance of viable referral networks between VA and the community will enhance services to women veterans.

Concur: Individual VA facilities use a variety of media outlets to educate their local community about VA services, veterans' issues and special programs. Such efforts frequently include a review and/or discussion of women veterans' issues and VA programs for women veterans. VA facilities generally hold at least one outreach program a year focusing specifically on women veterans, and many conduct more. Additionally, Women Veterans' Coordinators frequently present information programs before community groups, local women's organizations and audiences concerned with veterans' issues. Within Veterans Health Administration (VHA), individual Veterans' Integrated Service Networks (VISNs) have developed marketing plans specifically designed to reach out to women veterans. An example of such a plan (VISN 8) will be disseminated in the Spring 1999 Issue of the Women Veterans' Health Programs Office Newsletter. All Women Veterans' Coordinators are encouraged to establish viable networks with non-VA service providers in their local communities and participate in programs that educate them regarding VA programs and services for women.

Since 1992, the number of women veterans seeking services from VA healthcare facilities increased by 32%. During this same time, the number of male veterans seeking services increased by only 2.2%. This substantial increase in women veteran users, we believe, is due in part to the aggressive outreach of VA providers.

3. Require by legislation, all federally funded social service agencies, community programs and organizations, identify, within their served population, veteran clients and annually report these statistics to the Department of Veterans Affairs.

Non-Concur: Although it is possible to prepare a legislative initiative consistent with this recommendation, VA questions whether this information, if collected, would be of significant value to VA. Also, we believe that non-VA program officials would oppose such a measure on the basis that it would permit VA to exercise control over their internal procedures.

Additionally, at the current time there are no standard queries for identifying or classifying veteran clients in non-VA programs, precluding comparability of VA and non-VA data and systems. If such legislation were enacted, standardized probes would have to be designed and some data collection systems might require redesign to accommodate their use. There is a strong possibility that the cost involved in implementing such legislation could outweigh any benefit gained. Clearly, a cost-benefits analysis would need to be done prior to initiating any such legislation.

VA suggests that the Committee determine exactly what information they are interested in and explore other avenues to obtain it. With more guidance from the Committee on their objectives, it is very likely the Center for Women Veterans, and other VA program offices could develop collaborative relationships with other Federal agencies and obtain the needed information without legislation.

4. Develop and produce a video to address issues affecting women veterans, such as VA eligibility criteria, benefit and healthcare services, and the contributions of women to the United States Military. Distribute this video for use in Transition Assistance Program (TAP) Briefings, local media presentations and Public Service Announcements (PSAs).

NonConcur: Individual VA facilities develop information videos and PSAs for community audiences that describe the range of benefits and healthcare services particular to their facility. Since all facilities do not have the same array of services, it would not be feasible to develop a generic video appropriate for national viewing. Eligibility information and assistance is readily available through VA's national toll free information phone number and Webpage, as well as at all VA regional offices, healthcare facilities, and vet centers. Additionally, as the determination of which of the seven veteran priority categories will be eligible for enrollment in VHA healthcare programs is determined on a yearly basis, a video presentation could be outdated very quickly.

Veterans' Benefits Administration (VBA) provides a thorough overview of VA benefits and services at TAP Briefings. The Center for Women Veterans works closely with VBA to assure that information about women's programs is included in these presentations. CWV will collaborate with VBA in assessing what, if any, deficiencies exist in this area.

The Women in Military Service Foundation developed a videotape presentation on the history of women in the military entitled "In Defense of a Nation." This video was distributed to all VA Women Veteran Coordinators in FY '95, and should be available for viewing at every VA facility. As such, there is no reason for VA to replicate the production of such a video. However, the Center for Women Veterans will send a letter to the field reminding all Women Veterans' Coordinators of the importance of having this as a resource and incorporating it into new employee orientation programs.

TAP is a joint endeavor sponsored by the Departments of Defense (DOD), Labor (DOL) and Veterans Affairs (VA). TAP's primary purpose is to educate and inform separating service members of the benefits and services available to them as veterans, and assist them in making a successful transition to civilian life. The inclusion of a video on the history of women in the military is not consistent with the goals of TAP and not in line with the other topics included in the program.

5. Incorporate an orientation to VA programs and services as part of basic military training.

Refer to DOD: VA does not have the authority to determine or dictate the content of basic military training programs. However, VA will forward this recommendation to DOD for review and consideration. The Center for Women Veterans will follow-up on their response and provide this information to the Committee.

6. Place VA benefit and healthcare information in professional medical, nursing, social work and psychiatric publications to alert community caregivers to the existence and availability of VA benefits and programs. Articles should routinely solicit assistance of the community and address the difficulties experienced by VA in identifying women veterans.

NonConcur: General publicity regarding VA services usually originate through PSA broadcasts during donated air time and/or news programs sponsored by the media. For information regarding VA benefits and publicizing programs, VA is dependent on public relations activities and the subsequent interest they generate through local press releases, community involvement, etc. Prior to December 1997, VA was expressly prohibited from using appropriated funds for generic outreach and advertising by VA policy. Revisions of that policy were made in December of 1997 and that prohibition was rescinded. The decision to use medical care funds for outreach and information is made at the local level. Information on VA services, programs, entitlements and eligibility is also available from general VA publications like VA Pamphlet 80-98-1, "Federal Benefits for Veterans and Dependents".

7. Provide VA orientation training about VA's Compensation and Pension benefit programs and examination requirements to Department of Defense military healthcare staff.

Refer to DOD: The Department of Veterans Affairs does not have the authority to determine the content of educational programs for DOD personnel. However, we will forward this recommendation to the DOD for review and consideration. The CWV will follow-up on their response and provide this information to the Committee.

8. Develop a strong, collaborative relationship between the Departments of Veterans Affairs, Labor, and Defense to better serve active duty service members, transitioning service members and veterans. Department of Defense should enforce mandatory attendance of all separating service members at TAP briefings. All three Departments should reemphasize the Disabled Transitional Assistance Program (DTAP) goals developed for special consideration of service members unable to attend regular TAP briefings because of physical impairment, disability or hospitalization. Include spouses and other family members as audience participants for TAP and Conservators, if the service

member is incompetent, incapacitated or cannot comprehend the content of the briefing.

Concur/Refer to DOD: The Department continues to work on strengthening its relationship with other Federal agencies involved in providing services for veterans. TAP is an example of one area where this is being accomplished. VA staff collaborate with DOD and DOL to assure that information presented at TAP briefings is relevant, up to date, and of value to separating service members. The Department of Labor permits spouses to attend its three-day TAP workshops and is taking steps to encourage more spouses to attend. Spouses are helped with job searches, preparation of resumes, and similar services.

VA has no authority to mandate attendance at TAP programs. Participants in TAP are, for the most part, active duty servicemembers. Company commanders and the formal chain-of-command on each military base have the sole authority to relieve eligible participants of other duties in order that they may attend the programs. VA will forward this recommendation to DOD for review and comment. CWV will follow-up on their response and provide this information to the Committee.

The second part of this recommendation implies that the Committee has identified difficulties with the effectiveness of DTAP. It is difficult to outline a specific plan of action without specific details regarding the problems service members who are disabled while on active duty encounter in attempting to access this program. If the Committee has such information, VA will be glad to follow-up on any issues presented to us.

- 9. Advise the Defense Advisory Committee on Women in the Services (DACOWITS) of the importance and the need to increase training opportunities for women service members about benefit programs and healthcare services administered by the Department of Veterans Affairs. DACOWITS can support and increase the availability of participation in TAP for women service members and provide technical assistance to facilitate a successful transition of military women into the civilian communities. Special emphasis must be placed on addressing the needs of Selected Reserve and National Guard women serving on active duty who are disabled in line-of-duty. These women are often overlooked because they are not stationed or attached to an active duty military unit and are not invited or assigned to attend routine Transition Assistance Program briefings.**

Concur: The DACOWITS Military Director is an ex-officio member of the VA Advisory Committee on Women Veterans. She participates in all Committee discussions and deliberations. As such, VA is confident that DACOWITS is aware of the concerns of the Committee and their desire for DACOWITS to emphasize training on VA services to active duty women. The Director, Center for Women Veterans also participates in the DACOWITS meetings to assure a continued exchange of information between VA and DOD. Additionally, in FY 1999 the Chairs of the Advisory Committee on Women Veterans and DACOWITS met to discuss common areas of interest and concern to both

Committees. We anticipate these meetings will continue, and ultimately lead to improved collaboration between these two committees.

B. RECOMMENDATIONS: HEALTHCARE

10. Develop VA outreach initiatives to inform Selected Reserves and National Guard Commanders of the current exclusion, for reservists and guard members, to VA sexual trauma healthcare treatment and counseling. Ensure that alternative services can be provided to assist these troops should they experience a sexual assault, trauma or harassment during their military assignments.

NonConcur: In 1997, VA General Counsel held that, with one exception, Reservists and members of the National Guard who experienced sexual trauma while on active duty are eligible for VA counseling under the Department's special sexual trauma treatment authority in 38 U.S.C. 1720D. Reservists and members of the National Guard not eligible for such treatment are those who experienced sexual trauma while serving on active duty for training (ADT). This exclusion is based on the statutory definition of "active duty" which excludes periods of active duty for training from the definition of active duty. Accordingly, we do not concur with this Recommendation because it does not accurately reflect the current status of these individuals' eligibility for VA sexual trauma care and counseling.

For those who are not eligible for such services, VA service providers and health care professionals ensure they are referred to local community providers or assistance organizations for treatment of the aftereffects of their sexual trauma.

11. Seek legislative authorization to allow members of the military, including Selected Reservists and National Guard members, who experience sexual assault, trauma and harassment while in performance of their military duty, to be eligible for VA sexual trauma counseling and healthcare.

Response: Members of the active military may receive sexual trauma counseling from VA providers through contract agreements between DOD and VA. To date, the Administration has taken no position on the proposals in this recommendation.

12. Eliminate any and all restrictions and time limits on VA's (including Readjustment Counseling Service) ability to provide sexual trauma counseling and healthcare.

Concur: VA has authority to provide sexual trauma counseling and care through December 31, 2001. This is the only limitation on VA's ability to provide this care. The Committee, through this Recommendation is, therefore, recommending that this treatment authority be made permanent. To date the Administration has taken no position on this proposal. We do not foresee any problems, however in making such a change.

13. Establish and maintain a consistent level of staff training focusing on treatment protocols, sensitivity concerns, and other issues instrumental to providing effective sexual trauma counseling. Continuing education of VA clinical staff, Readjustment Counseling Service staff, and Veterans Benefits Administration's regional office staff will ensure quality of care for all veterans.

Concur: VA staff training efforts in the area of sexual trauma treatment and counseling will remain an ongoing activity.

Residents and students begin their VA experience often without a clear picture of what it means to be a veteran and, most importantly, how military experience can impact health. To meet this need, a pocket guide and a supporting Internet website have been developed. The pocket guide focuses on history taking and a review of systems, specific to an occupational medicine review of the veteran's military experience. It includes unique health risks and issues of concern for veterans' health and includes sexual harassment and trauma as well as Post Traumatic Stress Disorder (PTSD). The website, is located on the Office of Academic Affiliations' homepage, within the VA Intranet, and offers a rich resource for students and residents. The questions found on the pocket card link to primary review and research articles, abstracts, additional readings, and links to other appropriate websites. Additional training efforts have included the following:

- (i) Two satellite video teleconferences on the treatment of sexual trauma aired in FY 1997. One broadcast targeted mental health professionals, and the other targeted primary care providers. Copies of these videoconferences are available in the library of every VA facility.
- (ii) The videoconferences mentioned above were used as the basis for two 1998 continuing education supplements to the Federal Practitioner (a Journal for health care professionals of VA, DOD, and PHS). Supplement I "Sexual Trauma in Women Veterans – Screening and Referral" and Supplement II "Sexual Trauma in Women Veterans – Primary Care Challenges." These supplements were approved as independent study programs providing clinicians an opportunity to earn continuing education credits by completing a short examination on the content of the articles.
- (iii) During FY '98, concurrent mini-residencies in "Women's Mental Health in Primary Care" were held by the Women Veterans Comprehensive Health Centers at the Minneapolis and Boston VA Medical Centers. Minneapolis' program highlighted training for primary care providers in working more effectively with interpersonally-difficult patients and Boston highlighted the assessment and management of stress, and traumatic events and their mental health consequences in the primary care setting.

- (iv) In FY 1998, eight videotapes on sexual trauma produced from 1993 to 1997 were packaged under the title, "Sexual Trauma: Diagnosis, Treatment and Related Issues" and made available through the Library Service of each VA medical center.
- (v) Similar initiatives occurred in Veterans Benefits Administrations (VBA). VBA's women veterans' advisory committee conducted two national satellite interactive videoconferences on PTSD and Sexual Trauma for selected VBA staff. Copies of the videoconferences are available in each VBA regional office. Other conferences have addressed sensitivity training and techniques for interviewing sexual trauma claimants. Additionally, individual VARO's conducted training on women veterans' issues for their staff.

14. Authorize eligible women veterans to obtain prosthetic appliance i.e. shoes, cane, hose etc, designed to fit her specific body proportions and height specifications. If feminine apparel is not available; a program should be established to permit the issuance of a voucher to authorize the purchase from a private vendor.

Concur: All veterans enrolled in the VA healthcare system, women and men, have the right to receive appropriate and adequate prosthetic appliances for the treatment of their medical condition. After medical need and eligibility have been established, VA Prosthetic Departments procure an appliance in one of three ways: a) custom-fabrication by a commercial or in-house source, b) VA stock, or ordered from commercial sources, or c) on VA contract. Appliances are provided in consideration of and consistent with the gender of the patient and her or his physical abilities, limitations, etc. If the appliance is found to be unsatisfactory by the patient or inspecting official, the Prosthetic Department will make all necessary arrangements for obtaining adjustments or replacing the appliance. While it is true that most VA prosthetic appliances/equipment in stock are not of gender-specific design, VA accommodates the needs and desires of women veterans by providing them with local procurement authorization to supply and/or repair the appliance.

Prosthetics also manages the National Footwear Center (NFC). The NFC is a national program that provides footwear to VHA.

The NFC identified the need for women's shoes for the female veteran population and addressed this issue by identifying a vendor with a wide assortment of modern female shoes. Although VA does not stock female shoes per se, the shoes can be specially ordered. Shoes are usually delivered to the veteran within seven days. The VA Prosthetic and Sensory Aids Service Strategic Healthcare Group in Washington, DC, should be notified immediately if any Prosthetic Department issues appliances inconsistent with the medical needs and gender of an eligible VA patient.

15. Authorize legislation to permit Medicare-subvention for VA healthcare programs and services and mandate that funds recovered under this reimbursement program be retained by the Department of Veterans Affairs as a resource to use to enhance medical care for Veterans.

Response: VA has been interested in becoming a Medicare provider for several years. In 1995, the Vice President accepted as a REGO II (Reinventing Government) initiative VA's proposal to study the feasibility of receiving Medicare reimbursement for treating dual eligible higher income veterans at VA facilities. VA believes that Medicare beneficiaries who are veterans should have the choice of where to use their Medicare benefits, including VA. Medicare reimbursement is also a critical element of the Under Secretary for Health's long-range goals for the Veterans Health Administration to increase its non-appropriated funding sources.

VA, OMB and the Health Care and Finance Administration (HCFA), worked together to develop a Memorandum of Agreement (MOA). The MOA will establish the operating principles for conducting a pilot test at VA facilities. The proposal is for a three year pilot where participation would be limited to higher income (Priority 7) veterans not currently treated by VA. Reimbursement rates would be 95 percent of what is paid to private sector providers. Other adjustments would reduce VA's reimbursement rate even further from the private sector. VA agrees to meet all Medicare conditions of participation and would offer at least the same benefits as other Medicare providers.

Currently, with few exceptions, Medicare is not allowed to reimburse other Government entities. Legislation is required to allow Medicare to reimburse VA. The Department has submitted legislation over the last two years, but they have not been introduced in Congress. Other bills have been introduced in the Senate and House; however they differed from the Department's proposals to varying degrees. A Medicare reimbursement pilot remains a top priority for VHA and the Department. We remain hopeful that legislation, similar to that already granted DOD, will be enacted this session to allow a Medicare pilot project to get underway in FY 2000.

C. RECOMMENDATIONS: BENEFIT ENTITLEMENT

16. Submit a formal legislative request to amend Title 38 United States Code, section 1114 (k) and the 38 Code of Federal Regulation, section 3.350 (a) to include a Special Monthly Compensation k-award for women veterans who have a simple or a radical mastectomy.

Response: Generally, Special Monthly Compensation (SMC) is authorized for the loss of or loss of use of a limb or organ. Additionally SMC can be provided for the loss of other body parts such as: buttocks, either eye, both ears and or the vocal organs. The Committee's recommendation for formal legislation to amend Title 38 USC, section 1114(k) and 38 CFR, section 3.350(a) to include the authorization of a k-award for women veterans who have a simple or radical mastectomy will be considered by VA

and vetted within the Administration. VA assures the Committee the Department will provide it with a formal position on this recommendation once a determination has been made.

D. RECOMMENDATIONS: WOMEN VETERANS WHO ARE HOMELESS

- 17. Develop VA pilot programs to adequately assess and address the issues, concerns, needs and problems of women veterans who are homeless. Develop protocols or guidelines to assist VA healthcare providers in accommodating the needs of women veterans that are homeless in various shelters and housing situations.**

Concur: The Center for Women Veterans is working closely with the Director of VA's Homeless Program to assure that the needs and problems of women veterans who are homeless are addressed by the Department. In the proposed budget for FY'00 VA plans to allocate two and one-half million dollars on targeted programs to improve VA services for women veterans who are homeless. A VA task force has been established to oversee VA initiatives in this area.

- 18. Increase the annual fund level allocated by the Department of Veterans Affairs and Congress for the VA Homeless Provider Grant and Per Diem Program.**

Response: VA will, under the Homeless Providers Grant and Per Diem Program, increase the amount of funding for new grants from \$5 million to more than \$12 million in FY 1999, and \$31 million in FY 2000. In addition, under this same program, there is a targeted initiative for women veterans in VA's proposed budget for FY 2000.

E. RECOMMENDATIONS: MINORITY WOMEN VETERANS

- 19. Expand VA outreach activities to minority women veterans, including Native American women veterans living on and off the reservations to include: ethnic media (print/radio/TV), churches and community-based organizations, minority women organizations and health fairs.**

Concur: The Center for Women Veterans (CWV) and the Center for Minority Veterans (CMV) collaborate in efforts to improve outreach to Native American Women Veterans living on and off reservation. Women Veterans' Coordinators (WVC's) have been encouraged to work with Minority Veteran Program Coordinators (MVPC's) to improve outreach among minority women veteran. MVPC's are skilled in utilizing a variety of methods to outreach to targeted communities, including those identified by the Committee. When MVPC's address veteran groups, they provide information on programs, benefits and services available to women veterans as well as minority veterans. Coordinators will be directed to increase their efforts in this area and to coordinate with WVC's to assure information on women veteran programs in their outreach programs. Recently, both Centers worked closely with VA's Office of Public

Affairs in distributing Gulf War benefits and information packets for minority and women veterans.

CMV has a designated Native American Program Manager/Analyst to work issues relative to the Native American veteran population who is available to assist the CWV with issues in the Native American Women Veteran Community. CMV and CWV collaborated with DOD in hosting a veterans information outreach seminar on the Blackfoot reservation in Montana. Both Centers also worked with a New Mexico based community non-profit organization, Veterans Rehabilitation and Training Services, in hosting open forums for veterans in Farmington (near the Navajo Reservation) and at the Albuquerque Indian Center.

CMV also hosted Native American town hall meetings on New Mexico's Laguna Pueblo, Acoma, Canconita, Navajo, and Santo Domingo Reservations, and with Sioux tribes on the Rosebud and Pine Ridge reservations. CMV includes many tribal veterans' organizations on the CMV bi-monthly telephone conference calls for minority Veterans' organizations and community based organizations. CMV, CWV and DOL will continue to actively collaborate on issues of mutual interest to Native American veterans.

20. Ensure that women veterans of color are included in all areas of VA health research and demographic studies that impact women's health.

Response: The Department's response to this recommendation can best be addressed by discussing the 5 different categories of demographic studies used to obtain data describing the veteran population: (i) general VA studies, (ii) National Survey of Veterans 2000, (iii) veteran population data, (iv) Census 2000 and related initiatives, and (v) VHA research policy.

- (i) In general, studies that do not focus specifically on the needs and problems of women veterans will not include sufficient numbers of women veterans in their sample designs to produce reliable data of any generality on women Veterans. The most effective way to obtain this information is through studies specifically focused on the target population: e.g., minority women veterans, either by VA, or in collaboration with other Federal agencies such as Labor or Defense. Such studies require a special funding initiative to support the sampling necessary to obtain a sample population large enough to assure the accuracy and applicability of the findings.
- (ii) VA's planned National Survey of Veterans 2000 (NSV2000) is currently in the design phase and the final sample design is expected to produce reliable detail on various subgroups of veterans. For a discussion of this effort see the response to Recommendation 29.

- (iii) With regard to veteran population data, VA's Office of Planning and Analysis maintains projections of the female veteran population from 1993-2020. Separately, the Office of Planning and Analysis, has 1990 estimates of the total veteran population by race/ethnicity from the 1990 Decennial Census. Combined current estimates of the female veteran population by race/ethnicity are available only from the Current Population Survey (CPS), conducted by Census for the Bureau of Labor Statistics. Each year, the CPS March Supplement is a source for annual demographic data on veterans and nonveterans, and maintains historical March CPS files from 1990 through 1998.
- (iv) With the upcoming Year 2000 Decennial Census, VA in conjunction with the Bureau of the Census, will obtain new Year 2000 estimates of the female veteran population by race/ethnicity. These data should become available in 2002 or 2003. In addition, VA has a new veteran initiative underway, namely a review of VA's current methodology for construction estimates and projections of the veteran population. The contractor will also review ways to maximize linkages to the Year 2000 Census and suggest ways to improve estimates and projections for subcategories of veterans, including female veterans.
- (v) M-3, Part I, Chapter 14, (July 24, 1992) "Inclusions of Women and Minorities in Clinical Research" established VHA policy regarding the inclusion of women and minorities in clinical research. Applicants for VA Central Office research support include minorities and women in their study population whenever possible and scientifically desirable.
- (vi) Special efforts are made to include members of minority groups and women in studies of disease, disorders, and conditions that disproportionately affect such groups. If women and minorities are excluded or inadequately represented in a proposed clinical research study, particularly in a proposed population-based study, an exception to the policy must be approved by the Chief Research and Development Officer. This guidance is also referenced in Health Services Research and Development (HSR&D) instructions to research proposal reviewers. HSR&D will remain cognizant of the concerns of the Advisory Committee and attempt to ensure their recommendations are met.

Additionally, CMV collaborated with the VA Office of Research to ensure that approved projects include research projects that focus, primarily, on healthcare issues specific to minority populations. CMV obtained funding for research projects that focus on disparities in medical treatment of minority veterans, based on race and gender.

In response to concerns about the inclusion of minorities and women in clinical research, Congress placed additional responsibilities on the CMV and CWV. One of these is a requirement to advise the Secretary on the effectiveness of the Department's efforts to include minorities and women in clinical research, and in the funding of

research initiatives particular to conditions affecting the health of members of minority groups and/or women.

- 21. Conduct demographic reviews of patient outcomes to identify healthcare disparities among women veteran sub-groups in diagnosis, treatment, rehabilitation and end of life care. Determine if minority women veterans are more frequently institutionalized for physical disability and mental illness rather than being treated in the more cost effective, efficient and sensitive community based care.**

Response: VHA's Health Services Research & Development (HSR&D) announcement IL 12-97-010 was a call for Women Veterans Healthcare research projects. The announcement addressed the role of ethnicity and culture in VA healthcare. The Department is aware that the healthcare literature indicates that gender, race and ethnicity are often associated with certain systematic differences in the amount and type of healthcare individuals receive, both inside and outside the Department of Veterans Affairs.

Both the CWV and CMV will continue to request VA program offices provide specific data on women, minorities and minority women veterans relative to utilization and treatment, and encourage research initiatives among these veteran groups.

- 22. Work with local tribal program officials to ensure Native American women veterans are afforded access to and receive VA benefits including assistance from VA's Vocational Rehabilitation Specialists and are afforded access to programs administered through the Department of Labor Veterans Employment and Training Service (VETS) programs.**

Concur: During the past two years, both the CMV and the CWV have increased collaborative efforts with DOL to address and improve outreach programs to Native American Veterans. Programs addressing employment services and issues have been held on reservations across the country. Additionally, DOL's Veterans' Employment and Training Service has opened discussions with the White House's representative for Native American affairs and the Senate Indian Affairs Committee regarding the provision of a job training grant tailored for the Native American veterans community. CMV includes many tribal veterans' organizations on the CMV bi-monthly telephone conference calls for minority Veterans' organizations and community based organizations. CMV, CWV and DOL will continue to actively collaborate on issues of mutual interest to Native American veterans.

F. RECOMMENDATIONS: WOMEN VETERANS' COORDINATORS

23. Monitor and appropriately allocate the amount of time Women Veterans' Coordinators are authorized and provided to perform the duties related to this position.

Response: In October 1991, VA issued the Women Veterans' Coordinators Program Guide, G-5, M-2, Part 1, to guide facilities in the development of Women Veterans' Coordinator (WVC) positions to oversee their local women veteran programs and to ensure that women veterans have equal access to VA facilities. M-2, Part 1, Chapter 29 (December 29, 1994), replaced these guidelines and mandated that a WVC, appointed by the Director, exist in each VHA facility. The designated WVC should be a healthcare professional with responsibility for assessing the needs of women Veterans at their respective facilities, and assisting in planning, organizing, and coordinating facility services and programs to meet those needs. In addition, WVCs make recommendations to the Director to assure compliance with policies and regulations and provide clinical care to women as part of the function of the job. Chapter 29 (in concert with program staff, WVC community, VISN staff, and other relevant offices) is being revised to include outcome measures for WVCs that relate to outreach. VHA's goal is to move the job focus away from process (time) to outcomes (performance measures) and to prioritize the various functions previously assigned to WVCs in administrative, clinical, educational and marketing areas, and to look for alternative strategies for accomplishing goals.

VBA fully supports the Women Veterans' Coordinator program and agrees that WVCs must have management's support to perform what is largely a collateral function within VBA. Allocation of the amount of time that WVCs need to perform these duties is controlled at the local VBA regional office level. Differences in station size, work load and population of women veterans all impact the amount of time needed to perform coordinator duties.

24. Post and disseminate flyers, brochures, etc., providing access information for contacting the Women Veterans' Coordinator. Ensure that staff in public areas such as the telephone operator, admission's office, triage units and ward nurses are aware of these procedures to ensure effective referrals.

Concur: VA agrees that the role of the WVC is one of our best "natural resources." VA personnel in both the regional offices and healthcare facilities should be aware of and understand the Coordinator program. The information needed to make referrals and provide accurate information crosses all VA functional areas. There is no question the Department can better operate as "One VA" when all Coordinators within a region work together as a team. VA also agrees that flyers, posters, and brochures concerning

women veterans and the Coordinator program should be displayed in all public areas of VBA and VHA facilities. We believe that in most of our facilities the WVCs is well known throughout the organization and publicized on public bulletin boards. However, in order to assure this practice is in place system-wide, the CWV will send a memo to the field asking facility directors for their support of this recommendation.

25. Continue the Veterans Health Administration's Women Veterans' Deputy Field Director positions to assure continuity in approach and implementation of coordinated healthcare initiatives to improve outreach, program development, public relations, and the utilization and quality of care for women veterans.

Concur: VHA agrees that Deputy Field Directors (DFDs) are an important part of the Women Veterans Health Program. Their first hand assessments and program oversight has proven invaluable tools in improving services to women. DFDs made 47 site visits to clinics and VA medical centers during FY 1998 to assure consistency and continuity between the Center for Women Veterans, Women Veterans Health Program, VISNs and Women Veterans' Coordinators. The CWV supports the continuation of these positions.

26. Support and fund educational programs on issues related to women veterans including satellite conferences and biennial educational meetings for all Veterans Health Administration's and Veterans Benefits Administration's Women Veterans' Coordinators.

Concur: VA agrees on the importance of educational programs for issues related to women veterans. A women's health update conference planned by the Women Veterans Health Program was held in conjunction with the National Association of VA Ambulatory Care Managers meeting, in August 1998. Clinical educational conferences were held at both the facility and VISN level.

Mini-residencies in women's health/primary care initiated were continued in FY 1998. Mini-residencies in women's primary care were held at the Los Angeles/Sepulveda VA Medical Centers (in conjunction with UCLA) and the San Francisco VA Medical Center (in conjunction with UCSF). Mental health residencies were held at the Minneapolis and Boston VA Medical Centers, and Durham VAMC held residencies in the development of Comprehensive Breast Health Centers. Mini-residencies for new Women Veterans' Coordinators continue to be held at the Bay Pines and Tampa VA Medical Center.

Additionally, in 1997, VA held the first joint conference for VA Women Veterans' Coordinators (VBA & VHA). This conference was quite successful. Although there are no plans to hold another such conference in the near future, CWV is planning a National Women Veterans' Summit for FY 2000 which may provide an opportunity to bring these two groups together to share their experiences and ideas.

27. Appoint an individual with expertise in women's health as a representative on the VISN clinical executive board (or its equivalent).

Concur: WVCs meet regularly with their VISN and Women Veterans' Health Programs (WVHP) DFDs to discuss issues related to program administration. DFDs have been tasked, in FY 1999, to solicit a designated representative to the WVHP from each VISN. They are also tasked with assuring each VISN appoint a "lead" WVC.

28. Establish a Women Veterans' Advisory Committee in every VISN and VA Healthcare facility. The membership of this committee should include VA personnel from the medical facility, vet center and regional office as well as minority women and disabled women veterans from the local catchment area who are current consumers of VA healthcare services and benefit programs.

Concur: We believe the vast majority of VA facilities have developed working groups, task forces, or committees to address issues related to customer satisfaction and provide feedback to program administrators on the services they are providing women veterans. The composition of these committees is generally consistent with the recommendation the Advisory Committee has made. Additionally, VHA is surveying each of its field facilities to determine the existence and membership composition of such groups.

G. RECOMMENDATIONS: RESEARCH

29. All studies and surveys sponsored, funded or conducted by VA must include gender specific information. VA analysis should routinely report the results of these studies and the gender-specific responses through circulation of the information within the veteran community service providers' networks.

Concur with noted exception: The Office of Planning and Analysis is responsible for the conduct of National Surveys of Veterans. These surveys routinely collect data useful for policy and planning purposes. Typically, sample sizes of subgroups of the veteran population are determined based on issues the survey is designed to address. The 1992 National Survey of Veterans was designed primarily to address healthcare eligibility issues and required oversampling for VA and non-VA healthcare users by age and service-connected disability groups. While there was a gender specific question on this survey and some gender specific data were presented in the report, the sample size allowed only limited data to be presented by gender. The Office of Planning and Analysis recognizes the evolving role of women in the military, their increase in the veteran population and the growing need for current information on the demographic characteristics, health profile, and socioeconomic status of these veterans. A contract for the design phase of a new National Survey of Veterans (NSV2000) was recently awarded. The design phase for

NSV2000 will consider not only items and sample sizes for a "core" NSV survey, but the need for supplementary surveys as well. As part of this design phase, needs assessment interviews will be conducted within VA offices that have been identified as customers of data collected through this vehicle. The CWV has been identified as one of those offices. CWV will also coordinate input from the Advisory Committee. During the needs assessment phase, uses and unmet needs of the 1992 NSV will be covered as well as new needs identified for the next survey.

In regard to specific program evaluations conducted by VA, the Office of Planning and Analysis has made a commitment to collect and report gender-specific information on all program evaluations conducted by or contracted for this office. Upon completion of the evaluations, reports will be delivered to the Center for Women veterans who is responsible for distributing the findings to the veteran community. A copy of the program evaluation reports will also be posted on VA's Homepage on the World Wide Web.

In November 1996, VHA's Research and Development Service invited VA investigators to submit health services research proposals in the area of "Gender Differences in Healthcare and Improving Health Services for Women Veterans." In response to this initiative, five proposals were funded in FY 1998. Additionally, under the Office of Research and Development's Nursing Research Initiative, two additional studies on women's health were approved and funded.

In FY 1998, a total of \$13.2 million dollars was spent on VA research focused on the health of women veterans. VA's Research and Development Service spent approximately \$3.8 million dollars (for 37 projects) on research focused on the health of women veterans. The total set of funded proposals includes scientific initiatives ranging from basic biomedical research to applied health services studies.

In addition, VA investigators received over \$9.4 million dollars (for 166 projects) from other Government agencies, private foundations and pharmaceutical firms to conduct research in women's health.

Although the focus here is on studies specifically identified as dealing with women's health issues, it is important to note that women can be expected to benefit from a much wider range of VA research studies. This seems to be a reasonable assumption given that many biological processes are common to both men and women. Further, since it is VA policy that both men and women be involved in all clinical studies whenever possible, the information resulting from such studies will be applicable with precision to both genders.

Exception: VBA agrees that gender specific information should be collected and reported on all studies and surveys that pertain to benefit claims processing, award, and benefits delivery. However, VBA sponsors or participates in many studies and surveys where gender specific information is not germane to the outcome. The Decision Review Officer (DRO) study, Regional Office workload studies, and the Systematic Technical

Accuracy Review (STAR) are examples where claimant and gender-specific information is neither applicable nor appropriate.

30. Require, by formal legislation, all federally funded research programs and studies include a schedule of questions to solicit information related to the military background and combat exposure for every study subject.

NonConcur: Although veteran status probes are included in some federally funded national surveys, all studies are not specifically designed to collect this information. Currently, there is no standard set of probes either for veteran status or combat status, precluding comparability of VA and non-VA data and systems. Thus, such responses would be of little benefit to VA. There would be costs associated with developing standardized questions and adding them to all Federally funded research initiatives, and these costs could be prohibitive. Additionally, individual researchers and studies would likely find this demand intrusive on the part of VA and resist the passage of such legislation, just as VA would if another agency attempted to interfere with its research designs. A better way to accomplish the aim of this recommendation is to request focused studies on women and other veterans, especially designed to elicit reliable detail on military background and the combat status of study subjects.

31. Monitor and analyze data on utilization of gender specific VA programs by women Veterans.

Concur: As stated in our response to Recommendation 29, VA is committed to including gender-specific identifiers in future evaluations whenever the use of such identifiers are feasible. It is important to note that the majority of VA programs are available to any qualified veteran, without regard to gender. That being said, every effort is being made by VA to assess women veterans' utilization of VA programs, whether they are gender specific or available for all veterans. For example, the Office of Planning and Analysis has begun a series of evaluations through which the major program areas administered by VA will be reviewed. Currently, the Office of Planning and Analysis is conducting evaluations of VA's Education Programs and planning one of the Cardiac Care programs; in both instances gender-specific data will be collected. It is important to remember, however, that without oversampling of women veterans, the use of gender specific identifiers may preclude some analyses of the data collected on women veterans.

32. Identify and eliminate barriers experienced by women veterans in accessing VA benefits and programs. Develop corrective action to ensure quality and timeliness in the delivery of VA health care services and benefit programs for women veterans.

Response: VA believes that most of the barriers to VA care experienced by women veterans have been abolished. However, staff continues to work on a day-to-day basis at the local, regional and national level to assure women are able to access all VA benefits and programs. VA is committed to ensuring the quality and timely delivery of

services to all veterans and has incorporated measures into their strategic plan to assist in evaluating each administration's success in doing so. More exhaustive data on this issue is expected in the findings of the "National Study on Barriers to VA Care for Women Veterans." This study, which is under the direction of Dr. Jessica Wolfe, Director of the Women's Health Sciences Division of VA's National Center for PTSD, is currently underway. CWV will share the findings of this study with the Committee and continue to work with on resolving specific problems in this area.

33. Require all VA healthcare facilities to maintain and advertise internal policies established for privacy and security issues as they relate to women veterans.

Response: As part of the 1997 Women Patient Privacy Survey, VHA surveyed all VA medical centers on program/policy issues related to women patient privacy. In that survey, two-thirds of the VA medical centers responded as either having or in the process of developing, programs/policies addressing patient privacy issues. The safety and security of all patients is of ongoing concern. VA will continue to monitor the progress of individual facilities in addressing identified deficiencies.

34. Establish at least one site within each VISN for inpatient psychiatry care for women veterans.

Response: Although the need for inpatient services is declining system wide due to the promotion of alternative treatment approaches; there is still a need for inpatient care for veterans suffering from serious mental illnesses.

For women veterans whose mental disorder is so severe that inpatient care is required, the privacy and security afforded by an inpatient site that is specifically designated to meet their needs can be an invaluable aid to recovery. It has not been determined whether the most effective way to do this is through the establishment of a dedicated women's unit in each VISN. VA has established a work group to evaluate this issue and provide recommendations as to the best way to provide this service throughout the country.

35. Include information about issues affecting women veterans in all VA employee training and orientation. Address concerns and protocols for treatment, trauma intervention, etc., with residents and visiting faculty at VA healthcare facilities and regional office staff.

Response: Although VA appreciates the intent of this recommendation, we cannot support it as written. Information about women veterans is not appropriate for every training and orientation program. VA concurs with including this information in new employee orientation, relevant healthcare programs, as well as in training programs addressing outreach, benefit programs, and claims and appeals processing. Additional training initiatives are developed as needed, to inform and update VA staff on current issues affecting women veterans, their benefits and healthcare.

H. RECOMMENDATIONS: SELECTED RESERVE AND NATIONAL GUARD BENEFITS

36. Modify all regulations, guidelines and federal statutes that provide definitions of active duty, veteran and qualifying active duty to include, in part, service in the Selected Reserves or National Guard. This will ensure that appropriate healthcare and compensation benefits are provided for members who experience sexual assault or trauma during military training or drill period, are eligible for VA benefits.

Response: At this time the Department has no position on this proposed initiative.

37. Increase the availability of information exchange and network opportunities between the Departments of Veterans Affairs and Defense to ensure that all service persons, including the Selected Reservists and members of the National Guard who are injured in the line-of-duty are identified and referred to VA in a timely manner.

Response: VA supports all initiatives that improve the exchange of information and the fostering of communication between VA and DOD. Over the last two years, VA and DOD have developed a number of joint initiatives designed to improve communication between the two Departments and ultimately enhance services to veterans.

Within VBA, a number of initiatives are currently being considered to include expansion of the Personnel Information Exchange System (PIES) to electronically exchange data directly with the services. VBA is currently working with the military services, to implement comprehensive, pre-discharge, claim process at military separation sites. VBA is also piloting a joint examination project for members of a military service who are being separated under the Medical or Physical Evaluation Board process. VBA will continue to explore other opportunities to improve services to veterans through collaborative initiatives with the active military.

The section of the recommendation regarding the reserve components, has two elements. The first of these is the electronic referral to VA of information relating to members who incur in-line-of-duty injuries. Action to award benefits to a claimant is contingent on VA's receipt of an application filed by or on behalf of the injured individual. In the absence of a formal or informal claim, information received by VA from the service component is not usable. Procedurally, implementation of the Recommendation would present significant problems without a claim, because a claims file is unlikely to exist for most of these individuals with which to associate the information. It has, however, been our experience that when a Reserve or Guard member files a claim for compensation, based on an injury sustained in training, obtaining documentation from the reserve component is not difficult if it was created initially. If the primary evidence does not exist or was not created by the service component, such as is frequently the case in sexual trauma cases, alternate verification methods exist.

The second element of the Recommendation addresses steps taken by the various service components, with the assistance of VA, to advise members of their rights in the event of injury. Once again, while there has been significant cooperative work done with the active components, information for the Selected Reserves and National Guard may be less readily available.

VBA supports working with the various Reserve and Guard components to ensure members are aware of their rights in the event of an injury.

Within VHA, similar initiatives have led to the development of joint committees studying the health status of active duty and veteran participants in the Persian Gulf War. This experience has laid a foundation for future collaboration in this area.

Additionally, the final report (January 14, 1999) of the Congressional Commission on Servicemembers and Veterans Transition Assistance (CSVTA), made numerous recommendations that addressed improving information management, communication, and benefit delivery systems through improving coordination activities between VA and DOD. As this report was just recently published, VA has not had sufficient time to analyze its potential implication and affect on VA programs and services. The Committee can be assured that the Department will review the CSVTA report findings and recommendations and take them under consideration in VA's strategic planning process.

VA will also forward this recommendation for review by DOD's Office of Reserve Affairs.

38. Assess Department of Defense's increased reliance on the Selected Reserve and members of the National Guard as primary support personnel for military action. The results of this assessment should support the need for significant legislative changes that affect the administration of VA benefit's and entitlements to reservists/guard members.

Response: The intent of this recommendation is unclear. Reservists and members of the National Guard are, in most cases, eligible for VA benefits if they are called to active duty. Under current law, members of the Selected Reserve and National Guard are eligible for VA healthcare and benefits when discharged under conditions other than dishonorable, and meet one of the following criteria:

- a) complete equal to or greater than 2 years of active duty service;
- b) complete 2 years of continuous active duty service or the full period for which that person was called to active duty (if less than two years);
- c) complete less than 2 years or less than the full period called to active duty due to disability, retirement from active duty, or has a VA service-connected rating; or d)

discharged or released from active duty in less than two years for reasons of early-out for the convenience of the government.

Selected reservists and National Guard members are not eligible for VA benefits when they:

- a) complete less than 2 continuous years of active duty;
- b) complete less than the full period for which they were called;
- c) perform active duty for training purposes only, or inactive training and have no VA rated service-connected condition.

I. RECOMMENDATIONS: NATIONAL CEMETERY ADMINISTRATION

39. Provide appropriate legislative resources to permit VA to expand and acquire land adjacent to or near established cemeteries and facilities to accommodate the burial of eligible Veterans.

Concur: The National Cemetery Administration (NCA) plans to expand existing national cemeteries by completing phased development projects, where appropriate, in order to make additional gravesites or columbaria available for interments. In its strategic planning process NCA identifies national cemeteries that will close due to depletion of grave space to determine the feasibility of extending the service period of the cemetery by the acquisition of adjacent or contiguous land.

40. Construct Columbarium for cremated remains at all National Cemeteries.

Concur: Construction of columbaria should be determined based on an evaluation of the efficient use of cemetery land and whether the demographics of the local veteran population indicate support and willingness to use columbaria. The choice of method of interment is an individual decision and is strongly subject to influences such as culture/ethnicity, religion, geographic area of the country, and age/generational practices. Data show that most veterans and their families prefer full-casket interment. Therefore, in order to preserve space for full-casket interments, the incorporation of ground burials is carefully evaluated. The master planning, design, and phased development of national cemeteries consider the anticipated ratio of full-casket and cremain usage. Where space limitations preclude full-casket interments, in-ground cremain sites or columbarium niches represent a viable means of providing continuing service, and are evaluated within each annual update of the NCA five-year budget and construction plan.

41. Ensure that all existing and proposed State-owned cemeteries follow VA's interment goals to preserve the obligation to provide an honorable resting-place for those exceptional individuals who served their country.

Response: Under current law, in order for a state to qualify for VA's State Cemetery Grants Program, a cemetery must be operated solely for the interment of veterans, and

their spouses, surviving spouses, minor children and dependent adult children. Current law authorizes VA to recover a grant made to any state that ceases to operate such a cemetery as a veterans' cemetery. Any state may also have residency and other more restrictive requirements, but must conform to the above criteria. The cooperative efforts of State and Federal governments have increased the availability of grave space for eligible veterans. Participating States have constructed State veterans cemeteries to serve veterans, often in areas where there is no existing open national cemetery and where there are no plans to construct a new national cemetery. In some cases, State veterans' cemeteries have opened as a nearby national cemetery closed, thereby providing a continuity of service in the area. VA has no authority to enforce these criteria in State owned cemeteries funded solely with State monies.

J. RECOMMENDATIONS: EMPLOYMENT OF WOMEN VETERANS WITHIN VA

42. Ensure that women Veterans are equitably represented in appointed positions at all levels of authority within the Department of Veterans Affairs. VA should actively recruit qualified women Veterans that reflect the changing face of the veteran population, in positions within the Office of the Secretary and Under Secretaries, Assistant Secretaries, as well as VA working groups, task forces, advisory committees and research consultants.

Concur: Current data indicates women veterans make up 4.6% of the veteran population. As of September 1997, women veterans comprised 7.7% of the Executive Branch workforce. The Department of Veterans Affairs exceeded all cabinet agencies in the employment of women veterans with 11.6%. As of November 30, 1998, 2.5% of all females employed by VA at grades 13-15 and in the Senior Executive Service were veterans. Also, in order to monitor the status of veteran employment in VA, routine VA reports format show veteran numbers by male and female groupings.

Every attempt is made to assure that women veterans are represented on all working groups, task forces and advisory committees established by VA. Currently, VA has 19 scientific, technical and/or consumer advisory committees with a total of five hundred and forty (540) members, of which one hundred and eighty-five (185) are women. Thirty (30) of the women are veterans. Recognizing the need to increase the representation of women veterans on these committees, VA is aggressively working with the Center for Women Veterans, veterans service organizations, and other groups to identify and nominate qualified women veterans for appointment to these committees.

**Post-Hearing Questions
Concerning the June 8, 2000, Hearing**

for
The Department of Veterans Affairs

from
**The Honorable Terry Everett
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives**

1. Please explain the role and duties of the Women Veterans Coordinators.

Both Veterans Health Administration and Veterans Benefits Administration have designated women veteran coordinators in their respective facilities. In most cases, the women veteran coordinator is a collateral position. Therefore, the individual assigned this role has other responsibilities besides those associated with the women veteran coordinator duties. The following is a description of the duties of the women veteran coordinators in VHA and VBA respectively.

Role and Duties of Women Veterans Coordinators in VHA

The VA Advisory Committee on Women Veterans first recommended the Women Veterans Coordinator (WVC) in December 1983. In 1985, WVCs were appointed at all VA medical centers to function as advocates for women seeking care and services, to promote the provision of high-quality care and access in an appropriate setting.

In October 1991, VA issued the Women Veterans Coordinators Program Guide to assist facilities in the development of WVC positions to oversee their local women veterans programs and to help ensure that women veterans have equal access to VA facilities. M-2, Part 1, Chapter 29 (December 29, 1994) replaced these guidelines and mandated that a WVC, appointed by the Director, exist in each VHA facility. The designated WVC should be a health care professional with responsibility for assessing the needs of women veterans at their respective facilities, assisting in planning, organizing, and coordinating facility services and programs to meet those needs. The WVC is a recommended member of the Women Veterans Primary Health Team. The WVC is expected to participate in the regular review of the physical environment, to include the review of all plans for construction, identification of potential privacy deficiencies as well as availability and accessibility of appropriate equipment for the medical care of women. In addition, WVCs make recommendations to the Director to assure compliance with policies and regulations and many provide clinical care to women as part of their assigned duties.

Role and Duties of Women Veterans Coordinators in VBA

The role of the VBA Women Veterans Coordinator is to establish a comprehensive outreach program to address the needs of women veterans. The coordinator duties are outlined in M21-1, part VII, chapter 6, as follows:

- Participates in local women veterans events and provides training to organizations that may include women veteran members;
- Acts as the point of contact for VA and other service providers and, in some instances, for women veterans with special needs. For example, women veterans who experienced sexual trauma while on active duty should be referred to the women veterans coordinator;

- Establishes a network among community service providers and shares information on claims processing with women veterans coordinators at VAMCs, vet centers, and other community organizations;
- Develops a resource directory of service providers within the RO community that may provide services specifically to women and distributes the directory to appropriate VA personnel and others providing assistance to women veterans;
- Establishes liaison with women veterans organizations or those with predominantly women members, e.g., the WACS (Women's Army Corps), maintains rosters of the primary contacts, and provides speakers for their meetings and for special events when appropriate; and
- Advertises information about VA benefits and services in places where women veterans live or frequently visit.

2. Did the 11 sites chosen for the special initiative for homeless women have a track record of previously successful homeless veterans programs? If not, on what basis were they selected?

The Mental Health Strategic Care Group and the Center for Women Veterans collaborated to develop a survey about services and barriers to care for homeless women veterans. That survey showed that the Health Care for Homeless Veterans (HCHV) teams generally do not specifically target outreach to homeless women veterans and most programs do not have adequate staff to seek women veterans in emergency shelters that specifically serve homeless women or homeless women with children.

In an effort to assure that VA addresses the needs of homeless women veterans, facilities located in the 25 most populated cities were contacted and asked to submit innovative proposals to develop programs for homeless women veterans. Applicants were asked to describe the medical center's plan to outreach to homeless veterans with special emphasis on female veterans with children at sites where they are often found. The other critical elements of the proposals were arrangements for residential treatment, domiciliary care, referral to VA and non-VA service providers for appropriate treatment, case management to help establish permanent housing and employment.

All selected sites have excelled in providing services to homeless veterans. Five of the selected sites have Comprehensive Homeless Centers that place the full range of VA homeless efforts under management within a single medical center; they are: Brooklyn, New York; Cleveland, Ohio; Dallas, Texas; Los Angeles, California; and San Francisco, California. The Los Angeles site is designated as a Clinical Program of Excellence in the category of Health Care for Homeless Veterans, noting its highest standard of clinical care for veterans. The Cleveland site is designated as a Clinical Program of Excellence in the category of Domiciliary Care for Homeless Veterans.

Of the 25 sites invited to submit applications, 16 elected to do so. Competition was strong. A panel of experts in homeless veterans programs and women veterans programs rated and ranked the applications. They took into consideration various factors that included 1) ability to establish partnerships with community service providers; 2) ability to meet the needs of women veterans with children; 3) outreach methods; 4) both the VISN and VA facility's support for the initiative; and 5) anticipated workload.

VHA's initial plan was to provide \$2.3 million to support the implementation of up to 10 programs for homeless women veterans. However, 11 proposals were exceptionally strong and VHA determined that an additional \$700,000 could be dedicated to this initiative to support the activation of these 11 programs.

3. According to the 1999 Women Patient Privacy Survey, 25 percent of VA medical centers apparently still do not have or are not in the process of developing programs/policies addressing patient privacy issues. Please provide my Subcommittee with the list of VA medical centers that make up that 25 percent.

There are six (6) women patient privacy issues that should be addressed in facility written policies. The 1999 survey of VA medical facilities found that compliance varies with each issue, ranging from 76% to 83% that have or are developing written policies. Because the 1999 survey did not clearly answer some of the issues, the Acting Under Secretary for Health directed that a plan be developed to review and assess the status of the privacy program/policy issues deficiencies identified in the 1999 survey and submit a complete, accurate, and up-to-date report by October 1, 2000. The Women Veterans Health Program in collaboration with the Healthcare Analysis and Information Group will develop this report.

Those facilities that had no plans or no need related to the various issues at the time of the 1999 survey are identified below for each issue.

Issue 1: The Women Veterans Coordinator must be an active participant in the *planning and design review processes for facility construction and renovation projects.*

81% of VA medical facilities either have or are developing written policies addressing this issue.

The VA facilities (19%) that had no plans or no need to develop a written policy addressing this issue are as follows:

VISN 1	VAMC Northampton*	VISN 13	VAMC Minneapolis
VISN 2	VAMC Albany VAMC Syracuse VA Western New York HCS*	VISN 14	VA Greater Nebraska HCS* VAMC Omaha*
VISN 4	VAMC Wilmington*	VISN 16	VA Gen. Ark. Veterans HCS
VISN 6	VAMC Durham*	VISN 17	VA South Texas HCS*
VISN 7	VAMC Atlanta VAMC Charleston	VISN 18	VAMC Amarillo VA Southern Arizona HCS
VISN 8	VAMC San Juan VAMC Tampa	VISN 19	VAMC Salt Lake City*
VISN 10	VAMC Chillicothe*	VISN 20	VAMC Portland*
VISN 11	VAMC Ann Arbor VAMC Battle Creek VAMC Detroit VAMC Indianapolis VA North Indiana HCS*	VISN 21	VA Central California HCS VA Sierra Nevada HCS

*Had no plans or no need to develop a written policy addressing any of the six (6) issues.

Issue 2: Privacy and security measures must be provided for women veteran patients who use communal bathroom/shower facilities on patient care units.

76% of VA medical facilities either have or are developing written policies addressing this issue.

The VA facilities (24%) that had no plans or no need to develop a written policy addressing this issue are as follows:

VISN 1	Northampton*	VISN 13	VAMC Minneapolis
VISN 2	VA Western New York HCS*	VISN 14	VA Greater Nebraska HCS* VAMC Omaha*
VISN 3	VAMC Brooklyn VAMC New York	VISN 17	VA South Texas HCS*
VISN 4	VAMC Clarksburg VA Pittsburgh HCS VAMC Wilmington*	VISN 18	VAMC Amarillo
VISN 6	VAMC Beckley VAMC Durham* VAMC Fayetteville VAMC Hampton	VISN 19	VAMC Denver VAMC Salt Lake City*
VISN 7	VAMC Atlanta VAMC Charleston	VISN 20	VAOPC Anchorage VAMC Boise VAMC Portland* VA DOM White City
VISN 8	VAMC Miami VAMC San Juan VAMC Tampa*	VISN 21	VAOPC Manilla VA No. California HCS
VISN 10	VAMC Chillicothe* VAMC Cleveland	VISN 22	VA S. Nevada HCS
VISN 11	VAMC Battle Creek VAMC Detroit VAMC Indianapolis VA North Indiana HCS*		

Issue 3: Appropriately sized privacy curtains are to be used in all areas such as emergency/urgent care areas, examination rooms, procedure rooms, and inpatient private rooms.

83% of VA medical facilities either have or are developing written policies addressing this issue.

The VA facilities (17%) that had no plans or no need to develop a written policy addressing this issue are as follows:

VISN 1	VAMC Northampton*	VISN 11	VAMC Indianapolis VA No. Indiana HCS*
VISN 2	VAMC Syracuse VA Western New York HCS*	VISN 12	VAMC Madison
VISN 3	VAMC Northport	VISN 13	VAMC Minneapolis
VISN 4	VAMC Clarksburg VA Pittsburgh HCS VAMC Wilmington	VISN 14	VA Greater Nebraska HCS* VAMC Omaha*
VISN 6	VAMC Durham*	VISN 17	VA South Texas HCS*
VISN 7	VAMC Columbia	VISN 18	VA New Mexico HCS VAMC Amarillo
VISN 8	VAMC San Juan VAMC Tampa*	VISN 19	VA Montana HCS VAMC Salt Lake City*
VISN 10	VAMC Chillicothe*	VISN 20	VAMC Boise VAMC Portland*

Issue 4: Examination tables in outpatient examination rooms used by women patients are to be positioned in such a way that the exam table is not visible from the doorway.

81% of VA medical facilities either have or are developing written policies addressing this issue.

The VA facilities (19%) that had no plans or no need to develop a written policy addressing this issue are as follows:

VISN 1	VAMC Northampton*	VISN 11	VAMC Ann Arbor VAMC Detroit VA No. Indiana HCS*
VISN 2	VAMC Syracuse VA Western New York HCS*	VISN 12	VAMC Madison
VISN 3	VAMC Brooklyn VAMC Northport	VISN 14	VA Greater Nebraska HCS* VAMC Omaha*
VISN 4	VAMC Clarksburg VAMC Wilmington	VISN 17	VA South Texas HCS*
VISN 6	VAMC Durham*	VISN 18	VA New Mexico HCS VAMC Amarillo
VISN 7	VAMC Columbia VAMC Charleston	VISN 19	VA Montana HCS VAMC Salt Lake City*
VISN 8	VAMC Tampa*	VISN 20	VAMC Boise VAMC Portland*
VISN 10	VAMC Chillicothe* VAMC Cleveland	VISN 21	VAOPOC Honolulu

Issue 5: Pajamas and robes issued to female inpatients, as well as gowns issued to female outpatients for diagnostic testing and/or procedures/treatments, must protect their privacy.

83% of VA medical facilities either have or are developing written policies addressing this issue.

The VA facilities (17%) that had no plans or no need to develop a written policy addressing this issue are as follows:

VISN 1	VAMC Northampton*	VISN 11	VAMC Indianapolis VA No. Indiana HCS*
VISN 2	VA Western New York HCS*	VISN 13	VAMC Minneapolis
VISN 3	VAMC Northport	VISN 14	VA Greater Nebraska HCS* VAMC Omaha
VISN 4	VAMC Clarksburg VAMC Wilkes Barre VAMC Wilmington*	VISN 17	VA South Texas HCS*
VISN 6	VAMC Durham*	VISN 18	VA New Mexico HCS
VISN 7	VAMC Augusta	VISN 19	VA Montana HCS VAMC Salt Lake City*
VISN 8	VAMC Tampa*	VISN 20	VAOPC Anchorage VAMC Boise VAMC Portland*
VISN 10	VAMC Chillicothe* VAMC Cleveland	VISN 21	VAOPC Manilla

Issue 6: Feminine personal hygiene products are to be provided in toilet rooms in clinics and other outpatient areas.

76% of VA medical facilities either have or are developing written policies addressing this issue.

The VA facilities (24%) that had no plans or no need to develop a written policy addressing this issue are as follows:

VISN 1	VAMC Northampton*	VISN 12	VAMC Madison
VISN 2	VAMC Canandaigua VAMC Syracuse VA Western New York HCS*	VISN 13	VAMC Minneapolis
VISN 4	VAMC Clarksburg VAMC Coatesville VAMC Wilmington*	VISN 14	VA Greater Nebraska HCS* VAMC Omaha*
VISN 5	VAMC Washington, D.C.	VISN 16	VA Gen. Ark. Veterans HCS
VISN 6	VAMC Durham*	VISN 17	VA South Texas HCS*
VISN 7	VAMC Atlanta VAMC Columbia VAMC Charleston	VISN 18	VA New Mexico HCS VA West Texas HCS
VISN 8	VAMC San Juan VAMC Tampa*	VISN 19	VAMC Denver VAMC Grand Junction VAMC Salt Lake City*
VISN 10	VAMC Chillicothe* VAMC Cleveland	VISN 20	VAMC Boise VAMC Portland*
VISN 11	VAMC Indianapolis HCS*	VISN 21	VAOPC Honolulu VAOPC Manilla VAMC San Francisco

All information provided above is taken from the FY 1999 Women Patient Privacy Survey results, Section IV, Summary of Status of Policies Addressing Women Patient Privacy Issues.

**Post-Hearing Questions
Concerning the June 8, 2000, Hearing**

for
The Department of Veterans Affairs

from
**The Honorable Corrine Brown
Ranking Democratic Member,
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives**

1. I want to know what is happening to the Women Veterans Coordinator. Specifically, please report:

- **The number of Women Veterans Coordinators in the VA system.**
- **The number of full-time Women Veterans Coordinators in the VA system.**
- **The number of Women Veterans Coordinator slots in the VA system that were held in 1998 by one person which are now split among two or more persons, broken out by how many people hold them?**

Women Veteran Coordinator Positions - VHA

The shift from inpatient to outpatient community-based care, integration of medical centers into health care systems and the reorganization of VHA into 22 Veterans Integrated Service Networks (VISNs) has presented challenges for the program that were not anticipated when the WVC role was originally developed and implemented. There are now Lead WVCs identified in each VISN who serve as the liaison between the field WVCs and the VISN office.

Facility-based WVC's program administrative responsibilities are being expanded to include remote community-based sites and, consequently, larger geographic areas. These expectations present increasing challenges to the cadre of WVCs who are also in many cases providing clinical care.

Central Area (VISNs 10-15): There are currently 43 WVCs in the central area. Six of these positions are full time. None of the WVC positions are split between two or more individuals in the central area. Five positions have been eliminated in the Black Hills, Chicago, Greater Nebraska, Iowa and Northern Indiana Health Care Systems as a result of integration of VA facilities and medical centers.

Eastern Area (VISNs 1-5): There are currently 38 WVCs in the eastern area. Nine of these positions are full time. There are currently six WVC slots that were held by one WVC in 1998 that are now split between two or more individuals at Altoona, Erie, Coatesville, Martinsburg, Syracuse, and Canandaigua facilities. One WVC slot has been eliminated in Pittsburgh and East Orange facilities as a result of integration.

Western Area (VISNs 18-22): There are currently 41 WVCs in the western area. Six of these positions are full time. There are currently three WVC slots that were held by one WVC in 1998 that are now split between two or more individuals in the Boise, Long Beach and Nevada Health Care Systems. One WVC slot has been eliminated in Puget Sound HCS as a result of integration.

Southern Area (VISNs 6-9, 16, 17): There are currently 47 WVCs in the southern area. 15 of these positions are full time. None of the WVC positions are split between two or more individuals in the southern area and no positions have been eliminated as a result of integration.

Women Veteran Coordinator Positions - VBA

Veteran Benefits Administration has 58 Women Veterans Coordinators, one in every regional office and one assigned to the satellite office in Cheyenne, Wyoming. VBA has one full-time coordinator at VARO St. Petersburg others are collateral duty positions. A number of VBA offices have both a Women Veterans Coordinator and an alternate or assistant. Since most of VBA's WVCs fill the position as a collateral duty, we do not know of any that have split the functions between two or more persons.

2. The 1998 Report of the Women's Advisory Committee began with several recommendations on conducting outreach to women veterans. What is VA doing to expand its health care and benefits outreach to women veterans?

The Center for Women Veterans has made outreach to women veterans one of its primary goals. Each year the center hosts numerous open forums, town hall meetings, and community-based meetings with women veterans throughout the country. The Center conducts approximately 25 such forums annually. Center staff also attends the regional and national conventions of most veterans' service organizations and women veterans' advocacy groups. At these meetings staff provide updated information on VA benefits and programs for women veterans and discuss issues related to eligibility and access to VA services. Additionally, Center staff presents on women's issues at many of the State Departments of Veterans Services and the National Association of County Veterans Service Officers' annual training. Issues related to the importance of outreach to the women veteran community are incorporated into all presentations.

The Center has established a web site within the VA Home Page to provide women veterans with information about the VA services, benefits and special initiatives for women veterans. Center staff have also contacted numerous Internet websites targeting women, women veterans, and the general veteran population and been successful in establishing links between our home page and their websites. Veterans accessing the Center's web pages may correspond with the Center via e-mail. The Center for Women Veterans website has been accessed over 30,000 times since its inception.

Additionally, The Center for Women Veterans has worked with both VHA and VBA to improve outreach to women veterans. Through this collaboration a number of initiatives have been undertaken to enhance outreach to women veterans. For example, the majority of VA Medical Centers host a women veterans outreach event every year and the women veterans coordinators visit local women veterans groups to provide information on the services available at their individual facilities. Individual facilities have also developed pamphlets describing the services available for women veterans, including primary care, gender-specific care and sexual trauma counseling.

VBA has also developed local outreach programs that have been very effective in identifying individual women veterans, as well as service organizations, with predominately women membership. A recent example of this outreach includes a special VBA Fact Sheet entitled "Disability Compensation for Sexual Trauma," which is distributed nationally during Transitional Assistance Program (TAP) briefings for active duty personnel within 180 days of separation from the military. During FY 1999, VBA military services coordinators briefed over 217,000 active duty personnel and their families on VA benefits and services.

3. In your response to the 1998 Report of the Women's Advisory Committee, VA concurred with a recommendation to expand outreach to minority women veterans. I'd like to know what you've done. How has VA

expanded its outreach to minority women veterans in terms of health care and in terms of benefits?

Expanding outreach to minority women veterans is a priority of the Center. In our attempts to reach out to the minority community, we have contacted many community-based organizations serving the minority community to inform them of VA programs and services for women. As a result, Center staff has been invited to present this information at meetings and other outreach events geared toward the minority community. Among the groups the Center has presented before are: The Congressional Black Caucus, the Black Veterans for Social Justice, the Harlem Vet Center, the American GI Forum (Hispanic Veteran Association), the Navajo Tribal Council, the Blackfeet Tribal Council, and the Vietnam Veterans of America Minority Committee. Additionally, the Center has requested the Minority subcommittee of the VA Advisory Committee on Women Veterans to assist us in developing a more comprehensive outreach plan for outreaching to minority women veterans during the next three years.

4. Why does VA keep considering sexual trauma counseling to be something it will do only if Congress requires it? Why is this not a permanent part of VA's services?

VA will continue to provide sexual trauma counseling for veterans eligible for care. The role of Congress is to authorize it for veterans who might not be clearly eligible for VA care, because their military sexual trauma cannot be documented.

Public Law 102-585 authorized VA to provide sexual trauma counseling to women veterans. Public Law 103-452 expanded the provisions of P.L. 102-585 to include male veterans and care and treatment for sexual trauma. These laws authorized VA to provide counseling and care for sexual-trauma that the VA determines occurred while the veterans was on active duty. They do not impose any requirement that an applicant for sexual trauma counseling or care have filed a claim for a service-connected disability in order to access these health care benefits. Thus, the laws expand access to these services to veterans who might not otherwise be eligible for VA care. Both laws were passed because many victims of military-related sexual trauma testified of the difficulties they encountered in attempting to report such incidents while on active duty. As a result, there is often no record of the incident in the veteran's military record to support their application for VA benefits.

VHA has engaged in sexual trauma counseling for many years. The VHA Mental Health Manual M-2, Part X, dated June 29, 1993, page 20, under 3.10, Special Programs, states that "victims of extraordinary trauma outside of combat, such as natural disasters, sexual or physical abuse, are also seen" by clinicians within our PTSD continuum of care. The Mental Health Guide 1103.3, dated June 3, 1999, page 62, states that Sexual Trauma Counseling is available at various outpatient settings. Specific clinic codes distinguish sexual trauma occurring during active military duty from that occurring entirely apart from active duty. In FY 1998, VHA outpatient files record 11,180 "stops" or encounters at 51 clinic sites for sexual trauma treatment and 10,081 stops at 12 sites at women's stress clinics. Within our specialized PTSD national program, 206 women were seen who had reported physical sexual harassment during their military tour by fur specialized sexual trauma teams. Of those, 43% reported rape or attempted rape during active duty.

Although the VA had no objections to the Advisory Committee's 1998 recommendation that VA's authority to provide sexual trauma care and counseling be permanent, Public Law 106-117 only extended the authority through December 31, 2004.

5. The Advisory Committee suggested requiring by law that all federally funded research and federally funded agencies and organizations identify

and report statistics on veterans, including military experience and exposure in the case of research. I was surprised that VA said such information would be of little value. If Congress required all federal agencies to collect such data, wouldn't we learn a great deal from it about veterans' needs and how we serve them?

VA did not indicate that such information would be of little value, rather it stipulated that currently there is no standard set of probes either for veteran status, experience or combat exposure, precluding comparability of VA and non-VA data and systems. The costs associated with developing such probes and adding them to all Federally-funded reports, surveys and research projects would be prohibitive. VA believes a better way to accomplish the aim of this recommendation is to request focused studies on women and other veterans, especially designed to elicit reliable detail on the military experiences of the study subjects.

Certainly if all federally funded research programs and studies included a schedule of questions soliciting information related to the military background and combat exposure of every study subject, a great deal of data would be gathered. The additional costs and burdens it would impose on research subjects as well as researchers, however, outweigh the potential benefits of such comprehensive data collections. Hypothesis driven studies, directed at known problems among specific populations of veterans can lead to answers more easily and obtain, if necessary, congressional action sooner than broad, less focused collections of data. Even these more focused studies, directed at known veterans' problems, can lead to reliable answers only after extensive information is obtained and analyzed. For example, the VA's study of the reproductive outcomes of women Vietnam veterans, which showed an increase in birth defects among their offspring, contained up to 90 questions on military experience and combat exposure as part of the interview schedule. Happily, as a result of this study's findings, we understand that legislation now is being prepared that would extend VA entitlement benefits to children of women Vietnam veterans born with birth defects that may be related to their service, in addition to those presently covered who were born with spina bifida.

6. To my experience, one of the real assets Congress created for women veterans has been the local Women Veterans Coordinators. What is VA doing with that part of the program?

Women Veteran Coordinator Program - VHA

The demands of the position have increased exponentially with the significant increase in women's utilization of VA. Recently, many WVCs have reported that most of their time is spent on clinical duties and thus administrative or outreach duties have received less than optimal attention. This concern was also raised by the Center for VA Advisory Committee on Women Veterans.

The concern has been reviewed since 1997 when then Under Secretary for Health, Dr. Kenneth Kizer, requested a study of the WVC position. At that time, a survey revealed that 59% of respondents performed their WVC functions as a "collateral" duty, in addition to their primary role. Forty percent spent only 1-5 hours in administrative management duties.

The Women Veterans Health program began to look for better ways to match human resources with program needs. In collaboration with a private consulting firm, a performance model for the WVCs was developed. A redesigned model for this position, entitled the Women Veterans Program Manager, moved the focus away from process to outcomes (performance measures). The position was defined as primarily administrative management with six performance results identified:

- Provide Quality Customer Service – Ensure satisfaction of women with the quality and manner with which care is provided.
- Outreach – Identify and locate women veterans in need of assistance.
- Increase utilization of women's health services – Increase usage of existing services that address the needs of women.
- Expansion of Services – Advocate for, and work to address issues and needs in women's health through expansion of services.
- Engage in Organization Improvement Plans – Work in support of improvement plans that benefit both men and women.
- Educate internal staff to needs of women veterans.

Multiple best practices were identified under each of these performance results. Quantitative and qualitative criteria were also identified for best practices identified to measure the outcomes.

This project was presented to the WVCs at the WVC conference last year. The reactions from the coordinators were very positive. The work group and the WVCs agreed that a pilot of this model was the next step. VISN 4 and VISN 9 have agreed to be pilot sites. The pilot was implemented in March of this year. During the pilot, the model will be tested for validity and more quantitative and qualitative criteria will be developed. After the pilot, we hope to implement the Performance Model nationally. Initial pilot results are expected in January 2001.

Women Veteran Coordinator Program - VBA

VBA has taken a number of steps to ensure the effectiveness of the Women Veterans program, as follows.

In September 1999, VBA and VHA Women Veterans Coordinators met in Chicago for a training conference. The program, titled "Women Veterans Coordinators Conference: Continuing the Commitment," focused on developing "One VA" outreach programs for women veterans. Two of the most pressing issues raised by the VBA coordinators were the need for training and the need for a definition of duties.

First, more than half of the VBA coordinators had been in their positions for less than a year and had been provided little or no training in relation to their duties as a Women Veterans Coordinator. Second, few coordinators have position description elements that encompass program responsibilities and several coordinators stated that because the duties were not part of their performance evaluations they were given little time to perform outreach duties.

In response to the coordinators concerns, the Deputy Under Secretary for Management requested that a WVC Training Development Committee be established. Nine coordinators volunteered to serve on the committee with three assigned to chair sub-committees. The Chair of the C&P Women Veterans Advisory Committee was also asked to participate along with the VBA Women Veterans Program Manager.

The members of the WVC Training Development Committee met at headquarters January 11-13. The committee addressed four main issues: developing a standard position description or statement of duties; designing effective outreach programs; updating the "Guide to Developing Personal Trauma Claims"; and conducting a satellite broadcast on "Interviewing Veterans in Crisis."

The committee reviewed the package of materials prepared by the Center for Minority Veterans that was recently approved by VBA and VHA and released to all field facilities covering Minority Veterans Program Coordinator responsibilities. The package contained: a statement of Core Operating Standards; a Memorandum of Understanding between the facility director, the direct line supervisor and the coordinator; and a sample position description/statement of

duties. The committee prepared a similar package for Women Veterans Coordinators.

An all station letter (201-00-09) was issued to all VBA regional offices and centers in February. A copy of that letter is attached. (Attachment 1)

The committee developed a format for an Outreach Handbook that will contain information on successful outreach programs submitted by WVCs nationwide. The handbook will be updated quarterly and included on the VBA Women Veterans Coordinator Intranet Site. The VBA Women Veterans Program Coordinator distributed a similar handbook at the September conference. The Outreach Handbook will be released by the end of FY 2000.

A Guide to Developing Personal Trauma Claims was developed by the C&P Women Veterans Advisory Committee, was first issued at the WVC conference held in San Antonio in June 1997. It outlines the steps a WVC or other Veteran Services Representatives (VSRs) should follow in developing personal trauma claims and contains addresses and points of contacts when requesting information from each of the Uniformed Services. The guide needs to be updated to include the effects of *Morton v. West*, *Patton v. West*, and the new technology available to develop and track special issue cases. It is anticipated that the revision of the guide will be completed by the end of August 2000.

Most WVCs and Veterans Service Representatives (VSRs) have not been formally trained to deal with an interviewee who is angry, traumatized, or presenting signs of mental illness. This situation does occur and employees must know what to do, particularly if the veteran is indicating suicide. Training in this area was conducted at the 1997 WVC Conference in San Antonio and was very well received. But, as noted early, many of the WVCs have been in their positions for less than 1 year and did not attend the San Antonio Conference. And, most of the new VSRs have not been trained in this area. Since this training must be conducted by professionals with expertise in this area and should be available to all VBA who work directly with veterans, it is beyond the scope of the WVC Training Development Committee and the Compensation and Pension Service. Compensation and Pension Service is working with the VBA Training Staff to develop a Satellite Broadcast to be aired in September or October 2000.

To improve communications between headquarters and the field, the following actions have been taken:

- A Satellite Broadcast on the Disorders of the Breast, developed by the VBA Women Veterans Program Coordinator and members of the C&P Women Veterans Advisory Committee, was aired December 3, 1999. About 300 field employees viewed the broadcast, and videotapes were distributed to all WVCs to be used for additional local training. The script has been posted on the VBA WVC Intranet Site. Written comments received from the audience were very positive.
- An information package containing various reference/training materials was sent to all WVCs in early January. Outreach activity items such as "Women Are Veteran" pins and WVC nametags were also included.
- A WVC Newsletter is now being issued to the field quarterly. The first issue was released in January 2000.
- Quarterly WVC conference calls were initiated in January 2000.
- The VBA Women Veterans Program Coordinator participated in an outreach program being conducted by VARO Waco in March 2000. The Deputy Director, Center for Women Veterans, also attended. As time and funds permit, Central Office will continue to support local outreach activities.

- 18 VBA WVCs attended the Women Summit held June 23-25, 2000 in Washington.



ATTACHMENT 1

DEPARTMENT OF VETERANS AFFAIRS
 Veterans Benefits Administration
 Washington DC 20420

In Reply Refer To:

OFO Letter 201-00-09

Directors (00)
 All VA Regional Offices and Centers

SUBJ: Women Veterans Program

1. In February 1999, the Directors of the Center for Minority Veterans and Center for Women Veterans expressed their concern to the Secretary about lack of support for the Minority and Women Veterans Programs at the field station level. The Secretary issued a memorandum in March 1999 to all Central Office and field facility key officials emphasizing the VA's commitment to these programs. Enclosed is a copy of that memorandum.
2. At the joint VBA and VHA Women Veterans Coordinators' conference in September 1999, many of the coordinators stated that they are experiencing difficulty in getting the time, resources and training essential to the success of the Women Veterans Program. And, recently this subject was again addressed to the Secretary.
3. The Demand Management Staff, Compensation and Pension Service, developed a Women Veterans Program Action Plan for the remainder of FY 2000 which covers many of the training and communications issues discussed by the coordinators at the September Conference. The plan calls for the establishment of a Training Development Committee and dissemination of periodic information packages containing brochures and other materials used for outreach programs and training purposes. The plan also establishes quarterly conference calls or "Fast Lines" covering such topics as dealing with veterans "in crisis", outreach strategies and homelessness in the women veteran population. There will also be a quarterly Women Veterans Coordinators' newsletter; continuation of the Broadcasts by the VBA Women Veteran's Advisory Group; and participation of selected coordinators in the National Summit on Women Veterans (Summit 2000) in June. It is important that your Women Veterans Coordinator is available and participates in these forums and activities.
4. To facilitate participation, coordinator duties should be included as an addendum to the employee's position description and performance standards developed as appropriate. Following is a summary of VBA Women Veterans' Coordinator duties as outlined in M27-1, part I, chapter 12, paragraph 12.07, which can be used as the basic language for an addendum to the assigned coordinator's position description:
 - Participates in local women veterans events and provides training to organizations that may include women veteran members;
 - Acts as the point of contact for VA and other service providers and, in some instances, for women veterans with special needs. For example, women veterans who experienced sexual trauma while on active duty should be referred to the women veterans' coordinator;
 - Establishes a network among community service providers and shares information on claims processing with women veterans' coordinators at VAMCs, vet centers, and other community organizations;
 - Develops a resource directory of service providers within the RO community that may provide services specifically to women and distributes the directory to appropriate VA personnel and others providing assistance to women veterans;

- Establishes liaison with women veterans' organizations or those with predominantly women members, e.g., the WACS (Women's Army Corps), maintains rosters of the primary contacts, and provides speakers for their meetings and for special events when appropriate; and
- Advertises information about VA benefits and services in places where women veterans live or frequently visit.

Also enclosed for your review and consideration is a package of materials (Core Operating Standards and Memorandum of Understanding) similar to the information recently issued to Minority Veterans Program Coordinators by the Center for Minority Veterans. This package was adapted to the needs of the Women Veterans Program and could be used to assist in meeting our commitment to the program.

5. Your cooperation and assistance in meeting our commitment to women veterans are appreciated. Questions should be directed to Diane Fuller, Assistant Director, Demand Management Staff (202-273-7598) or to Lynda Petty, Women Veterans' Program Manager (202-273-6981).

/s/

Michael Walcoff
Associate Deputy Under Secretary
for Operations (West)

Enclosures

MEMORANDUM FOR ADMINISTRATION HEADS, ASSISTANT
SECRETARIES, DEPUTY ASSISTANT SECRETARIES, FIELD FACILITY
DIRECTORS AND OTHER KEY OFFICIALS

In November 1994, the President approved Public Law 103-446 authorizing within the Department of Veterans Affairs two new centers: The Center for Minority Veterans and the Center for Women Veterans. The establishment of these centers is consistent with VA's long history of recognizing and responding to segments of the veteran population who, for one reason or another, have special needs, are underserved, or are alienated from the mainstream of our society.

On the occasion of the Centers' fourth anniversary, I am pleased to note their important role and significant achievements in our efforts to meet the needs of minority and women veterans around the country. I am fully committed to making sure that there are no barriers to the delivery of VA programs and services to our nation's heroes. In this regard, I want to make sure that VA senior managers and key officials are also committed to the full execution of our moral and statutory responsibilities to minority and women veterans.

Over the years, there have been numerous innovative VA programs to address the special and unique needs of veterans. The Centers for Minority and Women Veterans extend these programs to thousands of veterans, and ensure that the needs of minority and women veterans are addressed in every facet of VA's delivery of services and benefits around the country.

I strongly support these programs and urge VA managers to work to assure that these programs are successful throughout VA. Minority Veterans Program Coordinators and Women Veterans Coordinators at each station are critical to our ability to serve veterans. Without the dedicated work of coordinators, and VA employees in general, little can be accomplished. I urge facility directors and program coordinators to develop goals and outcome measures for their programs. They should also discuss staffing and training requirements essential to the success of these programs. The directors of the Centers for Minority and Women Veterans will monitor VA's nation-wide execution of these programs, at all levels of the organization. I will inquire about our success and expect reports on our progress.

I extend my thanks to all who have labored to the success of these programs.

Togo D. West, Jr.

**CORE OPERATING STANDARDS (COS)
for
WOMEN VETERANS COORDINATORS**

THE PROGRAM

Public law 98-160 established VA's Advisory Committee on Women Veterans in November 1983. This led to VA developing women veterans outreach programs at each facility in February 1984. Public Law-103-446 established the Center for Women Veterans within Central Office, which further demonstrates VA and VBA's commitment to meeting the needs of women veterans.

THE MISSION/GOALS

Title 38 USC requires VA to promote the use of VA benefits, programs and services by women veterans and to assess the needs of women veterans.

THE WOMEN VETERANS COORDINATOR

Each director of a VBA Regional Office is responsible for the execution of a women veterans program at his or her site. The WVC is responsible for field execution of the women veterans program. The duties and responsibilities of the coordinator are as follows:

- Advises the director on issues relating to women veterans.
- From broad policy statements, formulates, communicates and implements program objectives, policies, procedures and processes necessary to administer the women veterans program.
- Promotes the use of VA benefits, programs and services by women veterans.
- Reviews and evaluates RO statistical and narrative information to determine the use of services and benefits by women veterans.
- Assesses the needs of women veterans and makes recommendations for improving the delivery of services to women veterans.
- Prepares written materials or utilizes existing materials to educate women veterans and their families of VA services and benefits available.
- Develops written responses to inquires related to concerns of women veterans and works closely with RO management and staff, the VBA Woman Veterans Program Manager, and the Center for Women Veterans to alter perceptions and/or correct deficiencies.
- Conducts outreach—Maintains vigilance in the community through town hall meetings, conversations with veterans, visits to local women veterans' groups and organizations, civic and religious groups, and through health fairs and veteran information booth/displays.
- Establishes and maintains contact with various State and local Veterans Service Organizations in order to utilize their resources in fulfillment of program objectives.
- Establishes and maintains contact with women veterans organizations within the area(s) served by the Regional Office.
- Meets periodically with various organizations representing women veterans and/or with women veterans to verbally present information concerning benefits and to receive information regarding their concerns and answers questions.
- Identifies women veteran populations in service areas and maintains utilization trends with regard to programs and services offered by the Regional Office.
- Identifies barriers to women veterans' use of benefits, programs, and services. Develops plans and strategies to remove any such barriers.
- Meets periodically with RO management to ensure they are fully apprised of women veterans concerns and perceptions and that these are adequately addressed.

- Reports annually on accomplishments and achievements with regard to the implementation of the women veterans program at the local level.

CORE OPERATING STANDARDS – BASELINE REQUIREMENTS (OUTCOMES)

The Regional Office Director, through the WVC, is responsible for implementing the VA's woman veterans program at the local level. Baseline program requirements must be achieved, at each station, within 180 days, and sustained thereafter to ensure program success. The following are baseline requirements and core operating standards:

- Ensure that the WVC's name, telephone number and room number is listed in the station directory.
- Research the availability of statistical data which reflects women veterans' utilization trends for the station. Data can be used to determine the level and magnitude of outreach required in the community and to identify the needs of veterans in the community.
- Conduct at least one annual seminar to promote the use of VA programs and services and to educate women veterans on programs, services and benefits offered by VA. Maintain attendance data and assess the effectiveness of this particular outreach activity.

PROGRAM SUPPORT AND ASSISTANCE

WVC can obtain program support and assistance by contacting the VBA Women Veterans Program Manager (216), 810 Vermont Avenue, N.W., Washington, DC 20420. The telephone number is (202) 273-6981, or fax (202) 275-1728.

Coordinators are encouraged to work together to conduct joint outreach initiatives and should solicit the support of other Regional Offices and VHA and/or NCS stations when conducting or participating in town hall meetings, health fairs and veterans information forums. Regardless of the involvement of other VA business lines or agencies in planned outreach sessions, issues presented by veterans will be handled by the on-site participants (under the "one VA umbrella") and appropriately referred to the business lines for follow up action.

WOMEN VETERANS COORDINATOR PROGRAM

Memorandum of Understanding

_____ has been selected/appointed for a collateral duty or full time assignment as the **Women Veterans Coordinator** for the _____ Regional Office.

The incumbent will be required to devote _____ percent of work-time toward reaching goals and objectives of the women veterans program as outlined in the attached position description. The incumbent will report in writing to the facility director or his/her designated representative on accomplishment of program objectives.

The incumbent's performance shall be appraised by the Regional Office director or a designated representative during the annual performance evaluation period and will serve as input to the incumbent's immediate supervisor as a part of the overall annual performance appraisal.

This assignment has been discussed with and agreed to by the employee's immediate supervisor.

Director

Date

Supervisor

Date

Women Veteran's Coordinator

Date

