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STATEMENT OF
JOY J. ILEM
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JULY 14, 2009

Mr. Chairman and members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this hearing that is focused on women veterans, entitled "Bridging the Gaps in Care." This hearing is extremely timely given the changing roles of women serving in our armed forces today, the 1.7 million women veterans who served previously, and the dramatically growing number of women seeking health care and other benefits from the Department of Veterans Affairs (VA).

Ensuring equal access to benefits and high quality health care services for women veterans is a top priority for DAV. We have a long-standing resolution from our membership of 1.2 million disabled war veterans that seeks to ensure VA health care services for women veterans, including gender-specific care, are provided to the same degree and extent that services are provided to male veterans. Also, given the undoubted greater exposure of servicewomen to combat, we believe they should have equal access to supportive counseling and psychological services incident to combat exposure. Military sexual trauma, while not exclusively a women's issue, is also of special concern to DAV. Additionally, we urge VA to strictly adhere to their stated policies regarding privacy and safety issues related to the treatment of women veterans and to proactively conduct research and health studies as appropriate, periodically review its women's health programs, and seek innovative methods to address women's barriers to VA health care and services, thereby better ensuring women veterans receive the treatment and specialized services they rightly earned through military service to America.

Likewise, for many years, the organizations that make up the *Independent Budget*, (IB) AMVETS, DAV, Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars of the United States (VFW), have included a special section in the IB emphasizing women veterans, in an effort to call attention to the need to address many of the challenges VA faces in providing high quality health services to women veterans in a predominantly male-oriented health care system. We are pleased to see that many of the recommendations made in this section of the fiscal year 2010 IB have been addressed by VA in a recent ground-breaking publication—*Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans* (Report), published in November 2008 but released only very recently. Additionally, DAV included a special focus on women veterans as part of our ongoing *Stand Up For Veterans* campaign—focusing public attention on the unique needs of women veterans—with a special emphasis on women who became disabled during their wartime service.

VA's 2008 Report[1] reflects the most pressing challenges VA faces: specifically, developing the appropriate health care model for women in a system that is disproportionately male focused, the increasing numbers of women coming to VA for care, the impact of changing demographics in the women veteran population, and impact on VA health care delivery as well as the already-identified gender disparities in quality of care for women veterans.

Women veterans are the fastest growing segment of the veteran population—and according to the Veterans Health Administration (VHA), women are projected to account for one in every seven enrollees within the next fifteen years, compared to the one in every sixteen enrollees today. Because of the large and growing number of women serving in the military today, the percentage of women veterans is projected to rise proportionately from 7.7 percent of the total veteran population in 2008, to 10 percent in 2018. Additionally, VA notes that women who served in Operations Iraqi and Enduring Freedom (OIF/OEF) utilize VA services at a higher rate than other veterans, including other women veterans and male OIF/OEF veterans —with 42.5 percent of the 102,000 OIF/OEF women veterans having enrolled in VA, and nearly 43.8 percent who are consuming between two and ten VHA visits per year on average. Earlier generations of women veterans enrolled in VA health care at a 15 percent average rate.[2]

As reported by VA, historically, women have underutilized VA health in comparison to male veterans. In the past five years, on average, 22 percent of men versus 15 percent of women have accessed VA health care. Women veterans using VA health care are also younger—with an average age of 48 compared to male veterans' average age of 61. Among women users from OIF/OEF, more than 85 percent are under age 40 and of child-bearing age, and nearly 60 percent are between the ages of 20-29.[3] In addition, women veterans have been shown to have unique and more complex health needs with a higher rate of comorbid physical health and mental health conditions, *i.e.,* 31 percent of women have such comorbidities versus 24 percent of men. Even with this high rate of comorbidity, women veterans receive their primary and mental health care in a fragmented model of VA health care delivery that complicates continuity of care. In fact, according to the VHA Plan of Care Survey for fiscal year 2007, 67 percent of sites provide primary care in a multi-site/multi-provider model (*i.e.,* with primary care at one visit and gender-specific primary care at another visit), with only 33 percent of facilities offering care to women in a one-visit model. The Under Secretary's workgroup concluded given these facts that there are now sufficient numbers of women veterans to support coordinated models of service delivery to meet their needs, and that while women will always comprise a minority of veterans in the VA system, they represent a critical mass as a group and should therefore be factored into plans for focused service delivery and improved quality of care.

As indicated above, we have read with great interest a recently released VA publication titled: *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans,* dated November 2008. We are impressed with the thoroughness of the review

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[1] US Dept of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*. Washington, DC: November 2008.

[2] Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 1. June 2009. www.amsus.org/sm/presentations/Jun09-B.**ppt**

[3] Ibid.

of women's care in VHA, and also with the optimism of its recommendations to improve women's health. If implemented nationally its recommendations could assure that women veterans receive coordinated, comprehensive, primary care at every VA facility from clinical providers who are trained to meet their needs; an integration of women's mental health with primary care in each clinic treating women veterans; the promotion of innovation in women's health delivery; enhanced capabilities of all staff interacting with women veterans in VA health care facilities; and an achievement of gender equity in the provision of clinical care within VA facilities.

As directed by the VA Under Secretary for Health, the workgroup was charged with defining the actions necessary to ensure that every woman veteran has access to a VA primary care provider who can meet *all* her primary care needs. The workgroup reviewed the current organizational structure of VHA's women's health care delivery system, addressed impediments to delivering their care in VHA, identified current and projected future needs, and proposed a series of recommendations and actions for the most appropriate organizational initiatives to achieve the Under Secretary's goals.

CURRENT CHALLENGES

VA noted in its Report that only recently had it begun to address development of the most appropriate health care services for women veterans at each VA facility. The workgroup identified seven challenges that VA must overcome in order to deliver quality, comprehensive primary care to women veterans.

Challenge 1: VA recognizes that women have been under-served in the veterans health care system. Utilization rates for men have held at approximately 22 percent for many years—while utilization rates for women range between 11-19 percent. Research shows that women veterans do not self-identify as *bona fide* veterans, and are more unlikely to be unaware of their enrollment eligibility. Of special note to DAV—and greatest concern is that among women veterans in this study who had not had access to health care in the past 12 months, 18.7 percent of this group is service-connected for disability incurred in the line of duty.[4] This finding—that service-connected women veterans are without access to health care, are not enrolled in nor using VHA services—is especially distressing to DAV.

Challenge 2: VA acknowledged there is a clear and growing need for improved service delivery to women veterans in VHA. Given the significantly higher VA utilization rates among women returning from OIF/OEF as indicated above, VA expects the number of women veterans coming to VA for care will likely double within the next four years. The workgroup noted there are now sufficient numbers of women to justify a VA effort to produce coordinated models of service delivery to meet their needs—and that as a group women veterans should be factored in as a special population cohort in any new strategic plans for service delivery.[5]

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[4] Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 15. June 2009. www.amsus.org/sm/presentations/Jun09-B.**ppt**

[5] Ibid.

Challenge 3: In recent years, VA reports have shown a significant demographic shift related to women VA-users and notes the impact of age-related health concerns. Given the fact that almost all new users of the system are under age 40—and of child-bearing age—there is a need for a focused shift in the provision of health care services. The Under Secretary's workgroup also noted VA must continue to be sensitive to the needs of older women veterans as well, since women over 55 years of age face high risks for cardiac disease, cancers and the consequences of obesity (such as Type 2 diabetes).

Challenge 4: The workgroup identified and acknowledged gender disparities in quality of care in VHA. Despite positive results on gender-specific measures such as screening for cervical and breast cancer, significant differences are recorded in VHA performance scores between men and women on certain outpatient quality measures that are common to both men and women. Specifically, depression and PTSD screening, colorectal cancer screening and vaccinations were reported as less favorable for women.

Challenge 5: The workgroup identified routine fragmentation of health care delivery to women veterans that poses possible negative health outcomes. According to the report, to a large extent, health care services offered to women veterans have evolved in a patchwork fashion. Some facilities have strong champions with expertise in women's health and offer comprehensive services in one location; other facilities, however, require women to see several providers for basic primary care services, and some VA facilities rely heavily on fee-basis providers to care for enrolled women veterans.

Challenge 6: One of the most significant challenges VHA faces according to this workgroup report is an insufficient number of clinicians with specific training and experience in women's health. The report acknowledges that the historical predominance of male veterans in the VA setting has resulted in many providers lacking or having limited exposure to women patients.[6] According to the workgroup, women veterans' numerical minority in VHA has created logistical challenges in creating and sustaining delivery systems that assure VA's goal of equitable access to high quality comprehensive services that include gender-specific care.

Challenge7: Finally, the workgroup identified that there is inconsistent policy in place for women's health in VHA. The group noted that, in previous directives issued by VA Central Office, VA clinical staff were *required* to provide gender-specific care on-site in VA facilities, but, that more recent versions of the directives shifted the emphasis to "preferred" rather than "required." As a result, a decline in on-site gynecological services occurred with an increase in fee-basis referral for those key women's health care services. The workgroup noted that in contrast, gender-related care always has been recognized as an integral part of primary care delivery for men in VA health care.

To aid in the implementation of comprehensive health care for women veterans at every VA facility, the Women Veterans Health Strategic Health Care Group developed a Women's

[6] Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 16. June 2009. www.amsus.org/sm/presentations/Jun09-B.**ppt**

Comprehensive Health Implementation Planning (WCHIP) tool. The tool, which outlines a care gap analysis, market analysis and needs assessment, was designed to help VA facilities and VISNs assess and make decisions about which services need to be developed and what resources were necessary to carry out those plans. The stated goal was to then have Women Veterans Program Managers (WVPM) work directly with strategic planners at their VA facilities to incorporate the results of the WCHIP into the health care planning model for those facilities. We are pleased the WVPM position was made full time in July 2008, since these managers are clearly integral to providing increased outreach to women veterans, improving quality of care and developing best practices in the delivery of care to women veterans throughout the VA health care system.

WORKGROUP REPORT RECOMMENDATIONS

The workgroup made a series of key recommendations with accompanying action items, as follows:

Recommendation 1 focuses on the delivery of coordinated, comprehensive primary women's health care at all VA facilities, including the development of systems and structures for care delivery that ensure every woman veteran has access to a qualified primary care physician who can provide care for acute and chronic illnesses, gender specific care, and preventative and mental health services.

Actions items necessary to achieve this goal include using the WCHIP tool to provide an assessment of the current status of care delivery and resources at each facility; identify steps needed to achieve coordinated comprehensive primary women's health care and implement a practice plan for each facility and women's population in a particular catchment area; provide appropriate funding to build adequate infrastructure and program capacity; increase utilization rates for women and provide staff and resources to conduct outreach and education to women veterans; collect, analyze and report on data related to access, staffing flexibility, and cost to carry out plan; and, coordinate with VA academic affiliates for delivery of comprehensive primary care services to women.

The workgroup noted that current research evidence, clinical data and the adoption of models of patient-centered care support the advancement of comprehensive primary women's health care and are further supported by existing policies in VHA Handbook 1330.1 and Standards of Primary Care Directive 2006-031. These directives state that primary care includes gender-specific care services.

Recommendation 2 seeks to ensure integration of women's mental health care as a part of primary care. The workgroup identified that women veterans using the VA health care system carry a heavy burden of mental illness diagnosis—with depression being the most frequent condition in women seeking care in 2007. PTSD was the fourth most frequent diagnosis reported, above diabetes and hypertension.[7] The workgroup concluded the adoption of the

[7] US Dept of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, Page 52. Washington, DC: November 2008.

combined provision of primary and mental health care services would help women veterans overcome barriers to access needed mental health care.

Action items for Recommendation 2 include: assignment of mental health providers in primary care clinics who can provide assessment and psychosocial treatment for a variety of mental health problems, including depression and problem drinking with associated sexual behavior risk factors; facilitating collaboration of behavioral health with primary care to provide ancillary services such as pain management, weight management, and smoking cessation programs designed to meet the needs of women veterans.

Recommendation 3 focuses on promoting new ways of providing care delivery for women through support of best practices fitted to a particular facility or VISN configuration and the women veteran population in that location or region. The workgroup opined that individual VA facilities are best positioned to develop innovative programs to meet the needs of women veterans, especially sub-populations of minority groups and women veterans from rural areas. We concur with VA that best practices can help address variation in geographic and demographic challenges across the system, and that innovative technologies should be utilized to enhance delivery of care for this population.

Action items to achieve this goal include: sharing best practice models for comprehensive women's health care through an improved web portal, conferences and other appropriate information transfer methods; developing requests for proposals from VA field facilities for pilot project initiatives using new technology; collaboration between the Offices of Care Coordination and Information to explore new opportunities in telehealth, inclusive of women veterans; recognize and promote local achievements in creating environments of care that support privacy, safety and comfort for women veterans who seek VA care.

Recognizing that VHA has a longstanding history and focus on male patients, *Recommendation 4* addresses the need to cultivate and enhance the capabilities of *all* VHA staff—including medical providers, clinical support, non-clinical, and administrative staff, to meet the comprehensive health care needs of women veterans. The workgroup acknowledged that despite increasing numbers of women enrolling for VA care, women users of the system continue to be relatively "invisible." We fully concur that a paradigm shift is necessary and that a coordinated training and cultural sensitivity program will be essential to creating an atmosphere of equity and welcome for women veterans in VA health care facilities.

According to the workgroup, many VA clinical providers have acquired skills during health professions internships or residencies but have subsequently lost those proficiencies in their intervening years working in VA facilities therefore, a concerted effort must be made to cultivate and enhance the capabilities of all VA staff to meet the needs of women veterans. Action items to achieve this goal include: recruitment and training of practitioners to be proficient, knowledgeable, and engaged providers in women's health; funding mini-residency programs in women's primary care programs for current VA providers; continue to strengthen VA-based women's health fellowships; develop recruitment and retention strategies to increase

the number of trained staff in women's health; train and sensitize all VA staff on issues specific to women's health care.

Recommendation 5 seeks to achieve parity in clinical performance measures and gender equity in clinical quality of care issues by addressing the systemic reasons for the identified disparities in outcomes for women using VA in order to effect change in clinical practice.

Although overall quality of care is high compared to the private sector and despite positive results on gender-specific measures such as screening for cervical and breast cancer, VA acknowledges that clinical quality performance disparities exist in the provision of care to women for certain prevention measures. We are pleased the workgroup states its goal is to be a "national model for women's health care" and challenges VA to stand by its principles of providing the highest quality of care—the best care anywhere—and to ensure gender parity in the delivery of VA health care.

Actions necessary to achieve this goal include: assuring continual measurement of women veterans' health outcomes for gender-specific and gender-neutral care; continuing research that addresses best practice models for delivery of care to women veterans; working closely with the VA Office of Research and Development to better understand the unique health concerns of post-deployed women veterans; developing and implementing a validated tool for routine clinical assessment of sexual activity, risk behaviors, and anticipation of pregnancy.

These recommendations thoroughly address quality, efficiency, access and equity of VA care for women who use VA services. The workgroup found the need to improve all these areas in today's VA health care programs for women veterans, and to better prepare these programs for tomorrow's women veterans. We commend the members of the workgroup who contributed so much to what appears to us to be a comprehensive roadmap that could lead VA to make great strides in improving health programs and services for women veterans.

RESEARCH

Research plays an integral role in developing the most appropriate health care delivery model for women veterans and providing access to high quality health care services.

Over the years, VA researchers have brought to light a number of important facts that, if acted upon, would greatly improve the care that women veterans receive at VA health care facilities. Among these facts, it was shown that access and waiting time scores were better at sites where primary care and gender-specific services were available in a one-stop setting. VA facilities that have established this type of primary care delivery, whether in women's clinics or in general primary care, have better patient satisfaction scores on care coordination for contraception, sexually transmitted disease screening and menopausal management than facilities that separate these services across multiple clinics.

DAV is pleased that VA's Office of Research and Development (ORD) supports a comprehensive women's health research agenda, and VA has intensified its research on women's health in the last decade. The first comprehensive VA women's health research agenda, which

covered biomedical, clinical, rehabilitative and health services research, was directed by ORD in 2004 with the goal of positioning VA as a national leader in women's health research. ORD successfully mapped research priorities based on the needs of women veterans and capitalized on VA's significant and productive research enterprise while using evidence-based data on the health status and health care needs of women veterans to include a systemic literature review on health care research related to women veterans and women in the military. Within ORD, VA's Health Services Research and Development Service (HSR&D) is at the forefront of research focused on understanding and improving the health and health care of women veterans.

ORD currently supports a broad research portfolio that includes: studies on diseases prevalent solely or primarily in women; hormonal effects on diseases in post-menopausal women; PTSD and other post-deployment mental health concerns among women; and, osteoporosis and multiple sclerosis in women. Gender disparities have also been analyzed and highlighted in addition to the disparities in some types of preventative care among spinal cord injured women veterans that include the need of special equipment and body adjustments required to perform care. HSR&D is also currently funding 27 research projects that examine the health and health care of women veterans; the consequences of military sexual trauma and other military traumas; PTSD treatment in women; screening and utilization as well as post deployment access and reintegration issues; utilization; outcomes and quality of care for women veterans related to ambulatory care; chronic mental and physical illness, alcohol misuse, breast cancer and pregnancy outcomes. HSR&D is also in Phase II of a study examining VA's approaches for delivering care to women veterans while another is assessing the implementation and sustainability of VA women's mental health clinics. These studies include OIF/OEF populations.

We look forward to the results of these 27 research projects, and applaud VA for standing in the forefront and leading the way in assuring our women veterans that they will secure the same access to and quality of care that their male counterparts receive in the VA health care system.

SUMMARY

We congratulate the Women Veterans Health Strategic Health Care Group for an extraordinarily forthcoming report and highly relevant series of goal-oriented recommendations and action items. These recommendations are fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women's health, VA's Advisory Committee on Women Veterans, the *Independent Budget*, and DAV. DAV Resolution 238 seeks to ensure high quality comprehensive VA health services for all women veterans, with a special focus on the unique post-deployment needs of women veterans returning from OIF/OEF. DAV's resolution notes that VA needs to undertake a comprehensive review of its women's health programs, and to seek innovative methods to address barriers to care for women veterans to ensure they receive the treatment and specialized services they need and deserve. Therefore, we fully support the recommendations made in the Report and urge their speedy implementation.

We are pleased that VA Secretary Shinseki has testified previously that the delivery of *enhanced* primary care for women veterans is one of VA's top priorities. Likewise, the Women Veterans Health Strategic Health Care Group's commitment to assuring all eligible women veterans will receive gender-specific primary care by proficient and interested primary care providers; privacy, dignity, and sensitivity to gender-specific needs; state-of-the-art health equipment and technology; gender parity in performance measures; and, the right care in the right place and time are all laudable goals. We fully concur with the workgroup's conclusion that "the debt owed to all our veterans and to women in particular demands nothing less than our full attention."

However, making these goals a reality will require VA's building the proper resources and adequate infrastructure and program capacity and developing the internal support necessary at the highest levels to make the changes it says are needed. Without question, this is a significant undertaking by VA and there is a lot of hard work ahead to achieve the goals it has set out for itself, but we are hopeful with the attention, oversight and collaboration of this Committee that VA can achieve implementation of the recommendations in this report.

Mr. Chairman, a number of public events focused on women veterans have been held in recent months. All are essential to the process of change; however, nothing is more important than taking action**.** For these reasons DAV urges the Committee to carefully consider the recommendations outlined in the *Provision of Primary Care to Women Veterans* Report and to support VA's efforts to achieve these reforms.

We would like to point out, Mr. Chairman, that as of March 11, 2009, this landmark report on women veterans was distributed to VA field facilities and to regional network management offices within VHA. However, its transmittal to the field by VA Central Office did not take the form of a VHA directive; nor did it convey any mandatory implementation requirements or accountability on the part of local or regional officials. It was simply transmitted to VA field elements as an informational device, apparently for their discretionary use in planning. We recognize that VA has been making a good faith effort to move forward on its plans for improving women veterans' health services, and it is clear from VA correspondence included at the end of the workgroup report that at multiple levels work is underway to assess and implement principles outlined in the report. However, we note there is no formal expression of policy or directive to fill the gaps that this report identified.

For these reasons we ask the Committee to oversee and seek VA's commitment to issue instructions to all VA health care personnel who will be held accountable for implementation of this comprehensive policy. The implementation phase should include establishing performance measures for facility and network executive staffs, submission of appropriate reports and provision of other oversight to ensure these reforms are implemented and sustained at every VA facility caring for women veterans. Additionally, we ask that Congress ensure VA is provided sufficient resources to accomplish these essential reforms.

As you know, women are a growing population within the ranks of the active, reserve and Guard forces of our Armed Services, and women veterans are streaming into VA health care by the thousands. Soon women veterans will share ranks nearly two million strong and will

constitute one of every seven veterans enrolled in VA health care. Expectations for VA to step up to this challenge are high, and this report by VHA's own workgroup clearly reveals the necessity for VA to make significant changes in the short term to begin better addressing women's needs in the long term. This workgroup report is an excellent beacon to show them the way, but we must have, and seek assurance that its implementation will be faithfully executed.

Mr. Chairman, again we thank you for the opportunity to share our views at this important hearing focused on women veterans—and bridging the gaps in their care. We will appreciate your consideration of our views on this pressing and important matter to America's women veterans. I would be pleased to address your questions, or those of other Committee members.