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STATUS OF WOMEN'S HEALTH CARE PROGRAMS IN THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

OCTOBER 2, 2002

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STATUS OF WOMEN'S HEALTH CARE PROGRAMS IN THE DEPARTMENT OF VETERANS AFFAIRS

WEDNESDAY, OCTOBER 2, 2002

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Miller, Boozman, and Rodriguez.

Ex-officio present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. Our subcommittee will come to order. I would like to welcome our witnesses and eventually welcome some of the members of the subcommittee as they arrive.

This is a serious topic that for a long time I have thought deserves some attention. And especially with our country at war right now and with nearly 20 percent of our current active duty soldiers, sailors, airmen, and Marines who are actually servicewomen, not servicemen, it is important for this subcommittee to review and monitor the programs established at the VA that pertain to women's health care.

I recently visited U.S. troops in Afghanistan and saw the important role that female members of our military are performing in all areas of service. It was readily apparent that the health care needs of servicewomen may be different than that of the male servicemen. The same would hold true for veterans, once these individuals enter the VA system.

It is true that women's health is a very small fraction of the VA's overall health program. Admittedly, throughout most of the history, the VA has been a men's health and medical program almost by design, a tradition of being by, for, and of male veterans. But this is changing dramatically, and this needs to change more as the face of the military itself is changing. Women are taking on new responsibilities in the Armed Forces, on the land, at sea, and in the air. They are becoming a vital link in the success of our military today and will be even more crucial in the future. They serve as military police officers, forward observers for artillery, radar opera-

tors, pilots, navigators, flight deck crew, drill instructors, nurses, and physicians.

You name it, women are doing the job for our Nation in the armed services. They serve our country with distinction today, and women deserve our Nation's thanks as veterans today—and tomorrow.

As Chair of this subcommittee, I want to make certain that the VA is repositioning itself to make a significant place for women veterans, to welcome them to the VA health care system, to provide outreach to them, to be sensitive to their needs, and to ensure their health needs are being met with high-quality programs. We believe we must take strides towards main-streaming women's health care into the VA primary care, and to ensure that the specialized needs of women patients are met by the VA.

The specific purpose of today's hearing is to ensure that accommodations are made at the Department of Veterans Affairs medical facilities for female patients, and to make certain that the VA is making such accommodations a high priority.

We will also be reviewing the availability and variety of women's health programs the Department offers; the status of contract community care for female patients; and VA's responsiveness to advice and recommendations from the Advisory Committee on Women Veterans, as well as the effectiveness of the VA Center for Women Veterans in bringing these programs forward.

It is my hope today that through testimony from our witnesses we will smash any perceived "glass ceiling" or other limitations preventing women veterans from seeking out or receiving high-quality VA primary and specialized care, counseling for sexual trauma, mental health services, safe domiciliaries, private bed accommodations away from other patients, and even simple things like privacy curtains in women's restrooms. We have observed that some of these "no brainer" types of accommodations for women have not been available in the past, and change is still needed.

Every veteran has a right to personal privacy. There is always room for improvements in these women's health programs in the VA. And it is my expectation that by holding this oversight hearing, and the follow-up that comes from it, we will raise the bar on the VA's attention to these matters and its observed performance in meeting specialized needs of women patients.

We look forward to hearing today's witnesses. I will ask Mr. Filner for any opening remarks when he arrives, and would take this opportunity to first invite Dr. Roswell, the VA Under Secretary of Health. He is accompanied by Dr. Susan Mather, chief officer for public health and environmental hazards. Also joining them on this panel is Dr. Irene Trowell-Harris, the director of the Center on Women Veterans.

Good morning, Mr. Secretary, and welcome back.

STATEMENT OF ROBERT H. ROSWELL, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SUSAN MATHER, CHIEF OFFICER, PUBLIC HEALTH AND ENVIRONMENTAL HAZARDS AND IRENE TROWELL-HARRIS, DIRECTOR, CENTER FOR WOMEN VETERANS

Dr. ROSWELL. Well, good morning, Mr. Chairman. It is a pleasure to be here, as always. Thank you, Mr. Chairman, Congressman Boozman.

I am pleased to be here today to report on the status of women veterans' health care in the Department of Veterans Affairs. Today, I am accompanied by Dr. Susan Mather, our chief public health and environmental hazards officer. And I am also pleased that Dr. Irene Trowell-Harris, the executive secretary of the VA Advisory Committee on Women Veterans and the director of the VA Center for Women Veterans is here with me to provide testimony today.

The Department receives significant support in its mission to serve women veterans through the advice and counsel of the Advisory Committee. And we value not only its existence but its counsel and help in dealing and serving with women veterans.

Today, women currently make up about 4.5 percent of the 4.3 million veterans who use the VA health care system. But this number is expected to grow over the next decade to equal approximately 10 percent of the workload we serve.

VA has accepted the challenge of providing equitable access to health care services to these veterans. In 2000, 152,000 women veterans were seen as outpatients and almost 13,000 as inpatients. Last year, in 2001, those numbers rose to 166,000 outpatients and 13,640 inpatients. These figures, however, don't include the additional number of women who receive services on a contractual or fee basis or through sharing agreements.

Local leadership in women veterans' health care is provided by the women veteran coordinators, who have been responsible for significant advancements in the delivery of services within our medical centers and clinics. This network of advocates for women is supplemented by a full-time director of women veterans health in VA's Central Office, and she is with us in the hearing room today; four deputy field directors, located around the country; and lead women veterans program managers in each of the 21 networks. The significant contributions of this group to women's health were recognized in 2000 when they received the Wyeth-Ayerst Bronze HERA Award.

Outstanding clinical programs for women veterans are also included in VHA's Centers of Excellence Programs. Currently, there are six centers of excellence in Women Veterans Health. They are located in Alexandria, LA, Bay Pines, FL; Boston, MA; Durham, NC; Pittsburgh, PA, and San Antonio, TX.

In addition to our clinical mission, VA has a significant research mission addressing women veterans issues. In fiscal year 2000, funding for women's health research at VA totaled over $24 million and included over 300 studies.

We will continue to ensure that women veterans have equal access to high-quality care. We are changing the culture in VA with clinical guidelines, performance measures, quality improvement,

improved pace and safety, and veteran-relevant research to prepare for the veterans of tomorrow, which will include many, many more women.

Mr. Chairman, this concludes my statement. I have submitted a more detailed statement for the record. And Dr. Mather and I are prepared to answer your questions.

[The prepared statement of Dr. Roswell appears on p. 45.]

Mr. MORAN. Dr. Trowell-Harris, do you have comments or remarks?

Dr. TROWELL-HARRIS. I have brief remarks to make.

Mr. MORAN. Please proceed.

Dr. TROWELL-HARRIS. Mr. Chairman and members of the subcommittee, I am pleased to testify today on behalf of the Department of Veterans Affairs about services in VA for women veterans, and particularly the Department's responsiveness to advice on women's health issues, recommended by the Advisory Committee on Women Veterans and the Center for Women Veterans.

The Center was created by Public Law 103–446 in November 1994. The director of the Center serves as chief advisor to the Secretary of Veterans Affairs on all issues related to women veterans and serves as the executive secretary to the Advisory Committee.

The mission of the Center is to ensure that women veterans have access to VA benefits and services on par with male veterans; that VA programs are responsive to gender-specific needs of women veterans; that outreach is performed to improve women veterans' awareness of services, benefits, and eligibility criteria; and women veterans are treated with dignity and respect.

The Center also provides input to the Advisory Committee based on inquiries from women veterans from telephone calls, written correspondence, and web site e-mail. The Center facilitates the activities of the Advisory Committee and coordinates their report to the Secretary of Veterans Affairs.

The Advisory Committee was established in 1983 pursuant to Public Law 98–160. The Advisory Committee is charged with advising the Secretary of Veterans Affairs on VA benefits and services for women veterans; assessing the needs of women veterans; reviewing VA programs and activities designed to meet those needs; and developing recommendations addressing unmet needs. The Advisory Committee is required to submit a biennial report to the Secretary, incorporating the Advisory Committee's findings and recommendations.

As a means of obtaining information regarding the delivery of health care and services to women veterans, the Advisory Committee conducts site visits to VA facilities throughout the country. During these site visits, the Advisory Committee tours the facilities and meets with senior officials to discuss services and programs available to women veterans. During the site visits, the Advisory Committee also hosts open forums with the women's veteran community, encouraging women veterans to discuss issues and ask questions related to benefits and services.

The Advisory Committee meets twice a year at VA Central Office and receives briefings from the Veterans Health Administration, Veterans Benefits Administration, National Cemetery Administration, and other staff offices. These briefings update the Advisory

Committee on the status of VA programs and respond to concerns raised during the site visits. The Advisory Committee uses the information from the site visits and briefings to formulate its recommendations to the Secretary in biennial reports.

In the 2000 Report of the Advisory Committee on Women Veterans, the Advisory Committee made 25 recommendations. Of those 25 recommendations, 18 are in the process of being implemented and seven have been implemented. Some of the key issues included outreach, sexual trauma counseling and care, women veterans who are homeless, health care, education, and employment.

The requirement to submit the 2000 Report of the Advisory Committee on Women Veterans to Congress was terminated in 1999 by a sunset provision in the Federal Reports Elimination and Sunset Act of 1995. That was Public Law 104–66. And, therefore, a report was not forwarded. Later, Public Law 106–419 reinstated the requirement for submission of the report beginning with the 2002 report through 2004. The legislation that reinstated the submission authority did not require the submission of the 2000 report. The submission of the 2000 report to Congress was at the discretion of the Secretary. As a courtesy to the Advisory Committee, the former Secretary agreed to forward the report to Congress.

Two major factors, however, contributed to the delay in the submission of the 2000 report to Congress. First, it was necessary to clarify whether the sunset provision required submission of the 2000 report to Congress. Second, there was a change in senior leadership within VA.

In the area of health care, the Advisory Committee in its 2000 report recommended that VA ensure that the Center is provided an annual update on the effectiveness of VHA women veterans coordinator program. VHA officials, including the national women veterans health program director, briefed the Center and advised Committee members on this issue at the March 2002 meeting.

In addition, the director of the women veterans health program works closely with the Center on issues that are frequently referred to women veteran coordinators in field facilities. For example, since October 2001, I have completed 28 media interviews and 37 keynote speeches, transition assistance and veterans briefings where VHA has assigned a local women veterans coordinator to accompany me to answer general questions and see that health care issues raised regarding individual cases receive immediate attention.

In April 2002, the Director of the Women Veterans' Health Program, in conjunction with VBA, conducted a national conference for women veterans coordinators. Both the associate director and I attended this conference where many issues regarding the provision of health care to women veterans, as well as the role of women veterans coordinators, were discussed. This conference also provided a forum for VHA and VBA women veterans coordinators to network and discuss ways to bridge the gap in situations where women veterans had both health and benefits issues.

VHA officials and the Director of the Women Veterans Health Program also have an extensive working relationship with the Advisory Committee, especially about programs, plans, and legislation for women veterans. The Director of the Center for Women Veter-

ans is a consultant to the Advisory Committee and attends all meetings and site visits. For example, when the Advisory Committee expressed concern about specificity in some of the responses to recommendations in the 2000 report, VA officials quickly responded and resolved the issues.

In the 2002 Report of the Advisory Committee on Women Veterans, the Advisory Committee has made 24 recommendations. Those include: outreach, sexual trauma counseling and care, women veteran coordinators, health, staff education, employment of women in the Federal Government, strategic planning, and women veterans who are homeless. Earlier this summer, representatives from the responsible staff offices met on several occasions to ensure that the Department thoroughly addressed the Advisory Committee's recommendations.

Mr. Chairman, these recommendations stem from data and information gathered from VA officials, women veterans, researchers, veterans' service organizations, internal VA reports, and site visits to VHA and VBA facilities. This report, including VA's responses, was provided to the House and Senate Veterans Affairs Committees on September 26, 2002.

The report and VA's responses address some of the following general topics: the creation or modification of services to provide specifically for the needs of women; staffing levels for women veterans coordinator positions; permanent removal of eligibility restrictions for sexual trauma training; the monitoring and analysis of services recently introduced by VA, such as obstetrical care and pilot programs for women veterans who are homeless, to ensure that services would meet potential increases in demand; the development and distribution of guidelines for case management of women veterans who are homeless based on the analysis of successful pilot projects; an emphasis on the need for research to determine the success of health and benefit programs in meeting the needs of women veterans, including women veteran subgroups such as Blacks, Hispanics, Asians, and Native American, as VA conducts strategic planning to design future care and services.

The need for research to assess the impact of the increasing numbers of women in the military and their changing military roles on the design and delivery of VA services. The rising proportion of minority women heightens the need for meaningful data regarding women veterans of all racial/ethnic groups.

VA is grateful for the work of the Advisory Committee because its activities and reports play a vital role in helping the VA assess and address the needs of women veterans.

This concludes my formal testimony. I will be pleased to answer questions.

Mr. MORAN. Dr. Trowell-Harris, thank you very much.

Mr. Secretary, you are relatively new to your current position with the VA, but you have long experience with the Department of Veterans Affairs. Do you bring to your new job any particular ideas about the issue of gender and the way we do or should treat female veterans? What would be your suggestions/recommendations? What plans would you have for the Department as it delivers health care services to veterans, specifically as it relates to women veterans?

Dr. ROSWELL. Well, thank you, Mr. Chairman. I appreciate that opportunity. I have been with the VA a long time, and I have a fairly lengthy involvement with improving and enhancing health care for women veterans, as well as providing for sexual trauma counseling, which affects women veterans at a much higher rate than their male counterparts.

I am deeply committed to making sure that we have women veterans health care programs throughout the Department that reflect the ever-increasing reliance our country places upon women in uniform. I think it is not only—it wouldn't matter, I guess I should say, whether they were a small minority but recognizing that women increasingly constitute a much greater portion of our military force. And, as you alluded to in your opening remarks, are serving not only in support roles but combat service roles and increasingly towards combat-related roles in the service, it is really critical that we address the programs and meet those needs.

I think VA has done a remarkable job of addressing the needs of women veterans. We have created women veterans' clinics. We have created services specifically addressed to gender-related disorders. But I think we have to do more. As much as I support the concept of having women's clinics dedicated to providing care to women veterans, I think we need to change the culture of VA. It is important that we have a women's clinic so that that initial rapport can be established between patient and provider so that women veterans feel comfortable in discussing some of the difficulties associated with their military service.

But over time, women veterans will utilize, we hope, all aspects of the medical center. So we really need to change the culture. And while we need to preserve our women clinics, we have to enhance gender sensitivity throughout the entire organization. I am committed to do that in a variety of different ways and look forward to seeing that happen over the next few years.

Mr. MORAN. Is separation of male and female veterans important in the care and treatment of women?

Dr. ROSWELL. It is to a certain extent. As I alluded to, initial contact with women veterans needs to be in an environment, initial contact with any veteran needs to be an environment where they feel comfortable. Women who may have been sexually traumatized during their military service or at other times, women who have disabilities related to their military service may not have the comfort level that would allow them to open up and reveal difficult situations, things that are very difficult to discuss, unless it is in a safe haven, if you will.

I believe that the women veterans' clinics create that safe haven. But ultimately radiology departments, surgical units, laboratory facilities, imaging facilities are areas of the medical center where women will be seen in these areas, which while we certainly protect patient privacy and dignity, aren't segregated by gender. And so we have to change the culture throughout the entire medical center.

Mr. MORAN. In your testimony you indicated that the instance of sexual abuse or sexual harassment or the consequences thereof are much greater for females rather than males. Are there other

conditions or afflictions that a female veteran is more likely to encounter?

Dr. ROSWELL. Well, obviously, there are a variety of gender-related illnesses and certainly pregnancy is not an illness. But because of the younger general age of the women veteran population, many of them are in their reproductive years and prenatal care is very, very important. It is, as you know, authorized.

We specifically need to address gender-related conditions and medical needs, including prenatal or obstetrical care. We also need to address gender-specific disorders. But when we really look at the military occupational experience, the one thing that stands out, embarrassingly I might add, is that women have a tremendous probability, likelihood of some type of sexual harassment, sexual assault during their military service. I think this is a shameful chapter in our military history but it doesn't mean that the Department of Veterans Affairs can turn its back on this. We need to respond to those needs because the trauma associated with sexual trauma leads to illness, disability, and is just as devastating as the trauma caused by a bullet or weapon fire.

So it is something that we have to recognize, we have to be sensitive to it, we have to develop more effective screening, and we have to be there to provide that treatment.

Mr. MORAN. Dr. Trowell-Harris, you indicated in your testimony four things that serve as the mission of your center: to ensure that (1) women veterans have access to VA benefits; (2) services are on par with male veterans; (3) VA programs are responsive to gender-specific needs of women veterans; and (4) outreach is performed to improve women veterans' awareness of services, benefits, and eligibility, and women veterans are treated with dignity and respect.

How do you grade the VA on those four things?

Dr. TROWELL-HARRIS. I grade VA very well, but I want to point out that most of the mission is ongoing. For example, look at outreach. Outreach is something that must be done on a continuous basis and right now we are really emphasizing the elderly minority veterans, specifically Native Americans, Asian, Hispanic, and African American. This is ongoing.

In respect to dignity and respect, this is something that we need to be mindful of for all veterans, not just women. But this is something that we do constantly monitor and make sure it does happen because historically, since the VA was mainly for male veterans, sometimes women veterans are not treated with dignity and respect.

Mr. MORAN. Thank you. Let me see if Mr. Boozman has questions?

Mr. BOOZMAN. I really don't have any. I want to just make a comment that I appreciate you for calling the hearing. And then also it looks like you all are really doing a good job of being proactive in this in the sense the numbers really are significant, 4.5 percent now, 15 percent on active duty, and then 10 percent in the next decade. So it really is something that you are going to need to deal with. And, again, I commend you for looking forward, everything as far as programs and then just basic facilities that are going to need to be modified as this thing comes on.

So, thank you.

Mr. MORAN. Mr. Boozman, thank you very much. I will see if Mr. Evans has any questions. But I am interested in just a statistic, the average age of a female veteran versus the average age of a male veteran within the VA system?

Dr. ROSWELL. The average age of a female veteran is under 45 years. And the average age of a male veteran is almost 60 years.

Mr. MORAN. Thank you very much.

Mr. Evans, welcome to our subcommittee. We are just about to dismiss this panel, although we will have questions that we would like to submit to the panel in writing for the record, particularly after we hear additional testimony. But I would like to give Mr. Evans any opportunity he would like to ask any questions of this panel.

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

Mr. EVANS. Thank you, Mr. Chairman. I know that some of the problems we have in dealing with women veterans in the Department of Veterans Affairs are that surveys indicated about 5 or 10 years ago that women veterans didn't see themselves as veterans and that there was a reluctance to decide major decisions based on the lack the availability of programs for women and everything. I think the efforts by this chairman to bring us forward are very timely. We are really way overdue in terms of dealing with this issue. There should be no way that we will ever return to such discrimination against women, and at least I think this committee is prepared to do the necessary follow-up.

And I do have a written statement, Mr. Chairman, and ask that it be included in the record.

[The prepared statement of Congressman Evans appears on p. 42.]

Mr. MORAN. Thank you, Ranking Member Mr. Evans, for joining us, and thank you for your comments. And without objection, it is so ordered.

We thank our first panel, and we will call our second panel. That panel consists of Ms. Marsha Four, a registered nurse and the current Chair of the VA Advisory Committee on Women Veterans. She is joined by Ms. Joy Ilem, who has the unique experience of working every day with us on behalf of the Disabled American Veterans organization, who is a distinguished veteran herself and who, until recently, was a member of the VA Women Advisory Committee. Finally, Dr. Linda Schwartz completes this panel as a former Chair of the Advisory Committee and current professor at Yale University in the School of Nursing in New Haven.

Dr. Schwartz, we would be glad to turn our attention to you first.

STATEMENTS OF LINDA SCHWARTZ, RESEARCH SCIENTIST, SCHOOL OF NURSING, YALE UNIVERSITY AND FORMER CHAIR, ADVISORY COMMITTEE ON WOMEN VETERANS; MARSHA L. FOUR, CHAIR, ADVISORY COMMITTEE ON WOMEN VETERANS, DEPARTMENT OF VETERANS AFFAIRS; AND JOY J. ILEM, DISABLED AMERICAN VETERANS, FORMER MEMBER, ADVISORY COMMITTEE ON WOMEN VETERANS

STATEMENT OF LINDA SCHWARTZ

Ms. SCHWARTZ. Can you see me? Good morning, Mr. Chairman, and thank you very much for inviting me to this hearing and thank you very much for holding this hearing.

As was mentioned before, the female veteran population is now 1.4 million and constitutes about 5.5 percent of all veterans. And, as was noted also, these women are younger. And because of the fact that we now have the all-volunteer force, the involvement of women in the military reflects a difference in the period of service. Most of these women have come into the military after the Vietnam War. In contrast to the overall declining veteran population, the number of women veterans is projected to increase 20 percent by the year 2020.

VA and this committee have developed a network of gender-specific programs and services, which now constitute the framework from which the evolving needs of women veterans can be addressed. The spade work has been done. We have maintained the perimeter.

Now, a new generation of women veterans, larger than before, will be eligible to use these programs and should expect care equal to, if not better, than health care services provided in the private sector.

As was mentioned before, one of the most pressing and important aspects of accessibility to VA, is knowing the eligibility criteria and where to begin the process. With recent and frequent changes on these criteria, outreach to veterans and education regarding their VA health care must remain a priority.

I was reading an April 2001 GAO report on DOD disability compensation workload, which reported that 22,780 service members met physical evaluation boards for fitness of duty determination. Of that number, approximately 50 percent or 11,390 were discharged for medical reasons, 11,390 new service-connected disabled veterans in one year. At the same time, DOD officials voiced concerns about the long lead time that elapses before a service member with injury or illness formally enters the disability system. Outreach at these PEV sites would be an effective means of assisting these individuals as they transition from active duty to veteran status. But how would these veterans know about the system? Where would they learn about VA and the many services available to them and their families?

I continue to believe that an orientation to the mission of the VA should 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. It is important for all military members to know and understand how to assess their VA benefits.

Since the problem of sexual assault and trauma in the military was first identified, VA has made some very sterling efforts to implement quality treatment programs. Congress, one of the things I have noticed, that it is almost with a succinct sense of timing, that every 4 years we all make a pilgrimage up here to the Hill to ask the Congress and this committee to extend eligibility criteria so that it will cover women who are sexually assaulted while they are in the military. For all practical purposes, this problem is not going away. 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 is why must we make this pilgrimage every 4 years? It is unquestionably a moral and ethical responsibility for Congress to eliminate all restrictions to the VA's authority to provide care to those who are victimized while in the military.

Women veterans who are homeless do have needs that are different from their male counterparts. I was an original reviewer for the proposals for the first site that Congress and the VA funded for homeless women veterans. When they announced that there would be 11 projects, it was a victory. But it seemed a hollow victory, because there was only one year of funding guaranteed.

I know that VISN directors had to make a commitment to fund these programs for at least 3 years but even before they came online, VISN directors were hedging their bets by using the money for temporary positions with no guarantees that they would continue more than 12 months. Now we hear that some of the programs for women veterans who are homeless are not able to function because of the lack of funding that has not come from VISN directors.

Mr. Chairman, this is not the program we envisioned, and I don't think it was the program that Congress intended. So although the programs have a lot of quality, I would ask that this committee look into how they are being funded at this time.

I know that this committee has already acted to assure that the biennial reports of the VA Advisory Committee on Women Veterans will continue to move forward by the Secretary of Veterans Affairs to the Congress. As was said before, the report that I submitted in July of 2000 did not make it out of the building in any shape or form until May of this year.

I was particularly disappointed as I read VA's responses to the recommendations made by my Advisory Committee, of which Joy Ilem was one of the members. For the most part, they were ambiguous, condescending, and trite. The attitude projected by these responses, coupled with the observations made by the committee on our site visits to specific facilities and VISNs, indicated that services and programs for women veterans are in danger of being eroded. And I know that Irene Trowell-Harris has offered an explanation. But I want you to know that as a committee that was chartered by Congress, a report that we forwarded 2 years to the Secretary, the explanation offered today seems somewhat trite also. The Secretary could have had the courtesy to inform you, the com-

mittee, that a committee that you chartered had made a report to him and they could have sent it over to you.

There is no doubt that this is insulting, not only to me and my committee, but the fact that it took 2 years for VA to respond to this report, that it was never circulated or discussed, is an insult to the women veterans who went 2 years without any answers to their questions on the recommendations they gave us and that we gleaned from our activities.

I believe this underscores the need for Congress to be vigilant. The situation also vividly demonstrates the fact that accountability needs to become a watch word at VA. Unfortunately, however, it also illustrates that at VA many only pay lip-service to the needs of women veterans and the goal of providing them with quality of care and the respect they have earned in the service of our Nation.

And let me say that I am not saying that anyone in this room—I am saying that it is the gatekeepers, some of the clinicians, who are the ones who have this attitude that service to women veterans is not a basic program of the VA.

I thank you very much, Mr. Chairman.

[The prepared statement of Dr. Schwartz appears on p. 53.]

Mr. MORAN. Dr. Schwartz, thank you very much. If it is okay—if you say it is not okay with the other two witnesses, I don't know what I will do. But assuming that it is all right with the two witnesses, Dr. Schwartz I think has a plane to catch. And I see if any panel member has any——

Ms. SCHWARTZ. I can wait. I can wait until the others finish.

Mr. MORAN. We have got to break for votes. And I would guess we will be back in about a half-hour. So let me see if anyone has questions for Dr. Schwartz and then we will come back and take the testimony of Ms. Four and Ms. Ilem. Is that okay?

Mr. Boozman? Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. I have known Linda for all my time in Congress, and I can't think of a better advocate for women veterans. It is not only because you said some nice things about me in your opening statement, however I do appreciate that. But it is the hard work that you have done when women were out in the cold as far as the VA is concerned.

So thank you for coming to testify. We look forward on other occasions to hearing from you as well.

Thank you, Mr. Chairman.

Ms. SCHWARTZ. I just want to say, Mr. Evans, that I believe you and I are probably the only people that were in this room 17 years ago when we started—were in this room 17 years ago when we started, and I agree that there is much work that has been done that we should be very proud of. And at times some of the comments that we hear, it makes us—it even gives me more energy to stick to the program that we have evolved over these last 17 years.

Mr. MORAN. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. First of all, let me thank you. And also just indicate that the Armed Services Committee is also meeting at the same time and most of us are on that committee. And the Democrats are just meeting on Iraq with our leader. And so the fact that

a lot of the Members are not here is not an indication that they don't have the interest. It just happened that those meetings were at the same time. And so I do want to thank you for what you have done. And I have asked my staff to look to see exactly—maybe get together with you to see what if we might be able to work together.

I don't know if—there are a lot of studies that have already taken place but maybe there are some specifics points where we can work with the GAO for study, and you might tell me what the GAO has already done to make an assessment of women in the VA and what the problems that exist. And some studies also come through the Library of Congress in terms of assessing the needs, we can look at the needs of women and veterans and maybe some recommendations will come out of those efforts.

And I apologize because oftentimes we do just have a whole bunch of studies and then we don't do anything. But I would like to get some feedback from you on that perspective?

Ms. SCHWARTZ. Well, I agree. As a research scientist at the Yale School of Nursing, there is a lot of research that goes unnoticed. And it can be helpful and I look forward to working with you and your staff in the future.

Mr. MORAN. Mr. Rodriguez, thank you.

Mr. RODRIGUEZ. Mr. Chairman, I also would like to submit some comments for the record, if possible.

Mr. MORAN. Without objection, so ordered.

[The prepared statement of Congressman Rodriguez appears on p. 39.]

Mr. RODRIGUEZ. Thank you.

Mr. MORAN. Thank you. Is the sexual abuse and sexual trauma treatment counseling similar inside the VA as outside? If you are a female who has encountered a sexual trauma or harassment in the private sector and you entered the private sector for counseling treatment, is that any different than the kind of treatment you would receive in the VA?

Ms. SCHWARTZ. Well, I think sexual trauma in a military setting is very different, because not only are you assaulted by someone in the system, it is very hard in that system for women to come forth and make the complaints that they might make easily if they were in the private sector. And so when you are doing the treatment for sexual trauma counseling in the VA, you have to take into consideration that military experience, that whole scenario. And that is why I believe that the VA would be able to attend to those needs as well as the sexual trauma issues itself.

As Dr. Roswell mentioned before, there are high rates, over 25 percent of the women that were coming into VA hospitals, were reporting incidences of sexual trauma and abuse while they were in the military.

Let me say from the get-go, I do use the VA and my practitioner asks me that question, not once but every time I come in to be sure. So that understanding of the uniqueness of a woman in a male-dominated society, even though they are growing, is a very important aspect because sometimes women feel betrayed by the system because it has taken such a diametrically-opposed position.

When I was in the military, it was very, very difficult to get any sort of response from commanders to prosecute. I think that is bet-

ter. But the point remains that in the system there are so many issues out of the experience in the military and how it reacts to these problems.

Mr. MORAN. Doctor, thank you. Perhaps to me, one of the most compelling portions of your testimony was the reminder of the failure of the VA to even publish or submit the report. I think Dr. Roswell made clear, and I guess this is a 2000 report, so we are not necessarily criticizing Dr. Roswell, but he made the point about the culture. The suggestion is if you can't release the report, can't respond in an adequate, appropriate manner and time frame, it is worthy of Congress and others looking at the system.

Ms. SCHWARTZ. Well, I would just like to give you one of the responses that was particularly troubling for me. Our committee recommended that a question about veteran status be included on intake statements for research and for social services sponsored by the government so you could identify veterans using that. The answer that came back was the VA does its best to ensure that questions about military service are included in briefings at TAP and DETAP. TAP and DETAP are when people are sitting in the room in their uniforms ready to be discharged. So I don't know who answered those questions, but that is just one example, among many, that make you wonder.

Mr. MORAN. Thank you very much, Doctor. We will let you catch your plane. We may have additional questions for you that we would submit in writing. Ms. Ilem and Ms. Four, I hope you will indulge the committee so we can go vote.

The committee will be in recess until the sound of the gavel, approximately a half-hour.

Ms. SCHWARTZ. Thank you.

Mr. MORAN. Thank you.

[Recess.]

Mr. MORAN. Our committee will come back to order. Thank you all very much for your consideration of our voting schedule. We have been joined by an additional witness, Congresswoman Heather Wilson, who is the sole female veteran Member of Congress. I had asked Heather if she would join us today for any comments or remarks that she would like to make for us and for the record on this issue of veterans' health care for women. We are delighted to have one of my classmates and distinguished colleagues join us now.

Thank you, Heather.

STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman. And I appreciate the honor you have bestowed on me in asking me to come and speak a little bit here today.

A couple of weekends ago, I went back for my 20th reunion at the Air Force Academy. And I remember when we were cadets that when the people came back for the 20th reunion, they were always really old. And that is not true anymore, at least in our minds it is not true anymore. But a lot of my classmates are getting to the point where they are eligible for retirement.

In thinking about what I wanted to say today and where we were 20 years ago and where we are with respect to health care, it is my belief that the VA is about to go through some of the changes and the challenges that the Department of Defense went through 15 or 20 years ago when we had increasing numbers of women in the military. And like it or not, we are getting older, and we are going to be needing more health care as women who can participate in the VA system over time.

The fastest-growing speciality group in the VA system out at the VA hospital, in Albuquerque, anyway, is women. And that will put increasing stress on the system for OB-GYN care, for preventive health care, eventually for diseases and disease groups that particularly impact on women, whether it is osteoporosis or certain kinds of cancers that have a particularly high propensity in women.

I also wanted to note that in addition to things that we often associate with women's health care, like OB-GYN care and differences in preventive care, there is another area of considerable interest and concern, and that is post-traumatic stress. And there is a higher than expected percentage of women veterans who suffer from it but it is from different triggering causes than in most cases of men veterans. Many of those cases relate to sexual abuse, assault, or rape while in the service. And I think this will put a particular—is a new demand and a new way of having to look at health care with respect to our women veteran population that will challenge the VA over time.

The final thing that I did want to mention has to do more with the culture of the VA and how you feel when you walk into a VA clinic or into a VA hospital. I go out to the VA hospital in Albuquerque quite a bit. I very rarely see women veterans there. It is highly unusual, in fact. It is interesting to talk to women who have been in the service and when you listen to the words they use, very few women who have been in the service call themselves veterans, even when they have served in a combat theater or in some cases now we are close to having women veterans who are combat veterans. They still are much less likely to call themselves or think of themselves as veterans. And also less likely to access the services provided by the VA hospitals.

Some of it is how we think of ourselves. Some of it is how we feel when we walk through the door of the VA and whether you feel as though you are in the right place with a doctor who understands who you are and what your needs are. And even just simple things like privacy.

So I think there are tremendous challenges on the way for the VA health care system to adapt to the needs of the veterans of the 21st century, an increasing percentage of whom will be women who have served their country. And I particularly thank this committee for taking a look at this issue, because I think over the next decade, it will be a continuing challenge for the VA health care system.

Thank you, Mr. Chairman.

Mr. MORAN. I thank the gentlewoman from New Mexico for joining us today and appreciate her perspective. And, Heather, we look forward to working with you on this and other issues as we try to

address the needs of men and women who serve in our military and become our Nation's veterans. So thank you again.

Mrs. WILSON. Thank you.

Mr. MORAN. I believe we are now ready for Ms. Four.

STATEMENT OF MARSHA L. FOUR

Ms. FOUR. Mr. Chairman, members of the subcommittee, I thank you for the opportunity to address this subcommittee on the interests and concerns related to women's health in the VA.

Mr. Chairman, as noted, I am sure, I am an aging woman veteran but I am a product of the Age of Aquarius and that of the Vietnam War, a time that took much to the streets here in America, not only the war but issues related to civil rights and women's rights. It was during these times that the voice of women veterans joined with those of the past in high crescendo. And I am proud to follow in their footsteps.

I was appointed as a member of the VA Advisory Committee on Women Veterans in March of 2001 and appointed its chair last August. The Advisory Committee recognizes the major advancements in the women health programs that the VA has made and the important contribution of the establishment of the Center for Women Veterans.

Women comprise nearly 20 percent of the active force and this will be placing an even greater future need and demand on women's health care within the VA. The title of the Advisory Committee report for 2002 is, "Forging the Future For Those Who Follow." That is our job and hopefully our legacy. Soon, however, it will be theirs.

As time permitted, we were hoping that there would be a number of issues presented before you by the panels and so there are just a few issues that I will be touching on.

The first is the biennial report of the Advisory Committee. During the discussions earlier, the report 2000 was heard. The purpose and level of the importance placed on the contribution of the Advisory Committee comes into question when responses are not interpreted as significant.

Considering the time spent on briefings, site visits, and presentations, not to mention the writing of the report, it is truly unfortunate that the report was lost to Congress for a time due to the sunset provision of original legislation. The committee hopes that this doesn't occur in the future with any Advisory Committee reports that Congress feels strongly enough to request in legislative action.

The VHE chief of staff assured the present committee that the response to its recommendations would be addressed in a timely manner with a coordinated approach process and that the chief of staff would oversee this process. The report has been submitted, reviewed, and the Secretary has signed off on it.

Women Veteran Health Clinics. Every 2 years in a competitive process, the VA selects centers of excellence in VA women's health care. In 2002, six were selected. The VA Advisory Committee on Women Veterans applauds these programs for the accomplishments of the delivery of service and care for women veterans. They meet the highest standards of clinical outcomes, patient satisfaction, and productivity. Only 50 percent of the VA medical centers

have women veterans health clinics. The diversity of services offered varies widely. Realizing this, the ability to address the health care issues of women veterans should not be compromised because performance measures also are very vital.

In today's health care delivery market, women's health is a fast-growing, widely-recognized, and professionally-accepted specialty. The female biology, the inter-relationship of hormones in the complex human physiological system, pharmacological considerations, the issues of sexual trauma, domestic violence in a therapeutic delivery setting.

Research opportunities. These are only a few focused points that substantiate the need for women's health clinics with an inter-disciplinary approach. The importance placed on women's health clinics is obvious. And the thrust is also apparent in the acceleration of the approach taken in medical school curriculum and the fellowships offered.

Recognizing this importance, in a report to Congress of the results of a national survey of medical schools and recommendations for a core women's health curriculum and medical education, a major leap was taken. Through the Office of Women's Health, in collaboration with representatives of the Health Resource and Services Administration, the NIH Office of Research on Women's Health, the Association of American Medical Colleges, and the American Medical Women's Association, significant steps were taken toward the design and implementation of a model curriculum to help medical schools achieve an innovative, multi-disciplinary approach with life spans for women's health.

Outcomes are the golden key. They unlock the door that restrains growth opportunities of innovative programs, services, and delivery systems. You want to see outcomes. You need outcomes, measurable evaluations of programs. These outcomes justify authorization bills, budget appropriations, dollars spent, staff assigned, and contracts formed or expanded. Without outcomes, how can we come to you seeking more? Even if it is the right thing to do.

The Advisory Committee stresses the valuable importance of the VA to work toward the continued and expanding process of collecting and reporting outcomes. Outcomes define quality and justify investment. They will ensure the continuance of our VA women health clinics.

I will reiterate a statement earlier: Why must we return over and over every 4 years for the authorization of the eligibility criteria for sexual trauma treatment in the VA? We would ask that this be a consideration for permanence.

On the issue of women veteran coordinators, they are truly vested in their job. They work endless hours, far many beyond the limits of their official FTEE in order to get the job done, actually. Their innovative approach to duty has driven the efforts of women veteran programs. FTEE allocation for women veteran coordinators at both the local and VISN level is a recommendation of the Advisory Committee Report 2002. Some report a mere 4 hours that they are allowed for this. We seek no less than half-time, a 0.5 FTEE for local women veteran coordinators and full-time for a VISN-level women veteran coordinator.

Here once more, the Advisory Committee appreciates the need for outcomes. However, we also appreciate the demand of time and the level of responsibility placed upon these coordinators. Another concern of the Advisory Committee is the fact that the language creating their position merely states that medical centers must designate a women veteran coordinator. It does not mandate that they be given any FTEE or that funds are earmarked for their positions.

According to the VHA handbook, 1330.1, Guide to the Women Veterans' Health Services, there is—may I continue, sir? There is reference to the involvement of the VISN women veteran coordinator at the VISN level on the strategic planning, space, environment of care, and pharmacy committees. I think if we look at this issue, we would see that this in fact is not the case in many or most instances.

We would also recommend that these committee assignments for the women veteran coordinator be considered at the local medical center level.

Privacy, of course, is always another issue, and I don't think I need to say anything more about it. We all know that it is still an issue, and we all know that it is a growing issue actually with the expanding number of the CBOCs coming online.

The Women Veteran Health Program Office, it is the program office under which the women's health care is coordinated for the entire VA. The Advisory Committee asks that you ensure its continuance and protect its position through legislation to mandate it as a permanent program within the VA. Without the Women Veteran Health Program Office, women veterans will be lost once again to a system that may be unresponsive to the growth of specialized progressive women health delivery.

The Advisory Committee has requested an update on the pilot programs for the homeless women veteran programs. We have been concerned about continued funding of these programs after the first year of designated funding. And this was an issue that we discussed actually at a hearing in the past. We were given to understand that the VISN directors and local medical centers understood that if additional funding was not designated in the budget for the second and third year of the pilot programs, that they would commit to the continued funding of the programs. It is unclear if this is in fact the case and if all Department chiefs are aware that this arrangement exists.

It is our concern—it was our concern from the beginning, that if the money for these special programs, set up as 3-year pilots, was not set aside protected dollars, as was the intent of Congress, that the money would be lost in the VA pool. We ask Congress to consider this when providing any funding for any special programs in the future, for outcomes take at least 3 years to come forward and the dollars must be protected to ensure that that can continue and exist.

This concludes my testimony, and I am available for questions.

[The prepared statement of Ms. Four appears on p. 62.]

Mr. MORAN. Thank you very much. Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you. Mr. Chairman and members of the subcommittee, good afternoon.

I am pleased to present the views of the Disabled American Veterans concerning women veterans health programs and services in the Department of Veterans Affairs. VA estimates that by 2010, women veterans will comprise 10 percent of veterans utilizing VA health care services. With increasing numbers of women seeking VA health care following military service, it is essential VA be prepared to meet their specific health care needs.

The Center for Women Veterans, the Women Veterans Health Program, and the VA Advisory Committee for Women Veterans all play a key role in assessing the needs of women veterans and ensuring they have access to equitable, comprehensive health care services throughout the VA health care system. Although VA has made significant improvements over the last several years, the level, quality, and availability of services for women veterans is not consistent throughout the system.

We are pleased, however, that the VA under secretary for health established the Women Veterans Health Program National Strategic Work Group to evaluate the current status of women's health care in VA and to make recommendations for strategic planning for women's health.

The November 2001, National Strategic Work Group preliminary report provides a comprehensive review of the Women Veterans Health Program, and we applaud the work group for its candid assessment of the challenges facing VA and providing equitable comprehensive health care to women veterans in a complex health care system and environment and fiscally-challenged system. The Work Group discussed the ramifications of main-streaming women veterans into existing clinical care lines; the evolving role and challenges facing women veteran program managers and coordinators; challenges in providing a private and safe environment for women veterans in a clinical setting; challenges in providing certain specialized services, such as mental health and homeless issues; budgetary issues; and other issues that affect the quality and availability of health care programs for women veterans.

DAV is especially concerned about the impact of re-integrating women veterans from separate designated women's clinics into existing service lines despite the fact that many clinicians lack expertise in women's health and maybe less sensitive to women's health issues. In a system where women are an extreme minority, VA will need to continue to place special emphasis and attention on specific health care needs of women veterans.

We agree that VA's biggest challenge in providing equitable, high-quality health care to women veterans will be to maintain the integrity of the women's health programs while meeting the needs of all veterans in a health care system that is clearly under funded.

Future decisions about health care delivery for women veterans should not be based solely on available resources but rather on sound research and clinical outcomes. The research studies of Drs. Katherine Skinner and Elizabeth Yano regarding variations in the structure and organization of women's health delivery and the experience of women veterans who use VA health care are especially

significant and should be carefully considered by VA when planning for the future.

Insufficient funding for VA health care threatens the progress that has been made in improving and enhancing services for women veterans and jeopardizes their access to quality health care in the future. Continued oversight of the Women's Veterans Health Program is essential, given the current fiscal crisis in VA health care and resulting rationing of care.

In closing, we urge VA to dedicate the necessary resources the Women Veterans' Health Program deserves and strive for excellence in women veterans' health in all its facilities. Despite budgetary and organizational challenges, VA must make providing equitable, high-quality, compassionate health care services to women veterans a high priority.

Mr. Chairman, that concludes my statement, and I will be happy to answer any questions.

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

Mr. MORAN. Joy, thank you very much.

Mr. Rodriguez, questions?

Mr. RODRIGUEZ. Once again, I just apologize I didn't get to hear your entire testimony. Let me ask you, in terms of all the studies that has been done specifically what do we need to do, and also in terms of some specific geographic area. For example, in my district in San Antonio, do we know exactly—do we know more or less the service level provided to women on a proportional level in terms of attendance or the difficulty that they are encountering, some specific scenarios in our area? I would like to know how my hospital is doing?

Ms. FOUR. Sir, I would have to say I don't know specifically about the hospital medical centers in your area. I do know that across the Nation the services vary widely, especially in those medical center women health clinics that are not designated as comprehensive centers. Oftentimes, GYN care has to be—they either contract a GYN physician to come in on a part-time basis, on a periodic schedule, in order to attend to the needs, the gender-specific needs. Or those services are contracted out into the community, sometimes at a situational problem for transportation for the women veterans. There is no real standardization that would be seen across the board in the VA medical center women health clinics.

Ms. SCHWARTZ. I would just like to add that your district is San Antonio and that is one of the largest military retiree communities in the United States. And I know for a fact, being retired from the Air Force, that many of the women who are there have depended on the retiree plans for their health cares but now look to VA for women veterans' health. So you will see, as TRICARE and the VA do more partnering, that women veterans who are in your community will probably gravitate towards the services or request the services from the VA.

But I think you raise an excellent point. And I think no one is asking for us to just blanket all these services everywhere. These need to be practically-driven by the need and the need does exist because of the largeness of your community. Outreach and advising these individuals in your community of what is available is a task

that would probably render more people using VA health services for women.

Ms. ILEM. And I would just add, I think both Marsha and Linda would agree, since we have all served on the VA Advisory Committee, one of the ways that we really learn about what services and programs are out there in different facilities is our opportunity for on-site visits to see those programs and services. The VA has always been very cordial, whether we have done them alone or with the committee, to put together a range of things for us to see, to talk about the programs and services they do have available for women veterans in the different sites.

So I encourage you if your staff is available locally to go out and see what is available at your sites. That is the best way because we learn a lot from doing those site visits and talking with women veterans. We hold a women veterans' forum with most of the committee site visit that we did and that was an excellent opportunity for us to talk to women veterans that use those services in that area. And they shared with us their concerns and the good, the bad, and in between. So I hope you will be able to do that or one of your staff members.

Mr. RODRIGUEZ. Now, those centers for excellence, I was told that we have one in my area. But in terms of across the country, where are we on those? Are they pretty widespread? Or do we know? Is lack of access a problem nationwide. Are there some areas that are doing better than others? Do we have a report card on some of the areas where we need to push?

Ms. FOUR. Yes, sir. There are centers of excellence from across the country every 2 years. Those women health clinic areas, I believe the process is they put forward their program and submit it to be considered for a center of excellence award. And then the VA evaluates the programs offered and the assistance provided and the diversity of the care. And it is based upon that criteria that they are given that center of excellence.

I think that this last—the last six that were chosen, only one was a comprehensive health center. The rest were women health clinic areas.

Ms. SCHWARTZ. I would just like to say one word about the site visits. And, excuse me, because I still am upset about the 2000 report. But it is important for you to know, and Joy just rocked my memory, that the committee at that time felt the need to know what was going on in the various sites. It was so important that they, irrespective and at their own expense, made site visits to VA facilities in the Midwest, here in Washington, DC, and in the New York area. And so part of what they gleaned from these site visits that they did at their own expense was in that report. And I think it is important for that to be added because they did that work because they wanted to be sure that the recommendations that we put forward were valid.

Ms. FOUR. And I think also when you only consider one site visit a year, I don't know what the life span of any of us, if it is appropriate to think that we can touch base and discover the issues and position of the women veterans in the medical centers across this entire country. I mean we hit one little spot and often it is because we have identified a specific program we would like to look at or

the committee or members of the committee have gotten some information that would lead them to believe that there is a necessity to go and look at the programs there.

I think also a very important aspect of, and I am not sure if Joy mentioned this, an aspect of the site visit is actually a town hall meeting that the committee holds so that the women veterans from in and around that area that utilize the system actually come in for several hours and discuss how they are finding the utilization of the VA for them, the issues and concerns they have. The Advisory Committee actually moves to have representatives from within the medical center and benefits arena there present on site. So specific issues can be answered in a more specific manner for the resolution of their problems at that point in time.

Ms. ILEM. I would just add one thing to your specific question on the variability of programs throughout the country. A lot of that also depends upon the availability of the women veterans coordinator and how much time, administrative time they are allowed to do outreach to women veterans in that community to develop a pool base of women veterans that may need services and are eligible for services. And as well as a variety of other factors, such as if the local management is supportive of women veterans' programs, how much time they allow them to develop those programs.

So that certainly is key to what services are available. They have to have the opportunity to put together those programs, the staff that is needed to run them, and that would factor in.

Mr. RODRIGUEZ. Thank you very much. Thank you.

Mr. MORAN. Thank you, Mr. Rodriguez. Let me ask a couple of questions of this panel. Joy, Ms. Ilem, your comment sparks this question. Is there a role model VISN or hospital when it comes to the care and treatment of women veterans?

Ms. ILEM. I would say I guess the centers of excellence are the key role models for VA health care. Those have certainly passed VA's test of what they feel is the best they have to offer around the country.

Mr. MORAN. But from the perspective of a member of your committee, if we were going to ask the VA to develop a plan, is that plan satisfactory? The centers for excellence, is that what you would like to see more of in more places? And in places that aren't centers of excellence, is there somebody who is doing the job well?

Ms. ILEM. The places that I have visited have all been very impressive. Certainly, the women veteran coordinators and the people involved in those programs have been so committed and they are so impressive but I can't think of one that——

Mr. MORAN. Let me tell you where I am coming from. I always think, particularly in an institution as large as the VA, what matters is individuals. Are there individuals within the system who are in leadership positions who have made the system work for women veterans despite the VA system?

Ms. SCHWARTZ. I would say that in my experience that there are many nameless individuals who everyday—and I would say it is the women veteran coordinators but it is not just those in the hospitals. It is those at the regional offices. It is your nurse practitioners who are dealing with women. They go that extra mile. They want this to work. They want to use their expertise, and we may

never know their names because there is not that standardization, because there are so many different obstacles on local levels that you cannot even imagine.

I recall that when we were in Seattle, the utilization of women veterans of that facility, they had thousands. It was wonderful. But unbeknownst to everybody, the gynecologist who was on staff was retiring and the chief of surgery, the chief of staff decided to fill the position. No one else knew that. No one else knew that.

So that is why the recommendations that Marsha Four made about the women veteran coordinators having access to the medical center directors is imperative. They need to have that link so that they can do their advocating without going through the usual bureaucracy of a hospital.

Ms. FOUR. I think in addition to that, when we talk about the women veteran coordinators being able to have a seat at the table, oftentimes the only seat at the table they have is that of the Women Veteran Advisory Committee within the local setting. They are not an active player in the leadership role at the committee levels within the hospital that some time come to the position of making decisions for utilization of resources, appropriate delivery of health systems.

And so I think therein lies also an additional aspect that we need to look at, the importance that the leadership at the local hospital places on the contribution that they make.

Mr. MORAN. Thank you. Let me ask this question. Your estimation, Dr. Schwartz, of why the delay in issuing the report occurred (we heard the VA's explanation): is there something more to it than that? And, Ms. Four—the 2002 report, is the atmosphere in which it was released different than what Dr. Schwartz's committee experienced, is there a change in the VA's receptivity to this topic?

Ms. SCHWARTZ. Let me just say that the report was finished in July of 2000. I know that it was sent forward at that time. I have no idea what happened to it. I did ask about it. And, of course, we had a change of administrations. We had changes in the Center for Women Veterans, who is usually the person who has to bulldog this report. I actually have to say I was kind of shocked that it even showed up on my doorstep in May of 2002, like an old visitor. But I think the explanation, and I really feel that this committee, the Women's Advisory Committee was one of the first advisory committees mandated by the Congress in 1983. And every year but the year 2000 was covered by a report that was conveyed to this committee. So I don't know if it is because I am getting older and know the history that it got lost. So I can only speculate. But, as I said, the responses were inappropriate in places.

Mr. MORAN. Your point being that there was a report every year since 1983——

Ms. SCHWARTZ. That covered every year——

Mr. MORAN (continuing). Makes it even more——

Ms. SCHWARTZ. It came every 2 years since 1983.

Mr. MORAN. Makes it even more inexplicable of why?

Ms. SCHWARTZ. Well, I don't know. I kept asking myself was it something I said?

Mr. MORAN. Well, this topic was raised to me by a Kansan, Sherry Blede, who was a member of the committee, who was very concerned that this was prolonged and prolonged and prolonged.

Ms. SCHWARTZ. Well, let me say that Sherry was one of those people who did do those site visits on her own time and at her own expense. And I feel that that is important for this committee to know, that that was the dedication of the committee. And I have no reason to believe that that fervor has not been carried on by the present committee.

Mr. MORAN. Ms. Four, in that regard, what was the atmosphere and attitude of the VA in accepting your report?

Ms. FOUR. Actually, I should say I knew of the situation with the 2000 report and many of the committee members who are seated now were in fact seated members of the committee for that 2000 report. So when I came on to the committee in 2001, there was still continued discussion about this. And the committee raised concern about how our report would go forward and the timeliness of its receipt.

There was then a briefing by the chief of staff, who brought to the table—helped us to understand the explanation of VA on why the 2000 report was late. And she explained to us that she was looking very closely at the process that would be used going forward in the review of the report that we would submit, that she in fact would oversee this process, that it would be a more coordinated process, that time lines would be followed, and those giving responses would be held to the task.

We at the committee submitted our report in a timely fashion, as were requested under the guidelines and dates expected of us. The report was sent forward by July 1st, I believe the date was. The chief of staff coordinated the process and within 60 days, those recommendations were formulated, reviewed, and signed off on by the Secretary. They were signed, I believe actually just in a very recent date. I can't give you the specifics.

Mr. MORAN. We just received a copy of the report 2 days ago, after scheduling this hearing. I think it was the 29th of September. So from our perspective, I don't know whether it was released any days before that, but it just arrived.

Ms. FOUR. Considering past experiences, I would suggest that the timeliness, the process has been greatly improved, that people at the table seem to be given—I can only speculate, maybe greater authority in providing responses that would be more appropriate, also suggesting guidelines to the committee for suggested updates on specific issues that they brought forward and need information on, and also information on programs that they were already working on to help us understand a better consideration for the recommendations we put forward.

Ms. ILEM. Mr. Chairman?

Mr. MORAN. Yes?

Ms. ILEM. If I may just add, just in my own personal experience as well, I would like to say Dr. Irene Trowell-Harris and Carole Turner, both of the Center of Women Veterans and the Women Veterans' Health Program, have been always willing to speak to DAV, to me personally at any time, anywhere wherever I have been, about women veterans' issues, coordinating with working on

the Women Veterans' Summit, which is very important, and any women veterans' health issues. I think they are very dedicated and committed and great advocates within the system.

So we look forward to their continued support. But they have always been more than forthcoming, and I think candid with me in their assessment of the program, the shortcomings and the positives.

Mr. MORAN. Do they have the ability to convey that support and enthusiasm to other levels of the VA?

Ms. ILEM. Well, I am not privy to those dealings, but I am hopeful that they—I think the strategic planning preliminary report that the work group worked on, and I know that Carole Turner was involved in that. And I think it was a very candid assessment and brought a lot of things to the forefront. And I was glad to see that in some of her—also they put out a newsletter that goes out, and I think that she has been very candid and forthcoming in that as well.

So I am hoping—I assume that those things go through the levels of VA before they go out. That is a first step forward in approaching the real problems that they have in those programs and providing services. So, hopefully, they are able to do that.

Mr. MORAN. Let me speak a minute about outreach and informing veterans about care and benefits that are available. It has been a surprise to me, as I have gotten more engaged in dealing with veterans, how many have little information about what they are entitled to, what services are available, where they go, and who they talk to. I understand from what you are telling me this is even more true for women veterans. There has been a lot of discussion in the recent month about outreach at the VA and trying to encourage participation by our veterans.

Any particular specifics that we ought to be aware of about how the VA could or should reach women veterans?

Ms. FOUR. If I could make just one suggestion. First of all, oftentimes the issue of outreach at the local level, I am speaking, for women veterans, the outreach is on the shoulders of the women veteran coordinator. It is one more piece of the responsibility that she often carries within the local medical center. I think because so many women veterans are not utilizing the VA, that are out in the community, I think a cross-reference over into community service providers and to community social service systems, into community action groups, getting the word out and really putting a strong push into committee—I mean community organizations and service providers at the local town, community, even state level through American Medical Association, through health care providers in the civilian population, I think therein may lie an additional outreach opportunity that in some cases I am sure maybe taken advantage of. But also are we sure that there is even time to do that on the plate of those who are held responsible for outreach responsibilities?

Mr. MORAN. It might not be a natural question for someone in a social service agency or medical setting to ask a woman, "Are you a veteran?" I am only speculating, but I would guess that would not be the natural question. Which then would lead to, "Oh, do you know that the VA provides these services?"

Ms. SCHWARTZ. Let me just say that one of the things that we learned from the beginning was the way in which you ask the question, saying, "Did you ever serve in the military" is easier for people to relate to rather than, "Are you a veteran?"

And I think outreach has to happen on a larger scale. We did suggest in our report to the Secretary that articles in professional journals, apprizing individuals of just asking—of service providers and clinicians asking that question. And I did submit, and it has been accepted for a presentation at the American Public Health Association Convention, I will do a presentation on "Is Your Patient a Veteran?" Because, as you know, many of the veterans in this country do not even use the VA, that there are some risk factors that go along with being in the military. So the outreach that I am trying to do, and was adopted by the American Public Health Association, is taking it to the professional community.

Mr. MORAN. Is it less likely that a female veteran belongs to a service organization?

Ms. ILEM. I think so. Traditionally, they have been more male-oriented. I think now, more recently, I think we have seeing more women veterans become members of service organizations. Again, it depends on the initial impression that they get, how welcome do they feel? Just like Representative Wilson indicated, that first impression makes a big—is really key because are they going to come back? Are they going to get involved? That is another issue. But hopefully they are reading magazines and the information that the VSO's put out.

I think most of these service organizations have tried to incorporate and really bring to the forefront the issue of women veterans to make sure that they are adequately represented on their issues, things that they are interested in, whether we put them on the web site or information in our magazines or other forums of outreach.

But it is key, women veterans often just disappear back into the community. They got involved in their education. They got involved in raising their family. And they didn't identify themselves as veterans. So they just have kind of missed out on that opportunity. But with VA providing the level of care that they are and some of their programs, and very comprehensive and excellent health care, now is the key time to bring these women veterans into the fold, give them the opportunity that other veterans have had.

Ms. SCHWARTZ. I just wanted to say that I read in the Federal Register last week that VHA will be doing a survey of women veterans about their access to VA health care. And, actually, the survey items were published for comment. And some of the women veterans that I know who do not belong to organizations thought that they could send their comments directly to VHA. They didn't realize it was the comments on the survey idea. So the idea of putting it on the Federal Register, someone picked it up and it now going great guns.

I think that survey and the items that they talked about and enumerated there about barriers to care in the VA is a very important part to understanding how you can more adequately attract women veterans who are eligible for care in the VA.

Mr. MORAN. Thank you all very much. Dr. Schwartz, particularly thank you for staying. And, Ms. Four and Ms. Ilem, we appreciate your testimony. Thank you.

Our concluding panel consists of Ms. Carole Turner, the VA director for Women Health Programs, VA Central Office; Ms. Toni Lawrie, the coordinator of the women's clinic at the VA Medical Center in Bay Pines, Florida; and Dr. Margaret Seaver, director of the Women's Health Care Program at Boston, Massachusetts VA Health Care System.

Thank you all very much for joining us, and, Ms. Turner, we are pleased to receive your testimony.

STATEMENTS OF CAROLE L. TURNER, DIRECTOR, WOMEN VETERANS HEALTH PROGRAM, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; TONI LAWRIE, COORDINATOR, WOMEN VETERANS CLINIC, VA MEDICAL CENTER, BAY PINES, FL; AND MARGARET SEAVER, DIRECTOR, WOMEN VETERANS HEALTH CENTER, VA BOSTON HEALTH CARE SYSTEM

STATEMENT OF CAROLE L. TURNER

Ms. TURNER. Thank you. Good morning, Mr. Chairman and members of the subcommittee, I am pleased to be here today to report on the status of the National Women Veterans Health Program within the Department of Veterans Affairs. I was appointed as the director of the Women's Veterans Health Program in 1999. I have responsibility for ensuring that the VA policies regarding the provision of health care services to women are administered at every VA medical center and community-based outpatient clinic. I speak to you today not only as a director of the Women Veterans Health Program but also has a Vietnam-era Air Force veteran, an advanced registered nurse practitioner and health care provider within the VA for some 20 years, and also a 15-year veteran user of VA health care services myself.

VA has responded to a 1983 General Accounting Office report entitled, "Actions Needed to Ensure that Female Veterans Have Equal Access to VA Benefits" by designing innovative health care systems and investing resources to address the deficiencies identified in that report.

As a result of the focus on women veterans, many improvements have been made, and innovative strategies were instituted and are now in place to provide high-quality health care services to women veterans. The program operates through a network of field-based deputy field directors. These directors provide needed regional leadership, guidance, and support to network and medical center leaders, and also support the field facility-based women veteran coordinators.

These women coordinators were appointed in all VHA medical centers as early as 1985 to advocate for women veterans seeking VA care. These coordinators are instrumental in the development, management, and coordination of health services, at not only their individual medical centers, but also the entire array of community-based outpatient clinics, which aim to enhance VA veterans' access to health care services. They also typically have significant clinical

caseloads in addition to providing local clinical expertise to other providers and health care managers.

As VHA was reorganized from a hospital base to an outpatient preventive medicine health care delivery model in the mid-1990s, leadership was decentralized into 22 veteran-integrated service networks, which are now 21. In keeping with these changes, lead or liaison women veteran coordinators have also been appointed for each one of these veterans-integrated service networks.

Now these VISN coordinators have been recently appointed as the official field advisory committee to the Women Veterans Program Office. Given the magnitude of their role in supporting the local women's health care delivery, newly appointed coordinators—women veteran coordinators may obtain further training through a mini-residency program that is offered in Tampa, FL. To date, 77 new coordinators have undergone this special training.

The Women Veterans Program Office was established within the Office of Public Health and Environmental Hazards and the first full-time director of the program was appointed back in 1997. My office is supported by two VA-Central Office support staff, which also support the four deputy field directors.

As Dr. Roswell has mentioned earlier, the ability to expand and organize women's health care services was significantly enhanced by the Veterans Health Care Act of 1992, which provided authority for the array of gender-specific services and programs to care for women veterans. As a result, there have been eight Comprehensive Women's Health Centers established, as well as four stress-disorder treatment teams. The Comprehensive Women's Health Centers serve as the VHA's model of the state-of-the-art in health care delivery for women veterans.

You heard earlier about the inter-disciplinary team and the array of services that are provided in these comprehensive centers but just to comment on a few. Of course, the array of gender-specific services, maternity services, general medical primary care, as well as MST screening and other treatment modalities for social and emotional problems.

Over half of the VA medical centers have a separate women's health clinic, with two-thirds of these clinics having been established since 1995. While the remainder often provide care in general primary care settings, women veterans are typically referred on to specialized women's clinics for the gender-specific care. Over 40 percent of the medical centers also have a designated women's health mental health counselor on these primary care teams.

The delivery of health care services to a diverse population of women veterans, ranging in age from 20 to 100 years, has been a challenge and will continue to be a challenge for VHA. The number of women veterans receiving care at the VA is growing. In fact, women veterans is the fastest growing population of the veteran population.

The Women Veterans Health Program has faced many challenges and instituted strategies that have markedly improved the way health care is delivered. However, these challenges will continue into the future. Quality improvement is a dynamic process. And in year 2022, our program for women's health services will

probably look quite different than it does today and different than it did 20 years ago.

So, in closing Mr. Chairman and members of the subcommittee, I would just like to say that the VA Women's Health Program is responsive to the growing needs of women veterans and the challenges that these women veterans place, my office, as well as the dedicated cadre of women veteran coordinators, stand ready to accept this challenge.

Thank you for my testimony, and I am prepared to answer any questions that you might have.

[The prepared statement of Ms. Turner appears on p. 75.]

Mr. MORAN. Thank you very much. Ms. Lawrie.

STATEMENT OF TONI LAWRIE

Ms. LAWRIE. Thank you, Mr. Chairman. Good morning, members of the subcommittee. I am Toni Lawrie. I am a registered nurse currently working as the women veterans program manager or women veterans program coordinator at Bay Pines, FL, on the west-central coast of Florida. I am also the lead coordinator for VISN 8.

Some 10 years ago, I came and provided a statement to the House Subcommittee on Oversight and Investigations in regard to VA actions to improve the provision of health care to women veterans and related issues. In reviewing that testimony most recently, I was reminded that I had asked for VA to open primary care clinics for women, regardless of service-connected status; for VA to identify several centers of excellence to show the way in women's health care; and for VA to eliminate physical and psychological barriers for women seeking health care from the VA. To my delight and surprise, VA has done just that.

Florida is home to 107,000 women veterans. And Puerto Rico, which is the other part of VISN 8, has 6,000. So VISN 8 has about 113,000 women veterans. This is an increase of 16,000 from the 1990 census figures, at which showed that women veterans totaled 97,000.

In 2000, three of our VA facilities in VISN 8 were ranked in the top 10 medical facilities in the Nation in treating unique numbers of women. Tampa was number one. North Florida, South Georgia, or Gainesville was number three. And Bay Pines was number nine. In 2002, we treated in excess of 21,000 unique women across the VISN, a 19 percent market penetration.

VA has a Women Veterans Work Group that is advisory to the VISN director through the Clinical Council. This work group developed a 5-year strategic plan to expand and improve care to women veterans. Three of the main goals in our plan speak to best practices and our vulnerabilities. These goals are:

To improve quality and availability of services to women by reducing privacy deficiencies and creating a uniform package of services available to them, particularly in the CBOCs;

Increase market penetration for women to 25 percent to equal the number of men that is targeted in VISN 8; and

To offer full service primary care clinics at VAMCs, especially for women, with as many disciplines as practical, such as primary health care, mental health, gynecologic, breast care, nutrition,

pharmacy, and social work services provided on site, to exceed patient expectations.

Privacy deficiencies in the hospitals have been largely overcome in the past several years. However, with the rapid proliferation of the CBOCs in the system and the conversion of inpatient space to outpatient space, the deficiencies are back.

Each of the women coordinators in VISN 8 surveyed the CBOCs in their particular areas and found many deficiencies. We found a lack of privacy curtains, restrooms unequipped for women's needs, misplaced exam tables, some exam tables without stirrups, exam rooms on public corridors, which could easily be accessed by other patients, and a lack of acoustical privacy at check-in. And, only a few on the staff of the CBOCs could offer gender-specific examinations for women. The reclaimed space in hospital facilities generally also exists on easily-accessed public corridors, and few rooms have been curtained.

The third goal of offering full-service settings for women to receive care is driven by the current practice in VISN 8 and by findings from satisfaction surveys of users. All of the VISN 8 facilities have dedicated space in the hospitals where women services are offered. They vary in the mix of services, some offering more than others. However, we have identified the more comprehensive mix of services as one of our best practices in the care of women. It is preferred not only by our patients, but also by our providers. Hallway or "curbside" consultation between a matrix of primary and speciality care providers saves time, money, and the potential for clinical error. We know our patients want this kind of service.

In a very recent survey of 243 outpatient women across the VISN, we asked if you had the option of choosing where you receive health care within the VA system, which of the following would you choose? Primary care, not separated from male patients; primary care separated from male patients; or in a women's clinic. Only 7 percent of respondents chose primary care not separated, while 86 percent chose women clinics and 6 percent chose primary care separated. A second question: If you were seen in the women's clinic, does it offer you privacy? Zero percent said less privacy. Some privacy was thought by 16 percent of the women. And fully, 82 percent said it offered more privacy.

Another important element in our program is the commitment that Bay Pines has made for a full-time program manager. As a full-time manager, I have been able to devote much of my time to improve and expand the services available to women veterans at Bay Pines and in VISN 8. We have a market penetration in our county population of about 35 percent. We have been able to develop tools and instruments to help us better communicate and serve women.

We have developed training programs for women veterans program managers and for mental health clinic clinicians, who work with sexual trauma victims. We developed a unique residential day treatment program for women who are suffering from PTSD and as a result of a grant given to us in 2000 for innovative practices initiatives. The program has been successful in treating women for whom outpatient therapy alone was insufficient in the treatment of sexual trauma. Pre- and post-testing of 75 women clients, who have

been through the four-week residential program, provides statistically significant evidence that the program works and works well. Data suggests that significant improvement of symptoms, including anxiety, depression, intrusive thoughts, sleep disturbance, and sexual functioning, as a result of the treatment intervention.

The patients are also very satisfied with this. We are using this model to develop a model of treatment for male victims of sexual trauma at Bay Pines. We are also asking for funding to train two post doctoral psychologists in these special programs yearly to begin developing a pool of highly-trained mental health clinicians from which VA can draw.

I thank the chairman and the committee for your patience and for inquiring of us in the field as to our opinions. And we appreciate your attention.

[The prepared statement of Ms. Lawrie appears on p. 78.]

Mr. MORAN. Thank you very much for your testimony. Dr. Seaver.

STATEMENT OF MARGARET SEAVER

Dr. SEAVER. Good morning. My name is Margaret Seaver, and I am a primary care internist and a primary care physician. I have been medical director of the VA Boston Health Care System Women Veterans Health Center for 3 years. This past year, we were recognized by the VA as a clinical program of excellence. Our program was among the original eight comprehensive women's health centers funded by the VA in the early 1990s.

We provide a broad spectrum of women's health services, both within our facility and on a contract and fee basis. Medical and mental health services are highly integrated in our program. At our facility, we have the Women's Stress Disorder Treatment Team, which is part of a National Center of PTSD. We have one of the few women-only psychiatric inpatient wards in the country and the first transitional residence for homeless women veterans. And we have a Women's Homelessness Program.

Although primary care is at the core of our program, to adequately serve our patients, our women's health program must be much more. The women veteran coordinators provide essential services as advocates, case managers, and resources for patients. The mandate that all VA facilities have a women veterans coordinator has made the difference for many women as they enter the VA system and continue as our patients.

The implementation of clinics and centers has contributed to a research-based body of knowledge about women veterans' health and mental health, expert treatment of military sexual trauma, coordinated care for complex medical and mental health problems, improved quality of life for patients struggling with PTSD and its co-morbidities, and excellent compliance with preventive health measures, such as pap smears and mammograms.

However, this is only part of the story. Fragmentation of care is still a major problem. A recent national survey in VA shows that many gender-specific services are contracted out to community medical providers or affiliates. Contract and fee basis arrangements for maternity, infertility, and sub-speciality women's health services add a layer of complexity that disrupts continuity of care.

In order to overcome this issue, women's health programs need to have adequate staffing for case coordination. We also need support from management to continue to provide this labor-intensive care.

VA women's clinics were established because, unlike the private sector where 50 to 60 percent of a primary care practitioner's clientele may be women, women veterans comprise less than 5 percent of the 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 women's complete health status. Women veterans differ from male veterans not simply because of their anatomy but because they have different demographics and their medical and mental health needs are different. For example, women respond to trauma differently from men and women experience higher rates of sexual trauma and military sexual trauma than their male counterparts.

The VA Women's Health Project found that 23 percent of women veterans report being sexually assaulted in the military and 55 percent report they were sexually harassed. Women who report rape as their most traumatic experience have significantly higher rates of PTSD than men reporting combat as their most stressful experience. And women with PTSD have higher rates of substance abuse.

There is a strong association between sexual assault and physical symptoms. Chronic conditions such as diabetes, arthritis, and asthma are seen with increased frequency in women reporting sexual assault. Other physical consequences of sexual violence include pelvic pain, irritable bowel syndrome, back pain, headache, eating disorders, poor reproductive outcomes, digestive problems, and hypertension.

Research has found that women with a sexual trauma history have long-term high rates of health care utilization subsequent to the experience of assault. Research also suggests that women with sexual trauma histories present in medical settings with significant mental health needs and that performing invasive gynecologic exams and other medical procedures on these patients may require a particular sensitivity on the part of providers. Our center offers these services in a safe, private setting that women with a history of military sexual trauma not only prefer, but also need. These women would not come for care if they had to sit in a room full of men. Thus, our patients' care can be resource-intensive. And in order to minimize this fact and to utilize our clinic space fully, we have developed a multi-disciplinary clinic with specialists and primary care providers.

The story of women's health in the VA is one of success, of building an outstanding program in just a few years. It was built on the foundation of the comprehensive women's health centers, and these centers still provide the highest quality of care, as evidenced by the fact that five of the original eight have been recognized as VA Clinical Programs of Excellence. But we still have a great deal of work to do to train more staff to care for women, to combat the discrimination that still exists in the VA, and to contribute to the growing field of women's health through our research.

I have personally cared for patients who could only have received the care they did from the VA because their issues were ones that the VA specializes in, such as military sexual trauma and PTSD that often results from these experiences. I am extremely proud of our women's health program, inspired on a daily basis by the dedication and commitment of my colleagues, and most of all, honored to care for our Nation's veterans.

I hope I have been clear that many of these problems that we face in caring for women stem from the fact that women continue to be an extreme numerical minority. We need to continue to have separate women's health clinics in order to provide the services women veterans need and are eligible for, as well as the resources to provide primary and gender-specific care in a safe and private environment.

Thank you.

Mr. MORAN. Thank you very much.

Ms. Turner, neither you nor Dr. Roswell mentioned the survey that Dr. Schwartz mentioned that was published in the Congressional Record.

Ms. TURNER. In the Federal Register?

Mr. MORAN. Yes, I am sorry, in the Federal Register. Thank you.

Ms. TURNER. Actually, I wasn't aware of this survey personally. One of the deputy field directors forwarded me a copy of the notification so I personally cannot give you any information on that particular survey but would be more than happy to get some feedback to you as soon as I——

Mr. MORAN. Thank you very much. For the record, if you would provide that information, the nature of the survey——

Ms. TURNER. I will be happy to.

Mr. MORAN (continuing). And its purpose and intentions, it will be useful.

Dr. Seaver, the VA is known in many instances for its outstanding research capabilities. Does the VA conduct research in the area of military sexual trauma? Is that an area that the VA is engaged in?

Dr. SEAVER. Yes.

Mr. MORAN. In what way?

Dr. SEAVER. Well, there are a lot of different research projects that have been done on military sexual trauma. And if you mean specifically among women, I think we are still collecting information about rates and the results of military sexual trauma. I think that we have more information about military sexual trauma among women than we do among men. But I think that by mandating that that question is asked, that we will get some sense of how frequently it does occur among men.

Mr. MORAN. What about research for the care and treatment, the successful after effects?

Dr. SEAVER. Did you want to?

Ms. TURNER. I can respond to that, Mr. Chairman. We have the National Center for PTSD. Actually, there is a women's division, and they are currently conducting a research study, which is a study looking at two different treatment modalities for military sexual trauma. The principal investigators on that particular study are Dr. Paula Schnurr and Matt Friedman. And that is looking at

two different approaches to compare the outcomes and the success rates of each of the various approaches. So that is a current study that is going on. But even prior to that, that center is renowned for the research that they do in the area of military sexual trauma.

Mr. MORAN. Are the results of that research transmitted to the practitioners?

Dr. SEAVER. Yes, it is. And it is put into practice on a daily basis at the national Centers for Excellence and PTSD. So we have those—we have one in Boston and that is where the study is occurring and is put into practice on a daily basis.

Mr. MORAN. One of the things that you said, Dr. Seaver, that caught my attention is the reason that someone who wishes to practice medicine dealing with female patients, the natural inclination may not be to go to work for the VA. And I assume that in part the significant number of men patients that a VA physician would see. Can we only provide medical services for women in urban settings where there is a large volume of patients and care to be had?

Let me describe the congressional district I represent. Basically, three-fourths of Kansas, no VA hospital in the district. Many veterans would drive 3, 4, 5 hours to a VA hospital. We have now three CBOCs, a relatively recent addition, all three. And the largest population center is 45,000 people. Is there a way for the VA to meet the needs of women veterans who live in rural America?

Dr. SEAVER. My opinion is that it is possible to meet the needs, the general needs of women, even in that sort of a rural setting: You can train particular clinicians to be sensitive to the needs of women veterans, and provide outstanding general gender-specific care. I think that the complexity comes when you are talking about people who need more specialized services. And then you really need the infrastructure of a larger medical center.

Mr. MORAN. Ms. Lawrie or Ms. Turner?

Ms. TURNER. From a national perspective, quite frankly, there is a wide range of diversity relative to the workload or the volume of women veterans in the different locales who access services. And so when you do go into the urban settings, you probably do have a much broader representation of providers who are skilled and trained to personally deliver those services. However, in those more rural areas, where you don't have that large concentration or the academic affiliates, the VA relies quite heavily on referral of those services to community providers who do in fact have the workload, the volume, to perfect and maintain their clinical skills. And I think it is far better, in fact, to refer women or males, quite frankly, for care to specialists who have the skills and the training and the volume to ensure that their services are of high-quality than it is to try to maintain or preserve their care in the VA if in fact we can offer that to them at high quality on the outside.

Mr. MORAN. And that would be true in the CBOCS setting as well?

Ms. TURNER. Quite frankly, as Dr. Seaver has responded, in many of the CBOCs we do have trained providers who can provide the basic care that women need. But when their care becomes a more specialized nature or their needs are much greater than those that can be provided at a CBOC level or with the providers in that

setting, than it is more appropriate and preferable that those services or those women be referred for that specialized care.

Mr. MORAN. I have already asked my staff to find out how many women patients are seen in our CBOCs in our state, what percentage of the veterans that the CBOC treats are female. And your testimony about privacy and the hallways and the volume, the acoustics, I am anxious to visit my CBOCs again to get a feel for those kinds of issues. I have been in each of the CBOCs before but never thought about the perspective of a woman patient. So you are highlighting something I think that is important. We talked a lot about outreach. You are doing a good job of outreaching to me, and I will do the same as I visit those that provide services to men and women in my district. So I appreciate that.

Let me ask about the centers. Are there six?

Ms. TURNER. Actually, there are eight comprehensive health centers. These eight comprehensive health centers were actually identified in the early 1980s after the first GAO report. Recently, the VA has undergone an initiative where centers of clinical excellence compete for that designation and every 2 years there are centers of excellence that are so designated. For 2002, in the area of women's health, there were six programs that were designated as clinical centers of excellence. And, quite frankly, I am sorry that Representative Rodriguez left because in his area, San Antonio, TX, is one of those centers of excellence.

Mr. MORAN. I am confused as to the other two. There were eight, now six?

Ms. TURNER. No, no, no. They are totally different initiatives.

Mr. MORAN. Okay.

Ms. TURNER. There are eight clinical health care—comprehensive health care centers. That is totally separate and different from the clinical programs of excellence initiative, of which there are six. So if you want to add them together there are 14. Fourteen state-of-the-art models that we rely on to set the standard relative to women's health care. But as far as clinical centers of excellence, there are six that were recently designated in 2002.

Dr. SEAVER. And the original eight were funded—they were competitively funded by the VA in the early 1990s. So it is a competitive process when they receive the seed money.

Mr. MORAN. Are those appropriate numbers, that six and eight?

Dr. SEAVER. There is overlap, sorry.

Mr. MORAN. Go ahead, I am sorry, Doctor.

Dr. SEAVER. I am sorry, there is some overlap.

Mr. MORAN. So when Ms. Turner says 14, it is something slightly different than that?

Ms. TURNER. That is true.

Mr. MORAN. Are those appropriate numbers? Do we need additional centers?

Ms. TURNER. Well, relative to the clinical centers of excellence, those are competitively selected. The centers, there are criteria established and the centers submit their proposals and are judged on their merit relative to their performance. So as many centers that really achieve that criteria, they could certainly receive that designation.

Mr. MORAN. So the number of centers is unlimited.

Ms. TURNER. That is true.

Mr. MORAN. It is a question of competing and receiving the certification?

Ms. TURNER. That is true.

Ms. LAWRIE. To answer, though, your question about the comprehensive health centers, only two for each region of the country were appropriated. For instance, in the South, which I am familiar with, there is one in Durham, North Carolina and there is one in Tampa. Now, the rest of the South, including Texas, doesn't have a comprehensive health center designated in that area.

Mr. MORAN. Would it be something that we ought to expect every VISN to have?

Ms. LAWRIE. At least.

Mr. MORAN. And that certainly is not the case now?

Ms. LAWRIE. No, no, far from it.

Mr. MORAN. I think that is the extent of my questions. I appreciate your testimony and time. The record will remain open. We may submit additional questions if you would be kind enough to answer. And I am sure there will be additional statements from a number of our Members that were not able to be here that will be included in the record.

Our committee will adjourn. Thank you very much.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CONGRESSMAN STEARNS

Mr. Chairman,

Mr. Chairman, I am glad we will have the opportunity to examine the status of how we are treating our women who served in the armed services. In June, I spoke on the House Floor commemorating the 60th Anniversary of the Founding of the Office of Strategic Services, the precursor to our CIA. In particular, I noted how one American woman who served in the ass, Julia McWilliams, later the world-famous chef Julia Child, had as her first choice of a service the U.S. Navy, but was rejected because of her statuesque height of 6 feet, 2 inches. How far we have come that not only are our armed services not only no longer rejecting capable women, but embracing their contributions. Thank you for holding this hearing to examine their status today.

PREPARED STATEMENT OF CONGRESSMAN FILNER

Thank you, Mr. Chairman. I appreciate you calling this important hearing on the Department of Veterans Affairs current health care programs for women veterans today. Women are a significant and growing population relying on VA for its health services. While about 5 percent of the today's veterans are women, about 25 percent of the new recruits into the armed services are women. It is imperative that VA fully address women veterans' needs and meet their expectations if it hopes to remain a viable health care provider in the rapidly approaching future.

We will hear a great deal today about the best approaches to serving women who use VA for their health care services. As a small, but significant part of the patient population, can women veterans be well-served in a primary care system which mostly treats men? VA's studies to date are somewhat inconclusive. Intuitively, however, VA's women veterans' centers, which offer a comprehensive and specialized array of services often in a more private setting, seem to hold a lot of appeal.

Almost every VA medical center offers on-site sexual trauma counseling services, and demand from both men and women is significant. Mr. Chairman, I hope that you will agree to work with me to provide permanent authority for the sexual trauma program before its authority program expires in 2004. According to VA planning documents, more than half of women veterans have experienced some type of sexual harassment and a quarter experienced sexual assault during military service. Unfortunately, I agree with the witnesses we will hear from today that the need for these serv-

ices is not diminishing and there must be specialized resources available to serve the victims of this abuse.

In a recent internal study, most (70 percent) women veterans' coordinators—VA employees who are likely to know the programs that serve women best—prefer to serve women in separate primary care women's clinics where "primary care is delivered in association with other services, such as mental health and gynecology". Most valued the privacy of the "center" approach and almost half of the coordinators believed that staff outside of women's clinics were not sensitive to gender differences in care. Even with these seemingly compelling findings, it is important to hear our witnesses discuss the pros and cons of specialized care in "centers" versus more generalized approaches to treating women veterans.

The important role of women veterans' coordinators in assisting women veterans cannot be overstated. At some VA medical centers, these coordinators are the only linchpin to a "non-system" of fragmented and inaccessible services for women. Unfortunately, too often, these coordinators have the women veterans' role on top of numerous other duties that do not allow the coordinator to fully address the needs of the women they serve.

Within the last four months, Congress received both its 2000 and its 2002 biennial reports from the Advisory Committee on Women Veterans. While I am pleased that the Advisory Committee seems to be back on track, I am disturbed about problems I have heard about in the production of the 2000 report. Why has it taken us two years to receive it? I am further disturbed by allegations in former Chairwoman Schwartz's statement about the lack of regard VA gave recommendations in this report.

Advisory Committees are only useful to the Secretary to the extent that their input is seriously considered on a timely basis as independent, expert counterpart to organizational policy. It is clear that the Secretary and his advisors may not always agree, but VA's failure to thoughtfully review timely recommendations is critical to the improvement of services for all our veterans. While I understand that Congress did not specifically require this report, with the history of biennial reports to Congress, it must have been clear that it was the Congress's intent to receive one. The chairwoman also felt it was her duty to file a report and expected that VA would respond in a timely manner—in this case, I agree with Chairwoman Schwartz that the agency has failed our women veterans with a lackadaisical and half-hearted review of its recommendations and am hopeful that Dr. Roswell and Dr. Trowell-Harris can reassure me that they intend to fully consider the advise of the experts who put themselves at VA's disposal in hopes of benefiting the nation's veterans.

Mr. Chairman, I appreciate you calling this hearing today and look forward to the testimony of our witnesses.

Statement for the Record

Congressman Ciro D. Rodriguez

HVAC – Subcommittee on Health

Oversight hearing on the Status of Women's Health Care Programs in the Department of Veterans Affairs

October 2, 2002

- Thank you Mr. Chairman and Ranking Member Evans for taking the time to hold this critical hearing.
- I am pleased that we are holding this hearing today to highlight the needs and review the status of women's health care programs within the Department of Veterans Affairs.
- Women represent an irreplaceable, invaluable part of the Armed Forces of the United States. Today, there are over 200,000 women in uniform, representing about 15 percent of the total active duty force.
- Women have served our country with courage, sacrifice, and patriotism—now it is our time to honor their service with access and care.
- Nationwide there are 1.2 million women veterans.
- They represent 4.9 percent of America's veterans, and 4.5 percent of the 4.3 million veterans who use the VA health care system. And these figures are projected to grow.
- The number of women expected to use the VA health care system will equal approximately 10 percent of total users within the decade (by 2010).
- With increased numbers of women veterans seeking health care from the VA following military service, it is essential that the VA be equipped to meet their specific health needs.
- The VA must make providing equitable, high-quality, specialized and compassionate health care services to women veterans a high priority.
- I would like to recognize the efforts and leadership already shown by Secretary Principi in recognizing the growing need for information and guidance in the area of women's health care.
- I commend his work and the work of the VA Advisory Committee on Women's Veterans. I look forward to the testimony today of representatives of this committee.
- Of special consideration should also be efforts to address sexual trauma among our women veterans—23 percent of women veterans report sexual assault and 55 percent report sexual harassment. We must continue to reach out through education and treat the challenges associated with these traumatic events.
- In closing, I would simply stress that women have health care needs which are different than men. We must ensure that health care programs focused on the care of women are adequately funded to ensure equity.
- Insufficient funding and support for these programs places in jeopardy the progress we have made.
- Thank you all again for being here and sharing your insight on this issue of critical importance to all veterans.
- Thank you.

PREPARED STATEMENT OF CONGRESSMAN GUTIERREZ

Thank you, Chairman Moran and Ranking Member Filner for your leadership and for calling this hearing today. I understand this may well be our last Subcommittee hearing of the 107th Congress, so I appreciate that we are committing the time to review the various women's health care programs provided by the Department of Veterans Affairs. I would also like to say 'thank you' to the witnesses who have joined us today to share their assessment of the current programs.

We all understand that the number of women veterans grows every year. As more and more women valiantly serve in our military, the number seeking VA's health care services also continues to grow. Today's hearing gives us a timely and important opportunity to assess the extent to which we are meeting the specialized needs of women veterans.

As many in this hearing room know, I have had particular concerns about the services available to victims of sexual trauma while serving in the military. And although both men and women are victims of such trauma, our servicewomen and female veterans are disproportionately represented in this group, not unlike our civilian population. In 1997, during the 105th Congress, I introduced a bill, the Veterans Sexual Trauma Treatment Act (H.R. 2253), which would have made VA sexual trauma and treatment services mandatory and available to *all* veterans of the armed forces, regardless of their length of service or reserve status.

The introduction of my bill carne on the heels of some serious incidents of sexual misconduct and rape. We all remember the trials at the Aberdeen Proving Ground, for example. The bill had the support of 67 of my colleagues and, more importantly, of the major veterans' service organizations and servicewomen, as well as women veterans themselves.

We will also hear today that sexual abuse in the military continues to be a serious problem. The VA's Women's Health Project found that almost one-quarter of all women veterans report being sexually assaulted in the military and over half report that they were sexually harassed. My bill to address this problem was needed then, and, clearly, it is still needed now.

Which brings me to my next point. When advocating for the passage of my bill, I and other supporters were told that there was not enough information, that a study was needed to evaluate the situation. Although concerned about delaying action on my bill, I was nevertheless pleased that Section 115(e) the Veterans Millennium Health Care and Benefits Act (Public Law 106–117) mandated a research investigation that would determine the extent to which members of the reserve experience assault of a sexual nature and to what degree such victims sought VA services related to those incidents. The study was also supposed to determine the additional resources that would be required to meet the need for counseling and services.

So, what happened to the study? I hear that data collection has proven to be "complicated" and that now the anticipated date of completion is March 2003. With all the resources the VA has, and the stellar record of its world-renown research, I hope that some-

one from the first panel [VA Under Secretary of Health, Robert Roswell, accompanied by two others] can offer an explanation in their testimony as to why this study was so delayed and if, in fact, we can expect a report next March—almost four years after the of passage of the Millennium Health Care Act.

As we continually demand more and more of our servicewomen, who valiantly serve our nation and take great risks to defend our freedoms, isn't it a shame we are unable to move forward and complete a study in an expedient manner on their behalf. It is bad enough that sexual exploitation continues to be rampant in the military, but it adds insult to injury that providing complete and comprehensive services to all victims of sexual trauma is held up by a study that doesn't appear to me to have been given the priority it deserves.

Thank you, Mr. Chairman, and thank you again to the panelists. I look forward to their testimony.

LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS

Subcommittee on Health
Hearing on Women Veterans' Health Programs
October 2, 2002

Of all the resources available to our women veterans, I believe one of the most, if not the most, is a knowledgeable, accessible women veterans' coordinator. Obviously, another important part of the program is a broad array of accessible expert professional services for women provided in a timely manner.

Women veterans' coordinators (now called women veterans program managers) can make a woman veteran's trip to the VA as convenient as "one-stop shopping". Some women veterans are knowledgeable, well-connected, or simply fortunate enough to seek out a women veterans' program manager who eases their transition into a traditionally male dominated system by providing information about enrollment and points of contact for specialized care needs, and by coordinating VA's array of services (including those available through contract) to meet their needs. These program managers can make a large, male-dominated health care system a much friendlier and coherent place for women veterans.

VA's Advisory Committee on Women Veterans clearly understands the value of women veterans program managers. In its 2002 report to the Secretary, it calls for a full-time women veterans program manager within each network and for allocating at least 20 hours/week to each women veterans program manager at the facility level. Clinical staff also agree with the importance of the role—more than 70% stated that they received most of their information about women veterans from these program managers. Program managers are also important advocates for women veterans and play important roles in outreach and education. Yet internal surveys estimate that 10-37% of women veterans' program managers are dedicated full-time to their efforts. Having knowledgeable and accessible women veteran program managers has been a goal for at least 15 years since I conducted the first hearing in the House in 1987 on VA benefits and services to women veterans.

Yesterday, I asked my staff to attempt to contact women veterans' program managers at 23 medical centers. Of the 23 medical centers contacted, at 11 facilities (almost half) were not available to speak to my staff after they attempted three contacts during that day. Of the program managers contacted, it took some persistence—often more than one phone call and some transfers—to reach the women veterans' program manager at most facilities.

Program managers were asked the following questions:

- How do I enroll?
- How long would it take me to get a check up?
- Is there a separate women's clinic?
- When is it open?
- Is it possible to have a female doctor?
- Where would I get a PAP smear? (a basic women's service most VA medical centers provide)
- Where would I get a mammogram? (a specialized women's service most VA medical centers refer to more complex VA medical centers or community providers)

I did not ask staff to quantify this data. Questions were asked primarily in an attempt to assess the program managers' knowledge of services and her courtesy and helpfulness in assisting veterans and to assess the scope of the women's program at each of the facilities surveyed.

The good news is that of the women veteran program managers contacted, most were extremely knowledgeable and helpful to the callers. Many offered to send materials or follow-up in other meaningful ways. Most of the responding facilities did seem to have specialized services for women—either a women veterans' clinic or a gynecological clinic. One facility that did not have specialized services for women was also eager to assist in referring the caller to community-based clinics or other appropriate facilities.

The lesson I learned from this informal survey is that, if they are accessible, women veterans' coordinators can smooth the path for our women veterans even when resources to serve them are limited. They can make access to enrollment, basic and specialized care easier for women

veterans. They can be particularly helpful if they understand procedures, such as enrollment, eligibility, contracting authorities and other services outside of the women's programs.

If VA wants to be the provider of choice for a substantial and growing part of its market, it is imperative that women veterans' program managers be given more time and resources to do their jobs. I understand that, in response to the Advisory Committee's recommendations, VA has contracted with an outside human resources consultant to develop a "performance model" for the women veterans' program manager's position. I will be eager to see this evolve. I certainly recommend that VA give thoughtful consideration to the Advisory Committee's recommendations regarding allocations for women veterans' program managers and would like to work with you Chairman Moran and Ranking Member Filner to ensure that we investigate and respond appropriately to this matter. Women veterans have waited at least 15 years for easy access to knowledgeable women veterans' program managers. At some locations this has apparently been achieved. At other locations the wait continues. That's totally unacceptable. My message to VA is just do it and do it now.

Statement of
Robert H. Roswell, M.D.,
Under Secretary for Health
Department of Veterans Affairs
on the
Status of Womens Health Care Programs
before the
House Committee on Veterans' Affairs Committee
Subcommittee on Health

October 2, 2002
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Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to report on the status of women veterans health care in the Department of Veterans Affairs (VA). I am accompanied by Dr. Susan Mather, Chief Public Health and Environmental Hazards Officer. I am also pleased that Dr. Irene Trowel-Harris, the Executive Secretary of the VA Advisory Committee on Women Veterans and the Director of the VA Center for Women Veterans, is here with me to provide testimony today. The Department receives significant support in its mission to serve women veterans through the advice and counsel of the Advisory Committee.

Women currently make up about 4.5 percent of the 4.3 million veterans who use the VA health care system. However, since women now make up approximately 15 percent of the active duty forces, the number of women expected to use the VA health care system will equal approximately 10 percent of total users within the next decade. VA has accepted the challenge of providing equitable access to health care services to these veterans.

While all veterans require convenient access to primary care, medical subspecialty care, mental health services, and long-term care, women also have some special needs that include access to gynecology and reproductive health services. These latter needs are in part the result of the unique demographics of the women veterans population. Over 50 percent of the women seeking care in VA are under 45, compared to only 15 percent of men. This was recognized with the inclusion of maternity benefits and limited infertility services in the uniform benefit package available to veterans.

In FY 2001, 721 babies were born to women veterans whose care was paid for by VA. Obstetrical care, excluding care for the newborn, is provided under contract. VA facilities do not have the ability to care for newborns, and VA does not have authority to pay for the care of newborns.

Because many women veterans are so young, homeless women veterans present special challenges, since they may be solely responsible for the care of minor children. Traditional VA homeless programs cannot accommodate children, necessitating community partnerships with family and child agencies

and with women's social and support networks to provide a seamless continuum of care.

We are learning much more about women veterans than we once knew. The large national survey of veterans done in 1999 included an over-sample of women, and analysis of the data from that survey shows a number of interesting things.

- It confirmed what we have seen in veterans seeking VA care, that most male veterans are older than 55, while most women are younger.
- More than twice as many women as men never married (18 percent vs. eight percent), and almost half as many women (37 percent) as men (63 percent) are currently married.
- Women veterans scored significantly lower in overall mental and physical health status than non-veteran women. (The same is true for men.) Even when stratified by age, veterans as a group (both men and women) were less healthy. This has implications for the intensity of health care resources required by veterans, including women, who may also be less likely to have a caregiver at home at the end of their lives.
- Men and women using VA facilities showed similar levels of satisfaction with the care received. We believe that this indicates that many of our efforts to meet the needs of women who have chosen to use our system have been successful.

Local leadership in women veterans health care is provided by the Women Veterans Coordinators, who have been responsible for significant advancements in delivery of services. This network of advocates for women is supplemented by a full-time Director of Women Veterans Health in VA Central Office, four Deputy Field Directors located around the country, and Lead Women Veterans Program Managers in each of the 21 networks. We are very proud that accomplishments of this group were recognized in 2000 for their significant contributions to women's health when they received the Wyeth-Ayerst Bronze HERA Award. The Veterans Health Administration also recognizes the Outstanding Women Veterans Coordinator each year, a selection that is always difficult to make, given the large number of outstanding candidates.

Outstanding clinical programs for women veterans are also included in VHA's Centers of Excellence Programs. Currently, there are six centers of excellence in Women Veterans Health, located at Alexandria, LA; Bay Pines, FL; Boston, MA; Durham, NC; Pittsburgh, PA; and San Antonio, TX.

The provision of high-quality, comprehensive services for women veterans has been promoted through legislation, particularly the Veterans Health Care Act of 1992, Public Law 102-585, which authorized VA to provide gender specific services, such as Pap smears, breast examinations, management of

menopause, mammography, and general reproductive health services to women veterans. This legislation also authorized VA to provide counseling services needed to treat sexual trauma experienced by women while serving on active duty. In 1994, this authority was made gender-neutral and has now been extended through December 2004.

Last year, 1932 women veterans and 516 men received treatment as outpatients for military sexual trauma in VA facilities. There were 218 women and 86 men treated as inpatients. Treatment for military sexual trauma was provided through fee basis for 164 women and 13 men, and through contracts for 28 women and 4 men.

In 2000, 152,094 women veterans were seen as outpatients and 12,955 as inpatients. In 2001, these numbers rose to 166,108 outpatients and 13,640 inpatients. In 2001, 14,790 Pap smears were done in VA clinics and 17,209 screening mammograms. In addition, 21,268 diagnostic mammograms were done. These figures do not include procedures done through contract, fee basis, and sharing agreements.

We are continuing to improve the privacy provisions in VA facilities. As the shift in health care from the inpatient to the outpatient setting has occurred over the past several years, VA has been able to modernize its health care settings so that they provide adequate privacy for both women and men.

We continue to work to provide an appropriate clinical milieu for treatment of psychiatric inpatients where there is a disparity in numbers such as exists between women and men in VA facilities. The balance of appropriate treatment, access to community and family support, safety and privacy must be achieved. Sometimes this is best achieved by using contract care. Sometimes special provisions can make direct VA care a more viable option. The same is also true for the provision of other gender specific services such as mammography. Where the volume of cases is not adequate to assure the clinical competency of an in-house program, VA is moving toward contract or fee-basis care.

In addition to our clinical mission, VA has a significant research mission, and it is established policy that VA-sponsored research specifically address women and minority women veterans issues. In FY 2000, funding for women's health research at VA totaled $24.2 million for 305 studies, with VA as the major funding source in 61 studies for a total of $5.8 million.

We will continue to assure that women veterans have equal access to high-quality care. We have come a long way since our early efforts in VA to provide for the needs of women veterans by creating women's clinics. While these clinics did welcome an important group of veterans who had been too long ignored, in most instances they could not provide the comprehensive, holistic care that all veterans deserve. We are changing the culture in VA with clinical guidelines, performance measures, quality improvement, improved patient

safety, and veteran-relevant research to prepare for the veterans of tomorrow, which, I can assure you, will include many more women veterans.

Mr. Chairman, this concludes my statement. Dr. Mather and I would now be pleased to answer any questions that you or other members of the Subcommittee might have.

STATEMENT BY
IRENE TROWELL-HARRIS, R.N., Ed.D.
DIRECTOR
CENTER FOR WOMEN VETERANS
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
October 2, 2002

Mr. Chairman and Members of the Subcommittee, I am pleased to testify today on behalf of the Department of Veterans Affairs (VA) about services in VA for women veterans and particularly the Department's responsiveness to advice on women's health issues recommended by the VA Advisory Committee on Women Veterans (Advisory Committee) and the Center for Women Veterans (Center).

Center for Women Veterans

The Center was created by Public Law 103-446 in November 1994. The Director of the Center serves as chief advisor to the Secretary of Veterans Affairs on all issues related to women veterans and serves as the Executive Secretary to the Advisory Committee.

The mission of the Center is to ensure that women veterans have access to VA benefits and services on par with male veterans; VA programs are responsive to gender-specific needs of women veterans; outreach is performed to improve women veterans' awareness of services, benefits and eligibility criteria; and women veterans are treated with dignity and respect. The Center also provides input to the Advisory Committee based on inquiries from women veterans from telephone calls, written correspondence and Web site e-mail. The Center facilitates the activities of the Advisory Committee and coordinates their report to the Secretary of Veterans Affairs.

Advisory Committee on Women Veterans

The Advisory Committee was established in 1983 pursuant to Public Law 98-160. The Advisory Committee is charged with advising the Secretary of Veterans Affairs on VA benefits and services for women veterans, assessing the needs of women veterans, reviewing VA programs and activities designed to meet those needs, and developing recommendations addressing unmet needs. The Advisory Committee is required to submit a biennial report to the Secretary incorporating the Advisory Committee's findings and recommendations.

As a means of obtaining information regarding the delivery of health care and services to women veterans, the Advisory Committee conducts site visits to

VA facilities throughout the country. During these site visits, the Advisory Committee tours the facilities and meets with senior officials to discuss services and programs available to women veterans. During the site visits the Advisory Committee also hosts open forums with the women veterans' community, encouraging women veterans to discuss issues and ask questions related to VA benefits and services. The Advisory Committee meets twice a year at VA Central Office (VACO) and receives briefings from the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA) and other staff offices. These briefings update the Advisory Committee on the status of VA programs and respond to concerns raised during the site visits. The Advisory Committee uses information from the site visits and briefings to formulate its recommendations to the Secretary in biennial reports.

2000 Report of the Advisory Committee on Women Veterans

In the 2000 Report of the Advisory Committee on Women Veterans, the Advisory Committee made 25 recommendations. Of those 25 recommendations, 18 are in the process of being implemented, and 7 have been implemented. Some of the key issues included outreach, sexual trauma counseling and care, women veterans who are homeless, health care, education, and employment.

The requirement to submit the 2000 Report of the Advisory Committee on Women Veterans to Congress was terminated in 1999 by a sunset provision in the Federal Reports Elimination and Sunset Act of 1995, Public Law 104-66, and, therefore, a report was not forwarded. Later, Public Law 106-419 reinstated the requirement for submission of the report, beginning with the 2002 report through 2004. The legislation that reinstated the submission authority did not require the submission of the 2000 report.

The submission of the 2000 Report to Congress was at the discretion of the Secretary. As a courtesy to the Advisory Committee, the former Secretary agreed to forward the report to the Congress.

Two major factors, however, contributed to the delay in the submission of the 2000 report to Congress. First, it was necessary to clarify whether the sunset provision required submission of the 2000 report to Congress. Secondly, there was a change in senior leadership within VA.

In the area of health care, the Advisory Committee in its 2000 Report recommended that VA ensure that the Center is provided an annual update on the effectiveness of the VHA women veterans coordinator program. VHA officials, including the National Women Veterans Health Program Director, briefed the Center and Advisory Committee members on this issue at the March 2002 meeting of the Advisory Committee. In addition, the Director of the Women Veterans Health Program works closely with the Center on issues that are

frequently referred to women veterans coordinators in field facilities. For example, since October 2001, I have completed 28 media interviews and 37 keynote speeches, Transition Assistance (TAP) and veterans briefings where VHA has assigned a local women veterans coordinator to accompany me to answer general questions and see that health care issues raised regarding individual cases receive immediate attention.

In April 2002, the Director of the Women Veterans Health Program in conjunction with VBA conducted a national conference of women veterans coordinators. Both the Associate Director of the Center and I attended this conference where many issues regarding the provision of health care to women veterans as well as the role of women veterans coordinators were discussed. This conference also provided a forum for VHA and VBA women veterans coordinators to network and discuss ways to bridge the gap in situations where women veterans had both health and benefit issues.

VHA officials and the Director of the Women Veterans Health Program also have an extensive working relationship with the Advisory Committee, especially about programs, plans and legislation for women veterans. The Director is a consultant to the Advisory Committee and attends all meetings and site visits. For example, when the Advisory Committee expressed concern about specificity in some of the responses to recommendations in the 2000 Report, VHA officials quickly responded and resolved the issues.

2002 Report of the Advisory Committee on Women Veterans

In the 2002 Report of the Advisory Committee on Women Veterans, the Advisory Committee has made 24 recommendations about outreach, sexual trauma counseling and care, women veteran coordinators, health care, staff education, employment of women veterans in the Federal government, strategic planning, and women veterans who are homeless. Earlier this summer, representatives from the responsible staff offices met on several occasions to ensure that the Department thoroughly addressed the Advisory Committee's recommendations.

Mr. Chairman, these recommendations stem from data and information gathered from VA officials, women veterans, researchers, veterans service organizations (VSOs), internal VA reports, and site visits to VHA and VBA facilities.

This 2002 Report, including VA's responses, was provided to the House and Senate Veterans Affairs' Committees on September 26, 2002. The report and VA's responses address the following general topics:

- the creation or modification of services to provide specifically for the needs of women,
- staffing levels for women veterans coordinators (WVC) positions,
- permanent removal of eligibility restrictions for sexual trauma counseling,

- the monitoring and analysis of services recently introduced by VA, such as obstetrical care and pilot programs for women veterans who are homeless, to ensure that services would meet potential increases in demand,
- the development and distribution of guidelines for case management of women veterans who are homeless based on the analysis of successful pilot projects,
- an emphasis on the need for research to determine the success of health and benefit programs in meeting the needs of women veterans, including women veterans subgroups such as Blacks, Hispanics, Asians, and Native Americans, as VA conducts strategic planning to design future care and services, and
- the need for research to assess the impact of the increasing number of women in the military and their changing military roles on the design and delivery of VA services. The rising proportion of minority women heightens the need for meaningful data regarding women veterans of all racial/ethnic groups.

VA is grateful for the work of the Advisory Committee because its activities and reports play a vital role in helping the VA assess and address the needs of women veterans.

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

TESTIMONY

of

LINDA SPOONSTER SCHWARTZ RN, DrPH, FAAN

RESEARCH SCIENTIST YALE SCHOOL OF NURSING

and

CHAIR VA ADVISORY COMMITTEE ON WOMEN VETERANS

(1996-2000)

before

HOUSE VETERANS AFFAIRS COMMITTEE

October 2, 2002

Good Morning Mr. Chairman, I am Dr. Linda Spoonster Schwartz, Research Scientist at Yale University School of Nursing. I also have had the honor of serving as Chairman of the VA Advisory Committee on Women Veterans for the period 1996-2000. I would like to thank you for holding these hearings and for your support of women veterans. I would especially like to thank my Congressman Rob Simmons and Congressman Lane Evans for their continued leadership and support for America's veterans especially VA services and programs that significantly enhance the quality of life for America's 1.2 million women veterans.

As you know, the VA Advisory Committee on Women Veterans 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.

In FY 2000, the female veteran population of 1.4 million constituted 5.5 percent of all veterans living in the United States, Puerto Rico and outside of the country. Women veterans as a population are expected to increase steadily because the number of women in the military continues to grow. The demographic profile of the female veteran population has several variations that are in contrast to that of their male counterparts. For example, the median age of female veterans is almost 14 years younger (44.2yrs) than that of male veterans (58.0yrs). With the advent of the all-volunteer force, the involvement of women in the military reflects a difference in the period of service. About 58% of all women veterans served during the post-Vietnam era. In contrast to the overall declining veteran population, the numbers of women veterans is projected to increase by 20% between 1990 and 2020.

In 1985, I first came to this Hearing Room to voice the concerns of women veteran to this Committee. In the time since then, 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
One of the most pressing and important aspect of accessability to VA is knowing the eligibility criteria and where to begin the process. With recent and frequent changes that we have seen, even in the last year, outreach to veterans and education regarding VA health care eligibility criteria must remain a priority. A common theme that runs through a majority of my testimony today has to do with the continued need for outreach and educating women about their eligibility for the 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 17 years outreach must continue to be a priority for the VA. Effort must be focused on new approaches needed 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.

I continue to believe that an orientation to VA programs and services should 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. It is important for all military members, from day one of their service, to know and understand how to access their VA benefits. Additionally, it is most important that DOD Healthcare Providers be oriented to the VA Compensation and Pension process. Educating 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. These educational activities 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.

As part of the outreach initiatives. it makes good sense to 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 are still 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 year to year, educating health care professionals in the public and private sectors about the array of services and benefits available to veterans will help to assure a smooth transition for veterans from Active duty to civilian life. As VA looks for more local venues to provide health care to veterans in their own communities, 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 suggested would be informational and will also assist health care professionals in the public sector to identify veterans and make appropriate referrals to VA. As practical and as cost effective as this may seem, this suggestion was turned
down by VA when it was recommended in the Advisory Committee Report.

Another approach that has been suggested concerns asking questions about veteran status on intake forms for federally funded social service programs and research projects to 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. Concerns have been voiced about the need to educate members of the Selected Reserves and National Guard about VA programs. 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 inactive 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. 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. Reservists on inactive duty training are injured and have to deal with returning to a civilian job that often has no sympathy. Insurance Companies are now refusing to cover the costs of injuries sustained while on training or Active Duty because they 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.

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 for VA services. 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. Although this problem was first addressed by the Advisory Committee in 1998, I understand that a study is now on the drawing board, to assess the need for extending sexual trauma counseling and providing access to VA care to Reserve and National Guard personnel injured or assaulted on non Active Duty training days. My hope is that the study will be initiated quickly and that information gathered can guide
this Committee and the VA to take action.

Mastectomy

I would like to thank the Chairman and Congressman Lane Evans for taking the initiative 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 women veterans who have survived radical or modified radical mastectomy of one or more breast. This action is most appropriate and in keeping with the spirit and intent of a 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. Changes which include provisions for women veteran who have sustained the loss of significant portion of their breast is both compassionate and reasonable. 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 the time and effort spent by Committee members and staff to remedy this oversight.

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 these needs to be considered from a holistic perspective.

Children of Women Veterans Who Served in Vietnam

The 1998 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 in successfully introducing legislation to compensate and care for children, of women veterans who served in Vietnam, severely impaired by birth defects. I share his concern that only one child has qualified for VA assistance. Here, too , we see the continued need for outreach and education regarding VA services especially for this unique and much needed program. 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, should only be used to gauge the health of that particular group of Vietnam veterans. It is not the complete answer to our question about the health status or reproductive outcomes experienced by all of the men who served in Vietnam.

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". The announcement that VA would be able to fund 11 projects for women veterans seems a hollow victory. I say hollow because there was 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 VA bureaucracy.

As an original reviewer of the proposals for the first sites, a part of the RFP required, VISN Directors to agree that if their programs were funded, they would commit, despite the availability of only 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. Even before these sites were funded or programs came on line, VISN Directors were hedging their bets by using the money for temporary positions with no guarantees of employment for more than 12months. It has also been reported that some of the programs for women veterans who are homeless are not able to function because of the lack of funding that has not come through the VISN Directors. Mr. Chairman, this is not the program we envisioned. I don't think it was the program Congress intended. It is imperative that this Committee take measures to protect these veterans and assure

adequate funding to sustain these valuable programs and in essence protect veterans with special needs.

Invisible Veterans

In 1985 when I first came to a Congressional Hearing on women veterans, 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 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. Let me say that the Report I submitted in July of 2000 did not make it "out of the building" until May 2002. I was particularly disappointed as I read VA's responses to the recommendations made by the1998-2000 Women Veteran Advisory Committee.
For the most part, they were ambiguous, condescending and trite. The attitude projected by these responses coupled with observations made by the Committee on our site visits to specific facilities and VISN's, indicated that services and programs for women veterans are in danger of eroding.

There is no doubt that there is a pervasive attitude that programs for women veterans are "window dressing" trivial or optional. We encountered these sentiments at every echelon of the Department of Veteran Affairs. The fact that it took 2 years to respond to these recommendations, that the Advisory Committee Report for 2000 was never circulated or discussed is not an oversight it is an insult. Let me be clear, it is an insult not to only to me or the work I and my Committee put into this document, it is an insult to the women veterans who went 2 years without any answers to their questions or the recommendations we gleaned from our years of activities. I believe this underscores the need for Congress to be vigilant. This situation also vividly demonstrates the fact that "ACCOUNTABILITY" needs to become a "watchword" at VA. Unfortunately However it also illustrates that at VA many only pay lip service concern for women

veterans and providing them with the quality of service they have earned in the service of our nation.

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

STATEMENT

BY

MARSHA L. FOUR, CHAIR

DEPARTMENT OF VETERANS AFFAIRS

ADVISORY COMMITTEE ON WOMEN VETERANS

BEFORE THE U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS AFFAIRS,

SUBCOMMITTEE ON HEALTH

SUBMITTED OCTOBER 1, 2002

Mr. Chairman, members of the Subcommittee, I thank you for the opportunity to address the Subcommittee on its interest and concerns related to women veterans' health within the Department of Veterans Affairs (VA).

I was appointed as a member of the VA Advisory Committee on Women Veterans on March 1, 2001, and will remain on the committee until July 2004. In August of this year, was appointed Chair of this Advisory Committee by the Secretary of Veterans Affairs. You have heard, in earlier testimony, the mission of the committee, its meeting schedules, and our reporting process.

Women veterans are a rapidly increasing population for the VA. Women comprise nearly 20% of the active force and will, in the near future, find themselves among our ranks, placing an even greater need and demand within the VA to provide women veterans health programs.

I would like to address a few specific points in this testimony that touch on the following topics: the Advisory Committee biennial reports; VA Women Veterans Health Clinics; VA Women Veteran Coordinators; the VA Women Veteran Health Program Office; Homeless Women Veterans Pilot Programs.

The Biennial Report of the VA Advisory Committee on Women Veterans

During the two years prior to the biennial submission of its report, the Advisory Committee reviews previously submitted biennial reports. The committee members form two working group subcommittees: health care or benefits. Briefings are requested from appropriate offices or departments within the VA and, annually, the committee conducts a VA site visit in the field. Our most recent site visit (September 2002) was to the VA Tampa and Bay Pines Florida campuses. It also included the Vet Center and Regional Office, and two Community Based Outpatient Clinics. The compilation of the information utilized for the coordination of the recommendations presented in the biennial report is an ongoing evolution.

Others may speak with greater understanding, however, before the 2002 Report, some past committee members have expressed their concern that the VA response process was done in an uncoordinated, independent and/or individual office/department approach and that the answers were at times somewhat ambiguous. The purpose and the level of importance placed on the contribution of the advisory committee come into question when responses are not interpreted as significant.

Considering the time spent on briefings, site visits, and presentations, not to mention the writing of the report, it is truly unfortunate that the 2000 Report was lost to Congress for a time, due to a sunset provision in the original legislation. The requirement for its submission was reinstated in Public Law (PL) 106-419. It is the Committees hope that this doesn't occur in the future with any advisory reports that Congress feels strongly enough to request in legislative action.

The VA Chief of Staff, in a briefing earlier this year, assured the committee that the response to each of the committees' recommendations in the 2002 biennial report, would be addressed in a timely manner with a coordinated approach process. Additionally, that the Chief of Staff would oversee this process. The Advisory Committee submitted its Report to the

Office of the Secretary before July 1, 2002 as requested. It was a finalized document in less than sixty (60) days. Having read the 2002 Report responses, it appears that authority was given by VA leadership to those responsible for responding to the recommendations, allowing for specific comment and committing to up-dates on subject matter.

WOMEN VETERAN HEALTH CLINCS

Presently, the VA has eight (8) designated Comprehensive Women Health Centers, four of which were given this designation nearly ten years ago. Perhaps, it is time to re-assess them and ensure there remains adherence to the criteria of care that sets them aside as Comprehensive Centers. Leadership must be held accountable for the standards of care delivered as determined by the outcomes acquired through an evaluation of performance measures.

Every two years, in a competitive process, the VA selects Centers of Excellence in women health care. In 2002, six were selected. They include The Comprehensive Health Care Program of Durham VA Medical Center, along with the Women Veterans Health Care Programs of Alexandria VA Medical Center, Boston VA Medical Center of VA New England Health Care System, Bay Pines VA Medical Center, VA Pittsburgh Medical Center, South Texas VA Veterans Health Care System. The VA Advisory Committee on Women Veterans applauds these programs for the accomplishments, energy, effort and effective programs they have instituted in the delivery of service and care for women veterans. They meet the highest standards of clinical outcomes, patient satisfaction, and productivity. Is it possible that some of these Centers of Excellence should be designated as Comprehensive Women's Health Centers?

In addition to the Comprehensive Centers, approximately eighty-five or fifty percent (50%) of the VA Medical Centers have women veterans' health clinics. Of this number, two-thirds (2/3) or 57 clinics, have come on line since 1995. The remaining VA Medical Centers deliver care to women

veterans in the general primary care setting with referral to clinics. Gender specific care is done in a GYN clinic or by contracting into the community.

In today's health care delivery market, women's health is a fast growing, widely recognized, and professionally accepted specialty. The female biology, the inter-relationship of hormones in our complex human physiological system, pharmacological considerations, the issues of sexual trauma, domestic violence, and a therapeutic delivery setting, culturally sensitive education programs, research opportunities, ...these are only a few focus points that substantiate the need for women's health clinics with an inter-disciplinary approach. The movement toward Women's Health Clinics in the community is obvious and the thrust is also apparent in the acceleration of the approach taken in medical school curriculum and the fellowships offered.

In a report to Congress, of the results from a national survey of medical schools and recommendations for a core women's health curriculum in medical education, a major leap forward has been taken to advance medical education. Through the Office of Women's Health (OWH) collaboration with representatives of the Health Resources and Services Administration, the NIH-Office of Research on Women's Health, (ORWH), the Association of American Medical Colleges (AAMC), and the American Medical Women's Association, significant steps were taken towards the design and implementation of a model curriculum to help medical schools achieve an innovative, multi-disciplinary, lifespan approach to women's health.

The diversity of services offered in the VA Women Veterans Health Clinics varies widely. But the ability to address the health care issues of the women veterans should not be compromised. Again, performance measures are vital.

Outcomes are the golden key. They will unlock the door that restrains the growth opportunities of innovative programs, services, and delivery systems. You want to see outcomes. You need outcomes...measurable evaluations of programs. These outcomes justify authorization bills, budget

appropriations, dollars spent, staff assigned, and contracts formed or expanded. Without outcomes how can we come to you seeking more? ... even if we say, "its the right thing." Without outcomes, can we ask you to expand programs for women veterans, even ask you to help us keep what we have fought for and labored so hard to obtain? If we, on either side of this table, as advocates, don't have the information necessary to carry on...we have all lost...but most particularly, the women veterans of America. The Advisory Committee stresses the valuable importance of the VA to work toward the continued and expanding process of collecting and reporting outcomes. Outcomes define quality and justify investment. If outcomes are significant, however, we need to know that all this work in data gathering is not a futile exercise. Will VA budget dollars follow?

This leads me to my next topic of discussion.

VA Women Veteran Coordinators

Women Veteran Coordinators are truly vested in their job. They work endless hours, many, far beyond the limits of their official FTEE, in order to get the job done. Their innovative approach to duty has driven the efforts of the women veteran programs. The FTEE allocation for WVCs, at both the local and VISN level is a recommendation in the Advisory Committee's Report 2002. We seek no less than .5 FTEE for local WVCs and full time at the VISN level. Here, once more, the Advisory Committee appreciates the need for outcomes. However, we also appreciate the demand of time and the level of responsibility placed upon the WVC. The level of FTEE for WVCs varies widely at the medical center level. Some report a mere four hours of FTEE validation. Another concern of the Advisory Committee is the fact that the language creating the position of the WVC merely states the medical centers must "designate" a Woman Veterans Coordinator. It does not mandate that they be given any FTEE or that funds will be earmarked for their positions.

In many instances, WVCs, at the local level, not only visit the in-patient women veterans on the hospital units, but also assist, represent, advocate,

and intervene on behalf of the women veterans seen in all the clinics areas. They plan and participate in outreach activities, coordinate local women veterans advisory meetings, monitor clinic utilization, assist with women veterans issues presented by homeless veteran outreach team members, serve as a resource for community partners serving women veterans, assist with the WVC strategic plans, work with the VISN WVC and contribute to the coordinated VISN WVC programs and the regularly scheduled conference calls. The WVC is often the first Point Of Contact for women veterans at the local VA Medical Center. Now we add on the necessity for the WVC to track performance measures in the quest of outcome numbers. .... If we asked the WVCs, I'm sure the list would go on and most likely include the ever-expanding number of women veterans in the Community Based Outpatient Clinics (CBOC's).

Many VISN WVCs are also local medical center WVCs. So to the list above place upon their shoulders the responsibility of VISN oversight and advocacy...and outcomes. According to the VHA Handbook 1330.1 Guide to the Women Veterans Health Services, there is reference to the involvement of the VISN WVC at the VISN level on the Strategic Planning, Space, Environment of Care, and Pharmacy committees. We would also recommend these same committee assignments for the WVC at the medical center lever. Privacy issues still remain in the system. Inclusion of the WVC on the above noted committees may assist with the correction of noted privacy issues and/or eliminate its occurrence when new construction or rehab of facilities is considered.

Women Veteran Health Program Office (WVHPO)

With PL 102-585, the Veterans Health Care Act of 1992, four (4) Regional Women Veteran Coordinator positions were mandated. Later they became known as Deputy Field Directors. The WVHPO, operates at the pleasure of the VA Under Secretary of Health. Its first Director was appointed in 1997. It is the program office under which women's health care is coordinated for the entire VA. The Advisory Committee asks that you ensure

its continuance and protecting its position through legislation to mandate it as a permanent program within the VA. Without the WVHPO, women veterans will be lost once again in a system, unresponsive to the growth of specialized progressive women's health delivery.

Homeless Women Veterans Pilot Programs

The Advisory Committee has requested an up-date on these pilot programs. We have been concerned about the continued funding of these programs after the first year of designated funding. We were given to understand that the VISN directors and local medical centers understood that if additional funding was not designated in the budget for the second and third year of the pilot programs that they would commit to the continued funding for the programs at the designated level of the first year. It is unclear if this is, in fact, the case and if all affected Department Chiefs are aware of this arrangement. It was our concern from the beginning that if the money for these special programs, set up as three year pilots, was not set-aside protected dollars, as was the intent of Congress, that the money would be lost in the big VA pool of need. We ask Congress to consider this when providing funding for any special projects in the future.

This concludes my testimony. I am available for questions.

Marsha Four, RN

Served in the Army Nurse Corps (1968 - 1970) with assignments at Fort Campbell, KY and the 18th Surgical Hospital (Camp Evans & Quang-Tri) in the Republic of South Vietnam.

In 1993, initiated Philadelphia Stand Down for homeless veterans and served as its Executive Director and President through 1998. Worked in nursing until 1996, when the position of Program Director for Homeless Veteran Services at The Philadelphia Veterans Multi-Service & Education Center was accepted. Responsibilities include a ninety-five-bed Transitional Residence (LZ II) and a Homeless Veteran Day Service Center (The Perimeter).

Is an active member of Vietnam Veterans of America (VVA) since 1987. Presently, is a Director-at-Large on their National Board of Directors (1999 to Present), Chair of VVA National Women Veterans Committee, and member of VVA's Veterans Health Care Committee, Government Affairs Committee and Homeless Veteran Task Force.

Serves as a member of the VA Advisory Committee on Women Veterans with an August 2002 appointment as Chair and is an Ex-Officio Liaison to the VA Homeless Veterans Advisory Committee.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
October 2, 2002

Mr. Chairman and Members of the Subcommittee:

On behalf of the 1.2 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, I appreciate the opportunity to discuss women's health care programs and services in the Department of Veterans Affairs (VA).

The Subcommittee requested that DAV discuss the level and types of accommodations the Department makes for women patients and whether making such accommodations is a high VA priority. The Subcommittee also asked us to consider the variety and availability of women's programs offered in VA facilities and the status of contract community care for women patients as well as the Department's responsiveness to advice on women's health issues recommended by the VA Women Veterans Advisory Committee and the Center for Women Veterans.

Women have served from the early days of this country to the present, including World War II, Korea, Vietnam, Panama, Grenada, Somalia, Kosovo, Bosnia, Operation Desert Storm, and aboard the USS Cole when terrorists struck in October 2000. Now, in Afghanistan. Throughout history, women have defended our democratic values and today play an integral role in our Armed Forces, most recently in the global war against terrorism. We recognize their contributions and honorable service and pay tribute to all American women who have served this country through military service. Likewise, we will never forget the courage, sacrifice, and patriotism of women and men who have paid the ultimate price for the freedoms we enjoy today.

More than 200,000 women serve on active military duty today and comprise nearly 15 percent of the active force. Another 212,000 women serve in the National Guard and Reserve. Currently, women veterans comprise approximately 5 percent of all users of VA health care services. VA estimates that by 2010, women veterans will comprise 10 percent of veterans utilizing VA health care services. With increased numbers of women veterans seeking health care from VA following military service, it is essential that VA be equipped to meet their specific health care needs. According to VA, enrollment of women veterans into the VA health care system increased from 275,316 in FY 2001 to 349,633 in FY 2002. Outpatient visits of women veterans increased from 152,094 in FY 2000 to 166,108 in FY 2001. In 2000, 28,416 women veterans were screened for military sexual trauma and in 2001, this number increased to 40,991.

DAV is pleased that, in February 2002, VA Secretary Anthony J. Principi renewed the charter for the VA Advisory Committee on Women Veterans. We believe this special 14-member panel plays an important role in advising the Secretary on issues affecting women veterans today. Secretary Principi stated upon renewal of the charter that VA must make a special effort to ensure it meets women veterans needs for health care, rehabilitation, outreach, and other VA programs. The Committee, established in 1984, reviews the adequacy of VA programs and services for women veterans and makes recommendations for administrative and legislative changes. I am pleased to have had the opportunity to serve on the VA Advisory Committee on Women Veterans from 1998 to 2001. During this time the Committee visited local VA medical facilities, regional offices, and Vet Centers and met with clinicians and women veterans regarding the variety and availability of women's programs offered in VA facilities. Recommendations from the Committee's findings were compiled in an advisory report and provided to the VA Secretary and Congress. Although VA does not concur with some of the recommendations made by the Committee, we believe the report is essential as it provides an assessment of the needs of women veterans and important recommendations for improvements in VA programs and services for women veterans.

The continuation of work by directors and staff of the Center for Women Veterans, the Women Veterans Health Program (WVHP) and the VA Women Veterans Advisory Committee reflect the Department's desire to deliver quality health care services to current and future users of VA's women's health programs. VA is clearly committed to improving benefits and services for women veterans and working to assure VA policies, practices, and programs are responsive to the needs of women veterans. However, VA continues to face challenges in inequities and disparities in health care for women veterans. Continued oversight of these programs is necessary to ensure women veterans receive high quality health care services on par with their male counterparts and that their unique health care needs are addressed and met.

In the past five years, VA has undergone significant organizational changes in the way it delivers health care. It shifted from a predominantly inpatient based system to a more comprehensive primary care based health delivery model. The advent of community based outpatient clinics made access to VA health care more accessible for all veterans. Assignment of Women Veteran Coordinators, now Women Veterans Program Managers (WVPM), at each VA hospital and regional office helps to provide outreach to women veterans and assists them in obtaining VA benefits and health care services.

Unfortunately, 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 and a growing trend to reintegrate women veterans into primary care clinics. The DAV is 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 practitioners 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 as a result of the restructuring of VHA and the advent of the primary care model. VA needs to increase priority given to women veterans' programs to ensure that quality health care is provided and that specialized services are available.

We are pleased that, in March 2000, the VA Under Secretary for Health established the Women Veterans Health Program National Strategic Workgroup (WVHP) to evaluate the current status of women's health care in VA and to make recommendations for strategic planning for women's health. In its November 2001 National Strategic Workgroup Preliminary Report, the Workgroup discussed the primary health care delivery model and the many challenges it faces in providing equitable comprehensive health care to women veterans. We applaud the Workgroup for its candid assessment of the WVHP. It clearly outlined and discussed the challenges the Department faces in meeting the changing health care needs of women veterans, including allocating the resources, personnel space, and time to the women's program required to ensure equal access and continuity of care in a safe environment. We believe this report provides a comprehensive review of the WVHP and represents an initial step forward in addressing the challenges VA faces in providing women's health care in today's complex health care environment. We understand the report is under advisement by the VA Under Secretary for Health at this time, with a request by the Under Secretary for the WVHP to further develop clinical performance measures to support its recommendations.

In the preliminary report, the Workgroup thoughtfully considers the ramifications of mainstreaming women veterans into existing clinical care lines. VA acknowledged that, although this health care delivery model appears to be a "reasonable approach and the easiest to maintain," the quality of care delivered in those settings must be considered—specifically where a majority of veterans seen in mainstream primary care clinics are male. The Workgroup noted that use of this care model requires a coordinated effort to ensure that comprehensive care is provided by clinicians who are knowledgeable and sensitive to women's health issues. It further discussed the fact that an increasing number of VA officials may no longer be supportive of gender-specific health care to women veterans in designated clinics, despite the minimal experience and training of many providers in women's health. Given these concerns, the Workgroup noted that the growing pressure to re-integrate women's health services into primary

care settings places the program at risk of losing the gains achieved thus far. The Workgroup concluded; "that it is crucial to assure the integrity of the gains made by VA in demonstrating to women veterans that their service and care is no less important that of men. The extreme minority status of women veterans within the complex health care system that is VA continues to place the attainment of equitable and appropriate services just out of reach."

The Workgroup also candidly discusses the role and challenges of WVPMs. WVPMs are a valuable resource for providing outreach, assuring quality health care, educating internal staff about women veterans' issues, and keeping the Under Secretary for Health informed about the unique health care needs of women veterans. WVPMs have also been instrumental to the growth and success of the WVHP over the years. However, the Workgroup notes that, over the last ten years, their responsibilities have evolved where less than ten percent of the WVPMs are currently full-time coordinators and that downsizing of these positions has resulted in more challenges in monitoring services for women veterans.

In the preliminary report, the Workgroup commented:

> Caught between the political pressures of designating a full-time WVPM, establishing a devoted women's health clinic and meeting other growing clinical demands, local and Network leaders are finding it necessary to utilize WVPMs in ways that decrease the amount of time available and needed to perform administrative responsibilities. Without administrative time, the WVPM's abilities to address issues and concerns while still improving services for women is greatly diminished. This may jeopardize the quality and expansion of women's health programs both locally and nationally. This trend has also resulted in a frustrating environment for the WVPMs who are deeply committed to women's health and continually strive to improve services offered to women veterans.

The amount of time WVPMs have to spend on women veterans' issues depends on a number of factors, including job description, case load, 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 caseload and have adequate time to perform duties related to their WVPM position. Their duties as WVPMs 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 WVPM position should be mandated as full time. Sufficient resources should be designated to support WVPMs and the Center for Women Veterans, including an adequate number of staff to accomplish their missions.

VA has six designated Clinical Programs of Excellence in Women's Health, which serve as role models for the entire Department and represent the best of clinical care the VA offers to women veterans. According to VA, these six sites in Alexandria, Louisiana; Bay Pines, Florida; Boston, Massachusetts; Durham, North Carolina; Pittsburgh, Pennsylvania; and South Texas have demonstrated the highest standards related to women's health in clinical care outcomes,

structures and processes, patient satisfaction, efficiency, productivity, teaching, and research. Although VA has made dramatic improvements over the last several years, the level, quality, and availability of services for women veterans is not consistent throughout the system.

Other issues discussed in the 2001 Preliminary Report included concerns about privacy and mental health care. 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," with hospital curtains installed to ensure privacy. If possible, women veterans should be placed near the nurse's 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. These are just a few precautions that can be taken to ensure a safe and private environment at VA facilities for women veterans.

Likewise, women veterans still frequently complain about a lack of sensitivity by health care providers to their military experiences and to their specific health care needs. We continue to hear complaints about lack of privacy during initial evaluations, especially related to discussing or seeking care for problems associated with military sexual trauma. Additionally, some women veterans indicate they feel uncomfortable sitting in a waiting room comprised mainly 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.

Individual women veterans undergoing treatment programs for posttraumatic stress disorder (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, e.g., combat-related vs. sexual abuse or trauma. Additionally, 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 and other specialized services. They should not be disadvantaged in terms of the quality of care they receive and are entitled to simply 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.

Unfortunately, one of the core obstacles VA faces in delivery of health care to all veterans is the lack of sufficient funding. With record numbers of veterans seeking VA health care, VA can no longer meet the increased demand for services in a timely manner. This has resulted in severe rationing of health care. Available resources have diminished system wide and threaten all health care programs, including those designated for women veterans. The VA health care system is in crisis, therefore we strongly support legislation to make VA health care funding mandatory (H.R. 5250/ S.2903).

While the VA has been working hard to improve health care services for women veterans, it is ever cognizant of fiscal restraints. The Workgroup stated: "At this juncture in time, competing political, fiscal and organizational demands challenge the sustainability, stability and the infrastructure of the services that VHA has vested in for providing quality care to women veterans, at a time when the number of women veterans we serve is increasing. Finite resources available to provide health care to all veterans necessitate difficult decisions for Network and local leaders. Decisions regarding the use of financial resources are even more complicated because of VA's responsibility to ensure equitable health care is provided to women veterans." Women's health programs must be adequately funded to avoid a decline in services. 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.

Despite considerable organizational challenges, VA must make providing equitable, high-quality, compassionate health care services to women veterans a high priority. We believe the issues discussed above represent the core obstacles VA faces with respect to comprehensive health care delivery to women veterans. These challenges must be met head on by the Department. VA must improve access for women veterans and remove real and perceived barriers to care. Improvements to data collection specific to gender are necessary, as it is essential to planning and management of future programs and services for women veterans. VA has an obligation to provide all veterans with the highest quality health care available. Women veterans should be afforded no less than what VA has to offer its male veteran population. They too should have access to, and benefit from, VA's many specialized programs and services.

In closing, we agree that VA's biggest challenge, related to the delivery of equitable, high-quality health care services to women veterans, will be to maintain the integrity of women's health programs while meeting the needs of all veterans in a health care system that is fiscally challenged. The preliminary report of the National Strategic Work Group provides a comprehensive and honest review of the WVHP and discusses the core challenges VA faces in fulfilling its mandate of providing comprehensive health care services to women veterans. It is now up to the Secretary to consider the recommendations posed therein and to develop policy and planning initiatives that ensure legislative mandates relative to women's health are carried out. We hope VA leadership will strive for excellence in women's health as it formalizes its 5-year strategic plan for assuring the quality of health care delivery for our nation's women veterans and dedicate the necessary resources the WVHP deserves. Decisions about the delivery of care for women veterans should not be fiscally driven but based on sound research and clinical outcomes related to delivery of women's health care.

Statement of
Carole L. Turner, RN, MN
Director, Women Veterans Health Program
Department of Veterans Affairs
on the
Status of Womens Health Care Programs
before the
House Veterans Affairs Committee
Subcommittee on Health

October 2, 2002

Mr. Chairman and Members of the subcommittee, I am pleased to be here today to report on the status of the National Women Veterans Health Program in the Department of Veterans Affairs (VA). I was appointed as the Director of the VA Women's Health Program (WVHP) and have served in that capacity since 1999. I have responsibility for ensuring that the VA policies regarding the provision of health care to women are administered at every VA facility and community outpatient clinic. I speak to you today not only from my position as Director of the WVHP, but also as a Vietnam-era Air Force veteran, an advanced practice nurse, and a 15-year veteran user of the VA health care services.

VHA responded to a 1983 General Accounting Office report entitled, "Actions Needed to Ensure that Female Veterans have Equal Access to VA Benefits" by designing innovative health care systems and investing resources to address the deficiencies identified in that report.

As a result of the focus on women veterans, many improvements have been made, and innovative strategies were instituted and are now in place to provide high quality health care to women in VHA. The Program operates through a network of field-based Deputy Field Directors who provide needed regional leadership, guidance, and support to network and medical center leaders and facility-based Women Veterans Coordinators. Women Veterans Coordinators (WVCs) were appointed in all VHA facilities as early as 1985 to be advocates for women seeking VA care. These Coordinators are instrumental to the development, management, and coordination of women's health services at not only their individual VA medical centers, but also the entire array of community-based outpatient clinics, which aim to enhance veteran access to VA health services. They also typically have significant clinical caseloads in addition to providing local clinical expertise to other providers and health care managers.

As VHA reorganized from hospital-based to an outpatient preventive medicine health care delivery model in the mid-1990's, leadership was decentralized into 22 (now 21) Veterans Integrated Service Networks (VISNs). In keeping with these changes, Lead, or liaison, WVCs have been appointed, one in each VISN. These VISN WVCs have been recently appointed as the official field advisory committee to the WVHP office to identify needed improvements and overcome gaps in services. Given the magnitude of their role in supporting local

women's health care delivery, newly appointed WVCs may obtain further training through a mini-residency offered in Tampa, Florida. To date, 77 new WVCs have been oriented in this program. The Women Veterans Program Office was established within the Office of Public Health and Environmental Hazards and the first full-time Director of the Program was appointed in 1997. Two VACO staff support the Program Director and Deputy Field Directors.

As Dr. Roswell mentioned, the ability to expand and organize women veterans' health care services was significantly enhanced by the Veterans Health Care Act of 1992, which provided authority for an array of gender-specific services and programs to care for women veterans. As a result, eight Comprehensive Women's Health Centers (CWHCs) and four Stress Disorder Treatment Centers were established. The CWHCs serve as the VHA's state-of-the art, best practice models for delivering women veterans' health care.

The CWHCs are comprised of interdisciplinary teams of health care providers delivering "one-stop-shopping" comprehensive health care to women veterans. Services include gender-specific preventive care (Pap smears and mammography) and primary general medical care, basic gynecologic services, mental health screening for MST, care for substance abuse and Major Depressive Disorders, general reproductive services, social support and case management (homelessness and domestic violence), and nutritional and pharmacological services. Patient and provider education and clinical research are also major components of these programs. Over half of VA medical centers (VAMCs) have a separate women's health clinic, two-thirds of which were established since 1995. While the remainder often provide care in general primary care settings, women veterans are typically referred to a specialized women's health clinic for preventive screenings or gender-specific care. Over 40 percent of VAMCs have one or more designated women's health providers in outpatient mental health clinics to accommodate their special needs, and 11 percent have developed specialized women's mental health clinics.

VHA has made considerable strides in providing Military Sexual Trauma (MST) Counseling to both female and male veterans. Readjustment Counseling Service in collaboration with Mental Health and Behavioral Sciences and the WVHP offices have designed systems and programs to ensure all veterans are screened for MST, and receive appropriate counseling and treatment when indicated. The collaborative efforts of these programs ensure that veterans receive timely, sensitive, and comprehensive MST treatment at all VA health care access points.

The WVHP office collaborates with the Patient Care and Pharmacy Services to ensure these program offices remain current and informed relative to unique and changing needs of the women veterans' population.

The delivery of health care services to a diverse population of women veterans ranging in age from 20 – 100 years (894 women were 94 year old or older in FY 2001) has been an ongoing challenge for VA. The number of women veterans seeking VA health care is increasing every year. As the Under Secretary has mentioned, in 2000, approximately 150,000 women veterans were seen as outpatients and 13,000 as inpatients. In 2001, these numbers rose to 166,000 outpatients and nearly 14,000 inpatients. In fact, women are the fastest growing segment of the veteran population. In anticipation of increased numbers of women, the next challenge for VA will be to evaluate which health care delivery model demonstrates the best clinical outcomes and are most cost effective in providing care to women. One possibility is to develop a scorecard to measure the efficiency and effectiveness of various models of delivering health care to women.

The WVHP has faced many challenges and instituted strategies that have markedly improved the way health care is provided to women. However, there will be more challenges in the future. Quality improvement is a dynamic process. In 2022, our women veterans health care delivery model will undoubtedly look very different than it does today. The WVHP and the Lead Women Veterans Coordinators, who comprise the Field Advisory Committee, are currently developing performance measures to facilitate this inquiry process and to position ourselves to be responsive to the growing number of women veterans and their changing health care needs. This is a challenge that my office and the dedicated group of Women Veterans Coordinators readily accept.

Mr. Chairman, thank you for this opportunity to provide a report on the status of the National Women Veterans Health Program. I would now be pleased to answer any questions that you or other members of the Subcommittee might have.

Statement of
Mary Antoinette (Toni) Lawrie RN, WVPM
Bay Pines VAMC, FL and VISN 8 Lead WVPM
Department of Veterans Affairs

Before the
House Veterans Affairs Committee
Subcommittee on Health
October 2, 2002

Mr. Chairman and Members of the Subcommittee, I am Toni Lawrie, a registered nurse currently working as the Women Veterans Program Manager (WVPM) at the Bay Pines VAMC on the west-central coast of Florida, and Lead WVPM for VISN 8. I am pleased to be here today to report on the status of women veterans health care at Bay Pines in particular, and VISN 8 in general. Almost 10 years ago, in March of 1994, I provided a statement to the House Subcommittee on Oversight and Investigations in regard to "VA actions to improve the provision of health care to women veterans and related issues". In reviewing that testimony I was reminded that I called for VA to open primary care clinics for women regardless of service connected status, for VA to identify several centers of excellence to show the way in women's health care, and for VA to eliminate physical and psychological barriers for women seeking health care from the VA. To my delight and surprise, VA has done just that. I can only hope I am as on target with my suggestions now as I was then. The Bay Pines Women's Program was recognized in 2002 as a VA Clinical Program of Excellence.

Florida is home to 107,000 women veterans, and Puerto Rico has 6,000; so VISN 8 has about 113,000 women veterans, according to the 2000 census figures. This is an increase of some16,000 from the 1990 census, which showed the VISN 8 women veteran total as 97,200. VISN 8 has the largest workload of women veterans in the nation. In FY 2000, three of our VA facilities were ranked in the top 10 VA medical facilities in the nation in treating unique numbers of women (Tampa # 1, NF/SG #3, and Bay Pines #9). In FY 2002, we treated in excess of 21,000 unique women across the Network (a 19 percent market share).

VISN 8 has a Women Veterans Workgroup that reports to the Director through the Clinical Council. This work group developed a Five- Year Strategic Plan to expand and improve the care of women veterans. Three of the main goals in the plan speak to both our "best practices" and our vulnerabilities. Those goals are:

- improve the quality and availability of services to women by reducing privacy deficiencies and creating a uniform package of services available to them, particularly in CBOCs;
- increase market penetration for women to 25% of the population across the network by 2007; and

- offer "full service" Primary Care clinics at VAMCs especially for women, with as many disciplines as practical (primary, mental health, gynecologic, breast care, nutrition, pharmacy, and social work services), providing on site service to exceed patient expectations.

Privacy deficiencies in the hospitals have been largely overcome in the past several years. However, with the rapid proliferation of Community Based Outpatient Clinics (CBOC) in the system and the conversion of inpatient space to outpatient space, the deficiencies are back. Each WVPM in VISN 8 surveyed the CBOCs, finding a lack of privacy curtains, restrooms unequipped for women's needs, misplaced exam tables without stirrups, exam rooms on public corridors which could be easily accessed by other patients, a lack of acoustical privacy at check in, and only a few that offered gender specific examinations for women. Reclaimed space in hospital facilities generally exist on easily accessed public corridors and few rooms have enhanced privacy provided by draw curtains.

The overall VISN 8 goal was to raise market penetration of the veteran population to 25 percent; so the goal for women was raised from 20 percent to 25 percent.

And the third goal of offering "full-service" settings for women to receive care is driven by current practice in VISN 8, and by findings from satisfaction surveys of users. All of the facilities in VISN 8 have dedicated space in the hospitals where "women's services" are offered. They vary in the mix of services, some offering more than others. However, we have identified the more comprehensive mix of services as one of our Best Practices in the care of women. It is preferred not only by our patients, but also by our providers. Hallway or "curbside" consultations between a matrix of primary and specialty care providers saves time, money, and the potential for clinical error. We know our patients want this kind of service. In a recent survey of 243 outpatient women across the VISN (September 2002), we asked, "If you had the option of choosing where you receive health care within the VA system, which of the following would you choose? Primary care, not separated from male patients, Primary care, separated from male patients, or in a Women' Health clinic?". Only seven percent of respondents chose Primary care, not separated, while 86 percent chose Womens Clinics and six percent chose Primary Care, separated. A second question, "If you are seen in the Women's Clinic, does it offer you...less privacy (zero percent), same privacy (16 percent), more privacy (82 percent)."

Another important element of our program is the commitment that Bay Pines has made for a full-time program manager. As a full-time WVPM, I have been able to devote much of my time to improving and expanding the services available to women veterans at Bay Pines, and in VISN 8. At Bay Pines, we have become a Clinical Program of Excellence. We have a market penetration in our county population of about 35%. We have been able to develop tools/instruments to better help us communicate with and serve women. We have developed training

programs for WVPMs and mental health clinicians who work with sexual trauma victims. We have developed a unique residential day treatment program for women who are suffering from PTSD as a result of military sexual trauma. This program was funded in FY 2000 by a grant from the "innovative initiatives" Request for Proposals of VA's Health Services Research and Development Service. The program has been highly successful in treating women for whom outpatient therapy alone was insufficient in the treatment of sexual trauma. Pre- and post-testing of 75 women clients who have been through the four-week residential program provides statistically significant evidence that the program works, and works WELL. Preliminary data analysis indicates significant improvement of symptoms including anxiety, depression, intrusive thoughts, sleep disturbance, and sexual functioning as a result of the treatment intervention.

The patients are also very satisfied with the care that they receive in the Sexual Trauma Day Treatment Program (STDTP); 99 percent indicate that they would return for additional treatment if needed, and 100 percent would recommend the program to a fellow veteran who needed treatment because of sexual trauma. Research associated with this program continues and holds promise of important findings. We are currently using the STDTP as a model to develop a treatment program for male victims of military sexual trauma at Bay Pines. We are also asking for funding to train two post-doctoral year psychologists in these special programs yearly, to begin developing a pool of highly trained mental health clinicians from which VA can draw.

The VISN 8 Women Veterans Workgroup has created several work products that are helpful to the overall effort, especially in the creation of instruments that survey the satisfaction of women with their care. VISN 8 is a "benchmark" network in the care of women veterans. We have seen that systems that work well for women also improve the care of men.

I thank the Chairman and the Committee members for requesting my statement. It is heartening to those of us in the field to know that our thoughts, ideas, and opinions are valued by the men and women in Congress who make the laws.

Statement of
Margaret Seaver, M. D.
Medical Director, Women Veterans Health Center
VA Boston Health Care System

October 2, 2002

My name is Margaret Seaver; I am an internist and primary care physician. I have been Medical Director in the Women Veterans Health Center at VA Boston Healthcare System for three years. This past year we were recognized as a VA Clinical Program of Excellence. Our program was among the original eight comprehensive women's health centers funded by the VA in the early 90's. We provide a broad spectrum of women's health services both within our facility and on contract and fee basis. Medical and mental health services are highly integrated in our program. At our facility, we have the Women's Stress Disorders Treatment Team, which is part of the National Center for PTSD, we have one of the few women-only psychiatric inpatient wards in the country, the first transitional residence for women veterans, and the Women's Homelessness Program. Although primary care is at the core of our program, to adequately serve our patients, our women's health program must be much more.

You have heard about the great improvements that the VA has made in caring for women. The Women Veterans Coordinators provide essential services acting as advocates, case managers, and resources for patients. The mandate for all VA facilities to have a Women Veterans Coordinator has made the difference for many women as they enter the VA system and continue as our patients. The implementation of women's clinics and centers has contributed to a research-based body of knowledge about women veterans health and mental health, expert treatment of military sexual trauma, coordinated care for complex medical and mental health problems, improved quality of life for patients struggling with PTSD and its co morbidities, and excellent compliance with preventive health measures such as pap smears and mammograms. However, this is only part of the story. Fragmentation of care is still a major problem. A recent national survey in VA shows that many gender specific services are contracted out to community medical providers, or affiliates. Contract and fee basis arrangements for maternity, infertility, and sub specialty women's health services result in a layer of complexity that disrupts continuity of care. In order to overcome this issue, women's health programs need to have adequate staffing for case coordination. We also need support from administration to continue to provide this labor intensive care.

VA women's clinics were established because, unlike the private sector, where women make up 50 percent to 60 percent of a primary care practitioner's clientele, women veterans comprise less than five percent of VA's total patient 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. Women veterans are different from male veterans, not simply because of their anatomy, but because they have different demographics, and their medical and mental health needs are different. For example, women respond to trauma

differently from men, and women experience higher rates of sexual trauma and military sexual trauma than their male counterparts. The VA Women's Health Project found that 23 percent of women veterans report being sexually assaulted in the military and 55 percent report they were sexually harassed.

Women who report rape as their most traumatic experience have significantly higher rates of PTSD than men reporting combat as their most stressful experience. And women with PTSD have higher rates of substance abuse. There is a strong association between sexual assault and physical symptoms. Chronic conditions including diabetes, arthritis, and asthma are seen with increased frequency in women reporting sexual assault. Other physical consequences of sexual violence include pelvic pain, irritable bowel syndrome, back pain, headache, eating disorders, poor reproductive outcomes, digestive problems, and hypertension.

Research has found that women with a sexual trauma history have long-term high rates of healthcare utilization subsequent to the experience of assault. Research also suggests that women with sexual trauma histories present in medical settings with significant mental health needs and that performing invasive gynecological exams and other medical procedures on these patients may require particular sensitivity on the part of providers. Our center offers these services in a safe, private setting that women with a history of military sexual trauma not only prefer, but also need. These women would not come for care if they had to sit in a room full of men. Thus, our patients' care can be resource intensive. In order to minimize this fact, and to utilize our clinic space fully, we have developed a multidisciplinary clinic with specialists and primary care providers.

The story of Women's Health in the VA is one of success, of building an outstanding program in a few years. It was built on the foundation of the comprehensive women's health centers, and these centers still provide the highest quality care to women as evidenced by the fact that five of the original eight have been recognized as VA Clinical Programs of Excellence. We still have a great deal of work to do to train more staff to care for women, to combat the discrimination that still exists in the VA, and to contribute to the growing field of women's health through our research. I have personally cared for patients who could only have received the care that they did from the VA, because their issues were ones that the VA specializes in, such as military and sexual trauma and the PTSD that often results from these experiences. I am extremely proud of our women's health program, inspired on a daily basis by the dedication and commitment of my colleagues, and most of all honored to care for our nation's veterans. I hope I have been clear that many of the problems we face in caring for women stem from the fact that women in the VA are an extreme numerical minority. We need to continue to have separate women's health clinics in order to provide the services women veterans need and are eligible for, as well as the resources to provide primary and gender specific care in a safe and private environment. We need to have access to specialists, and case managers who have the time to spend coordinating the care of each women veteran. Thank you for listening to my testimony.

STATEMENT OF
CAROL J. M. RUTHERFORD, DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
ON
STATUS OF WOMEN'S HEALTH CARE PROGRAMS
IN THE DEPARTMENT OF VETERANS' AFFAIRS

October 11, 2002

The American Legion is grateful for the opportunity to submit testimony concerning the status of women's health care programs in the Department of Veterans' Affairs (VA). Since it's inception in 1919, women veterans have served in positions of leadership at the community, state and national levels of The American Legion and have helped form the organizational mandates that define our mission as a Veterans Service Organization (VSO). Improving VA's ability to address the specialized needs of women veterans has long been an issue of importance to The American Legion.

In 2000, The American Legion published ***The American Legion Guide:*** *Women Veterans – Identifying Risks, Services and Prevention.* While providing valuable information on general veterans' topics, the guide focuses on gender-specific issues of importance to women veterans such as childcare, sexual trauma, domestic violence, and women's health care. It was our intention that the guide, in tandem with the efforts of the Center for Women Veterans, would provide much needed guidance to the often-neglected women veteran population.

Since the publication of the Women Veterans Guide, The American Legion has remained focused on ensuring that VA facilities are adequately equipped to provide quality health care to women veterans. Our team of field representatives visit Veterans' Affairs Medical Centers (VAMCs) nationwide and evaluate the quality of facilities and services provided. The availability of women veterans' services is always taken into account during field representative visits. It is our hope that the availability of services for women veterans will match the ever-increasing number of women joining the ranks of the veteran population each year.

According to the Center for Women Veterans, there are approximately 1.3 million female veterans and approximately 15 percent of the active duty forces are female. The number of women in uniform is expected to increase to more than 20 percent in the next several years. An increasing number of female veterans are seeking health care through VA. Currently, women veterans comprise approximately 5% of all users of VA health care services. It is estimated that this number will increase to 10% by the year 2010. This increase in usage by women veterans must be met with adequate resources to meet the unique requirements of the women veterans' population.

The demographic makeup of the women veteran population and their demand for services differ from the male veterans population. Women veterans seeking care through VA tend to be younger, better educated and less likely to be married. VA is primarily structured to meet the health care and benefit demands of an older male population. Although VA is recognizing the need for improved focus on the health care needs of women veterans, the level of available quality health care for women veterans must continue to improve.

Through the combined efforts of The American Legion and other VSO's, improved accessibility to care and treatment for gender-specific needs within the VA has indeed improved. The formation of the Advisory Committee on Women Veterans and the Center for Women Veterans was an effective first step toward establishing an effective forum to address the health care needs of women veterans and ensure VA is meeting

those needs. The efforts of both the Advisory Committee and the Center continue to lead to improved access to VA health care for women veterans.

The Veterans' Health Care Eligibility Reform Act of 1996, and more specifically the Uniform Benefits Package created as a result of the legislation, led to improvements in women veterans' health care within VA. The Uniform Benefits Package is a comprehensive health care plan emphasizing preventive and primary care available to all eligible, enrolled veterans. Women veterans covered by the Uniform Benefits Package receive gender- specific care in the following areas:

- 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 contracted through a VA affiliated hospital).

The American Legion commends Congress and VA for including these important health care services under the Uniform Benefits Package. However, in the male dominated health care environment of VA, disparities and inequities in health care for women veterans continues to hinder overall delivery of services. Accessibility is a common problem facing women seeking care at their local VA. Not all VA facilities are equipped to provide the needed services for women veterans. With the increasing number of female servicemembers and the growing percentage of women veterans seeking care from VA, the need to provide gender-specific health care at all VA facilities is paramount.

VA Secretary, Anthony Principi's renewal of the charter for the VA Advisory Committee on Women Veterans is a strong example of VA's commitment to improving the level of accommodations the Department makes for women patients. The American Legion supported the creation of the Advisory Committee as well as the Center for Women Veterans. The efforts of both the Advisory Committee and the Center for Women Veterans has led to significant improvements to women veterans health care since their creation. They serve as a valuable resource for the Secretary in understanding and responding to the health care needs of women veterans.

The recently released Advisory Committee on Women Veterans 2000 Report outlines key recommendations for improving overall services for women veterans within VA. Although this report was "lost" for two years, the issues addressed by the committee are as valid today as they were when first addressed by the Committee. Committee recommendations include:

- Increased outreach programs;
- Improved access to sexual trauma treatment;
- Properly address homelessness among women veterans;
- Support for Women Veterans Coordinators Program;
- Improved education of VA staff on gender-specific issues;
- Increased Guard and Reserve benefits;
- Improved burial benefits and options for side-by-side plots;
- Increased opportunities in Federal agency employment

The American Legion supports the Committee recommendations and urges VA to include them in any strategic planning initiatives.

The American Legion agrees that improved outreach programs to women veterans is vital. Although the past decade has brought a new level of awareness to the role of women veterans in U.S. military, many women veterans are still unaware of their earned benefits as former servicemembers. The placement of Women Veteran Coordinators,

now referred to as Women Veterans Program Managers (WVPM's) at VA health care facilities has been extremely beneficial, not only in improving outreach but, also identifying areas of improvement in women's health care. The American Legion supports the WVPM program and recognizes the important role these individuals play in the successful outreach and education of women veterans regarding their earned health care benefits. We are however, concerned that many WVPM's are becoming overwhelmed with additional duties outside the realm of women veteran issues.

The role of the WVPM was established in 1991 as a result of a General Accounting Office report that indicated women veterans did not have equal access to veterans' health care. Congress responded with the creation of the Advisory Committee on Women Veterans to assess VA's ability to provide quality health care to women veterans and to identify areas needing improvement. The Advisory Committee recommended placing WVPM's at local VA facilities to improve access to quality health care for women veterans. Since their creation, WVPM's have been instrumental in identifying barriers to access and quality care and improving the delivery of service to women veterans.

Although WVPM's have indeed improved VA health care for women veterans, organizational changes have served to complicate the role of the WVPM. According to the Women Veterans Health Program National Strategic Workgroup Preliminary Report published in November 2001, the reorganization of The Veterans Integrated Services Networks (VISNs); the outsourcing of services; the changing of demographics of women veterans; and the establishment of over 600 Community Based Outpatient Clinics (CBOCs) have all led to an overburdening of responsibilities for WVPMs. The shift in VA's focus from inpatient care to outpatient care and organizational downsizing have occurred at a time when women veterans enrollment is increasing. With the increasing demand for health care within the VA, WVPMs are routinely required to provide clinical care, which competes with other responsibilities. These competing demands, according to the report, have a negative impact on the performance and job satisfaction of WVPM's.

The American Legion agrees with the Women Veterans Health Program's recommendation to develop a performance model as the standard of performance for the WVPM position. The report recommends the allocation of a minimum 20 hours of protected time for each WVPM to focus solely on their responsibilities to improve women veterans access to health care. As more veterans enroll in VA and the increased demand for services places an added burden on all employees, WVPM's must be allotted the time needed to focus on their unique mission. The progress made in improving accessibility and quality of care for women veterans will undoubtedly suffer if WVPM's are continually tasked with requirements from other divisions within VA.

The American Legion is cognizant of the fact that any proposed improvement in care and delivery within VA is dependent upon increases in an already inadequately funded budget. Any improvements to women veterans' health care and general health care services within VA depend on improved budgetary outlays from Congress. With that in mind, The American Legion supports Medicare reimbursement for VA.

Unlike in the private sector, Medicare-eligible veterans cannot use their Medicare benefits in a VHA facility. When Medicare-eligible veterans receive health care treatment for any medical condition in the private sector, the federal government reimburses the health care provider for a portion of that service. When Medicare-eligible veterans receive health care treatment for the same medical conditions within VHA, the federal government will not reimburse VHA for any portion of that service. This equates to a restriction on veterans' right to access health care of their choice and using their Medicare insurance coverage.

The American Legion believes that Medicare reimbursement will result in more accessible, quality health care for all Medicare-eligible veterans. Today's fiscal realities requires VHA to seek other revenue streams to supplement the growing demand for service and not simply rely on saving more dollars to serve more veterans. The

American Legion strongly recommends allowing Medicare reimbursement for Medicare-eligible veterans enrolled in VHA.

The efforts to improve VA health care for women veterans in the past decade have indeed proven successful. The American Legion applauds Congress and VA for recognizing and addressing the unique health care needs of the women who have proudly served this country. We are heartened by Secretary Principi's recent renewal of the charter for the Advisory Committee on Women Veterans. The efforts of the committee and the Center for Women Veterans have led to improved access to care, more comprehensive health care, and improved outreach to women veterans regarding their earned entitlements.

It is our hope that VA will remain focused on meeting it's obligation to women veterans, especially at a time when Congress and The Administration are once again considering committing American troops – men and women - to war.

Once again, The American Legion appreciates the opportunity to provide testimony on this important issue.

STATEMENT OF

WENDY LAWRENCE, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

SUBMITTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

WOMEN'S HEALTH CARE PROGRAMS

WASHINGTON, D.C. OCTOBER 11, 2002

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, we wish to express our genuine appreciation for the opportunity to submit our views regarding the status of women's health care programs within the Department of Veterans Affairs (VA).

Women represent a unique, valuable part of the Armed Forces of the United States. The service of American women in wartime can be traced back to the Continental Army and our Nation's struggle for independence. The official inclusion of a female unit in our military structure however, did not come until just after the Spanish American War with the establishment of the Army Nurse Corps in 1901. Since then, the numbers of women in the military and the functions they serve have steadily escalated and expanded. Today, there are more than 200,000 women in uniform, representing about 14% of the total active duty force of about 1,384,000 members. While this number may represent a small sector of the veterans' population, their numbers are quickly growing. In 1982, there were about 740,000 women veterans and by 1996, that number increased to more than 1.2 million. According to the VA, as of July 2000, the population of women veterans is 5% of the total veteran population in the United States and Puerto Rico, which is an estimated 24,000,000.

Unfortunately, women have been historically underrepresented in utilizing the benefits provided for them, and have often been reticent in claiming their veteran's status. Despite their significant contributions, many people—including those women who served their country—mistakenly believe that there are no women veterans. This may be due in part that many link combat duty with "veteran" status, or the fact that women's military service organizations originally were designated as "auxiliaries."

Women veterans, however, **are entitled to the same VA benefits as male veterans**. In addition, Public Law 102-585, *Veterans Health Care Act of 1992* authorizes VA to provide gender specific services, such as pap smears, breast examinations, menopause management, mammography and general reproductive health care services to eligible women veterans. This law also authorizes VA to provide women veterans counseling services needed to treat sexual trauma experienced while serving on active duty. In addition to its clinical mission, VA has sponsored research that specifically addresses the needs of women veterans. Funding for women's health research totaled $24.2 million for 305 studies. The VA was the key funding source in 61 of the studies for a total of $5.8 million.

Aside from the level and types of services available to women veterans we want to emphasize our support for the guideline contained in *VHA Handbook 1330.1, VHA Services for Women Veterans*, that states: *Clinicians caring for women veterans in any setting must be knowledgeable about women's health care needs and treatments, participate in ongoing education about the care of women, and be competent to provide gender-specific care to women. Skills in screening for history of sexual trauma and working with women who have experienced sexual trauma are essential.*

Along this same line, P.L. 102-585 also mandates that each Veterans Health Administration (VHA) facility have an appointed Women Veterans Coordinator (WVC). This person should be a clinical health care professional (Doctor of Medicine, social worker, pharmacist, Registered Nurse) sensitive to the needs of women veterans, who is capable of working with caregivers and patients to ensure the proper delivery of health care in a positive environment, to include the contracting out of care when it is unavailable in a VA medical facility.

However, recent site surveys performed by our National Veterans Service Field Representative Staff have revealed that unskilled personnel have sometimes been placed in these roles. They often lack the advanced skills necessary to act as a liaison to women veterans concerning their precise health care needs. We have also observed that a number of facilities have yet to appoint a full time WVC on staff. Only when placing informed, clinical health care professionals in the WVC role can VA expect women veterans to have access to the scope and availability of women's health programs.

Further, the WVCs are also required to participate in the regular review of the physical environment, to include plans for construction; the identification of potential privacy deficiencies; as well as availability and accessibility of appropriate equipment for the medical care of women. The VFW is extremely interested in this aspect and as such, we passed VFW National Resolution 608 that strongly supports improved VA hospital facilities for women veterans. It is our contention that as the number of women increase in the military, more of them will have a need to utilize the VA health care system.

Therefore, it is imperative that VA has the proper medical facilities in place. More resolve and leadership needs to be brought to bear in this area because in several medical facilities that our organization surveyed, we continued to identify a lack of privacy in accommodations for women patients. Women did not have private or semi-private rooms on the inpatient wards nor did they have separate bathing or lavatory facilities. Other challenges faced by women veterans are misplaced examination tables without stirrups, examination rooms on

public corridors that could be easily accessed by other patients, placing waiting rooms largely comprised of males in close proximity to the Women's Health Clinic. This is a great area of concern especially when a female veteran may be suffering from Post Traumatic Stress Disorder due to sexual trauma.

We are pleased that at the National Summit on Women Veterans in June of 2000, Veterans Affairs Secretary Anthony J. Principi acknowledged the growth of women veterans in our society and that more progress needs to be made regarding their health care, rehabilitative programs and outreach. Further, Secretary Principi renewed the charter for the Advisory Committee on Women Veterans on February 1, 2002. This distinguished panel established in 1984, provides biennial reports to the Secretary on matters germane to the needs of women veterans. Its 14 members conduct site visits, tour VA facilities and convene with senior officials to discuss services available to women veterans. The Advisory Committee also seeks input from women veterans themselves encouraging them to share their experiences regarding VA health care and benefits.

In 2000, the Advisory Committee submitted its report to the Secretary integrating their findings and recommendations. The recommendations were made regarding outreach, sexual trauma counseling and care, women veteran coordinators, health care, staff education (as stated previously, the VFW believes this is especially important to have health care providers be sensitive to the needs of women veterans), strategic planning and women veterans who are homeless.

It is our understanding that while there is progress to be made VA is making a commitment to implement these recommendations nationwide. The Under Secretary for Health, Dr. Robert Roswell has acknowledged that the Department is learning more about women veterans than they did several years ago. This type of commitment to gain awareness of women veterans will facilitate VA's response to the various and demanding needs of women's health care.

In fact, we would like to highlight two of their six centers of excellence in women's health care. The VAMCs in Boston, MA and Bay Pines, FL have placed a high priority on women's health care. These centers are equipped with primary care clinics, women only psychiatric inpatient wards, and separate facilities for women and men. These types of model facilities need to be implemented across the board.

It is our contention that the Department will continue to stress the need to improve services for women veterans. We will continue to rely on VA Central Office and its medical directors to place a high priority on women's health care by communicating this message to those at the local level.

Thank you for the opportunity to submit our views. This concludes my statement.

RESPONSE TO FOLLOW-UP QUESTIONS FOR
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
FROM THE HONORABLE LANE EVANS, RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
October 2, 2002 HEARING

Question: Like so many of our witnesses, you cite growing need for sexual trauma counseling services. Do you believe that the Sexual Trauma Counseling program should be extended or made permanent? Why or why not?

Answer: The Disabled American Veterans (DAV) strongly believes the Department of Veterans Affairs (VA) Sexual Trauma Counseling program should be made permanent.

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.

The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that there is a high prevalence of sexual assault and harassment experiences reported among women veterans accessing VA services. Active duty military personnel report rates of sexual assault higher than comparable civilian samples.

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 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.

VA must not fail to meet these identified needs of women veterans who have experienced sexual trauma during military service. Given the significantly increased rates of sexual trauma reported by women who served or are serving in the military, with no sign of abatement, we urge the Subcommittee to consider legislation to make the VA Sexual Trauma Counseling Program permanent.

Question: Do you believe that women veterans will receive adequate treatment in community-based outpatient clinics?

We expect that for basic or primary health care services most women veterans will receive appropriate care, on par with male veterans, at VA Community Based Outpatient Clinics (CBOCs). Where CBOCs are staffed by contract primary care physicians, these physicians should be as familiar with the basic health care needs of women as private sector primary care physicians. However, for specialty care such as gynecological services, women veterans would generally be referred to a VA facility where the shortcomings in gender-specific care are well known.

It is VA policy that each health care facility, including CBOCs, ensure that eligible women veterans have access to all necessary medical treatment including care for gender specific conditions that is equal in quality to that provided to male veterans. CBOCs were designed as an access point for health care in the community setting. Most clinics provide only basic or primary health care services to veterans. The need for specialized care such as cardiology, orthopedics or gynecological services generally require a referral back to the nearest VA medical center.

Treatment available at CBOCs varies widely throughout the Network. Each Network determines the number of clinicians and types of health care services that will be provided at a CBOC. Some CBOCs are staffed by VA employees, others are staffed by private health care groups contracted by the local VA medical center to provide community based care. One could debate the quality of care women veterans receive at any VA clinic or facility. Women generally make up approximately, 50-60 percent of a private sector clinician's caseload. Therefore, it is likely they are more skilled in women's health and gender specific care such as gynecology than most VA clinicians, where women make up less than 5 percent of VA's total population. However, private sector physicians may not be as familiar with or sensitive to health problems unique to military service such as Post Traumatic Stress Disorder, Agent Orange exposure, Gulf War Syndrome, or military sexual trauma.

As noted in our October 2, 2002, testimony DAV is concerned that clinicians providing care to women veterans are qualified and have expertise in women's health. Because women veterans are an extreme minority in the veterans health care system, 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 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 at VA medical centers and a growing trend to reintegrate women veterans into primary care clinics. We are concerned about the incidental impact of the primary care model on the quality of health care delivered by VHA to some women veterans. This could be further complicated in CBOCs staffed by VA health care providers, as even fewer numbers of women are likely to be seen in these settings.

We strongly believe VA should address the barriers to healthcare women veterans experience, establish appropriate clinical outcomes for women veterans, and closely monitor the effects of various clinical settings on the quality of care provided to women veterans throughout the VA health care system.

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