STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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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.