OPENING STATEMENT OF CHAIRMAN AKAKA
HEARING ON VA HEALTH CARE SERVICES FOR WOMEN VETERANS
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TUESDAY, JULY 14, 2009
United States Senate,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to notice, at 9:33 A.M., in Room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Begich, Burris, and Brown.

OPENING STATEMENT OF CHAIRMAN AKAKA

Chairman Akaka. This hearing of the Senate Veterans' Affairs Committee will come to order.

Aloha and good morning to all of you. Welcome to this important hearing on VA's Health Care Services for Women Veterans. We will be looking at programs already in the works to improve access to and the quality of care and other unique issues facing women veterans.

Women veterans are the fastest-growing segment of veterans. In 1988, when VA first began providing care to women, they were only 4 percent of the veteran population. Today, the percentage of women veterans is nearing 8 percent and expected to rise substantially over the next two

decades. So, it is appropriate that we ask now "Is VA meeting the needs of women veterans?"

Many women veterans in need of services fall through the cracks because VA does not have a thoroughly gender-focused range of care set up to catch them. There are many obstacles that veterans face. Access to health care and homelessness are two, and many veterans, women veterans in particular, are struggling to get the services they deserve. For too long, the approach to helping veterans avoid obstacles through veteran benefits and services has been predominantly focused on men. Today, the committee will review these issues and how they affect women veterans.

While I applaud VA for the progress it has made in recent years to ramp up services for the rapidly growing number of women veterans, there is much still to be done to bridge the gaps in access to care that women veterans face compared to their male counterparts.

I am pleased that the committee, with the leadership of Senator Murray, recently approved legislation designed to enhance the understanding of women veterans' need for health care and to improve the delivery of that care. I hope to bring this legislation before the full Senate during this work period.

Today's hearing gives us a chance to better understand

the current situation with an eye towards fixing what is not working and expanding what is.

And now I'd like to call on Ranking Member for his opening statement.

OPENING STATEMENT OF SENATOR BURR

Senator Burr. Mr. Chairman, thank you, and I hope you're doing well this morning. Aloha.

Chairman Akaka. Aloha.

Senator Burr. Welcome to our witnesses.

We're here to look at the advocacy of health care services VA provides to the growing number of individuals who have proudly worn the nation's uniform: women veterans. The statistics do not lie. In 1990, there were 1.2 million women veterans. Today, there are 1.8 million, a number that continues to grow. In 1990, women represented 4 percent of the veterans' population. Today, they represent 8 percent. North Carolina is no stranger to this growth.

My own state ranks sixth in the total number of women veterans, with just over 67,000 residing there. Fourteen percent of the active duty force is comprised of women, many of whom have served in combat or war zones. They fly combat aircraft, man missile placements, serve on ships and dangerous waters, drive convoys in areas at risk of ambush.

In short, our military and our country are heavily dependent on the service of women. We must honor their

service by ensuring VA Health care Systems meet their unique needs.

As we move forward to do that, there is one more statistic that I would like to call to the attention of everyone, one that suggests we have some work to do.

According to the VA budget submissions, in 2007, just over 146,000 women veterans used gender-specific health care services at the Veterans Administration.

In 2008, despite the growing number of women veterans that I talked about, there were over 141,000 users of the system declined 3 percent from just 1 year ago.

The question this committee must ask is why? Why do women veterans feel comfortable coming to a hospital system largely comprised of male patients, or do they? Does the VA provide the unique services required by women veterans? Does it provide these services in enough locations to make travel convenient?

When VA cannot provide quality care, does it use services that already exist in the community that are specific to the needs of women? These are all questions that I am hopeful our panelists will help us find the answers to.

Mr. Chairman, just across the Potomac River stands the Women in Military Service for America Memorial. The memorial serves as the ceremonial entrance of Arlington

National Cemetery. I think its placement at the front gate of American's most hallowed military cemetery is symbolic.

For many years, the service of military women often went overlooked and unheralded. We now know better. As Former Senator Bob Dole said at its dedication 12 years ago, the memorial serves as "a lens through which we can better see and appreciate the dedication and sacrifice of American service women."

I look forward to hearing from our witnesses today, and I hope that this will serve as a lens through which this committee can see where improvements need to be made for women who have served their country and their military.

I thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burr.

Now I'd like to call on Senator Burris for his opening statement.

OPENING STATEMENT OF SENATOR BURRIS

Senator Burris. Thank you very much, Mr. Chairman, Ranking Member Burr.

Unfortunately, members, I am scheduled to preside over the Senate in just a few moments. But, before I go, I would like to recognize the importance of this hearing.

As someone who has fought for the quality and diversity throughout my career, I believe this hearing is long overdue. Too often, the role of women in military has been

misunderstood, the accomplishments, and needs overlooked.

In the VA Health System, women's status as a minority has lead to disjointed, gender-specific care that can be difficult to access and hard to navigate. There is no reason why a woman seeking basic, primary care should have to go to two or three different providers in order to meet their needs.

Women make up the largest-growing segment of the veterans' population, all the more reason for us to move forward, move toward integrated services, including mental health providers that recognize a unique need of women, such as the military sexual trauma.

I commend the work of the VA thus far at addressing these issues. Tremendous progress has been made, but I am concerned that only one-third of the Veterans' health facilities provide for the one-stop shop approach, an approach which shows the highest level of patient satisfaction. All of our female veterans deserve the highest quality of care, and we must work toward that day when every VA facility is fully equipped to address these needs.

And, Mr. Chairman, I recall a presentation on the floor by Senator Kay Bailey Hutchison from Texas about these women who were in the Air Force in World War II, and there are still a few of them that are still around, and what the

trauma was from Senator Hutchison's presentation, and she was trying to get a resolution. I came on that as a cosponsor, but I really want to know just where that is because these women flew those missions.

When the men were fighting the wars, they flew the supply missions on those airplanes, and they paid their way to Texas, and then, when they were discharged, unbelievably, as Senator Hutchison said, they had to pay their way back home. And some of their women are still alive, and after hearing that speech, I told her to put me on that bill as a cosponsor because we have to recognize those women, the same way we recognize the Tuskegee Airmen through their dedicated service to this country.

So I am going to still try to follow-up on that, Mr. Chairman, just what is really happening to that resolution that Senator Hutchison presented to the Senate because we need to recognize those women that are still alive and give respect to those who passed on for their service to this country.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burris.

And now we'll hear from Senator Murray with an opening statement.

OPENING STATEMENT OF SENATOR MURRAY

Senator Murray. Thank you very much, Chairman Akaka

and Senator Burr for holding today's hearing to have a chance to really examine the status of the VA's health care services to women veterans, and I want to thank today's witnesses for all of their hard work to both improve the level of care provided to women veterans and to increase the public awareness of this important issue, as well.

As has been said very well by my colleagues here, since the founding of our nation, women have always played a role in our military, and that role, of course, has changed over time, and, in today's conflicts, women are playing a far different and far greater role. And, while they have historically remained as a very small portion of the veteran population and a small minority at the VA, women veterans now total about 1.8 million, and they make up nearly 8 percent of the total veteran population in the United States.

That percentage, we all know, is expected to increase more than 14 percent by 2033, and the number of women veterans enrolled in the VA System is expected to double in the next 2 to 4 years. That makes female veterans one of the fastest growing demographics of the veterans today, and I think it is really important at this hearing and always that we remember that behind those statistics are real women. These are women who sacrificed for their country, they have borne the burden of battle, and they now deserve

the respect and the benefits that their service has earned.

Earlier this year, as has been referenced, the committee passed my bill, the Women Veterans Health Care Improvements Act of 2009. More recently, the full House has passed similar legislation, and I think this is very important progress. I hope we can pass this out of the Senate soon because that bill will encourage women to get access at the VA and increase the VA's understanding of the needs of women veterans and really the practices that helped them get the best kind of care.

But we cannot stop there and we are not stopping there, and I know that the VA is recognizing the need to improve services to women veterans and are taking steps to ensure equal access to benefits and health care for them.

So, I look forward to today's hearing for the steps the VA is taking and what else we need to be doing to achieve that goal.

I would say to Senator Burris, I believe that the bill that Senator Hutchison was talking about was a Congressional Gold Medal that has been sent to committee, but I appreciate you bringing that up, and hope that that can move forward.

Senator Burris. Mr. Chairman, my staff said the resolution was approved, but we need to get the gold medal part for the women. So, that is what is pending. That is correct, for the record.

Thank you very much, Senator, because we must do that.

Chairman Akaka. Thank you very much, Senator Murray.

I want to welcome our principal witness from VA, Dr. Patricia Hayes, Chief Consultant of the Women Veterans Health Strategic Health Care Group. She is accompanied by Dr. Irene Trowell-Harris, Director of the VA Center for Woman Veterans.

Following Dr. Hayes, we have GAO's Director of Health Care Issues, Mr. Randall Williamson.

Thank you, all, for being here this morning. Both VA and GAO's full testimony will appear in the record.

Before I call on Dr. Hayes for her testimony, may I call on Senator Brown for an opening statement?

OPENING STATEMENT OF SENATOR BROWN

Senator Brown. Yes. Thank you, Mr. Chairman. I appreciate that. I appreciate the work that Senator Murray has done in the Women Veterans Health Care Improvement Act of 2009, and thank you, Mr. Chairman, for holding this meeting.

I wanted to mentioned briefly, we know what the issue is, we know how important it is that there be more parity, if that is the right word, more equality in everything from the big VA Centers to the CBOCs to veterans' health care generally, but I wanted to tell a real quick story.

A woman by the name of Loretta Schimmoler of Crawford

County, Ohio, a rural county halfway between Columbus and Cleveland, was one of the first woman to be inducted in the Ohio Veterans Hall of Fame, helped to lead the way in what was to become the Flight Nurses Corps. Her story mirrors in many ways what women have faced in with the military dealing with VA care.

She was a dedicated patriot, intent on making our nation and our military better. Despite the hurdles she faced, she was able to change the way our military did business to the betterment of all those who served. She began the flight in 1932 for her service. And, at that time, nurses, of course, were almost exclusively women, and would serve on planes and helicopters that provided care and evacuation to wounded service members. It was not until World War II that the program became a reality, due in large part to her persistence and her vision.

The VA of her day, of Loretta Schimmoler's day, looked a lot different from the Department of Veterans Affairs today in meeting the needs of our women veterans, but much more needs to be done.

This hearing is a major step in doing that.

I thank the Chairman and thank Senator Murray for her work.

Chairman Akaka. Thank you very much, Senator Brown.

Again, let me then call on Dr. Hayes and ask for your

testimony.

STATEMENT OF PATRICIA HAYES, M.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP

Dr. Hayes. Good morning, Mr. Chairman and Ranking Member. Thank you very much for the opportunity to discuss how VA has provided and will continue to improve the health care for women veterans.

As you mentioned, I am accompanied by Dr. Trowel-Harris, the Director of the Center for Women Veterans. And thank you for submitting my written testimony into the record.

I also want to thank you, Mr. Akaka and Senator Murray, specifically again for your interest in working with VA to ensure that the quality of care for women veterans is improved and that they do get what they deserve for the service to their country.

The VA Secretary Shinseki has recently testified before this committee that enhancing the primary care for women veterans is one of VA's top priorities. Women who were deployed and served in the recent conflicts in Afghanistan and Iraq are enrolling in VA at record numbers.

Of all the women veterans who are deployed and served in Afghanistan or Iraq, VA knows that 44 percent have enrolled in VA Health Care, which suggests that many of these newly-enrolled women veterans really rely on VA for

their health care needs.

Women veterans are entering VA's Health Care System younger, and they have health care needs distinct from their male counterparts. The average age of women veterans is 48-years-old compared to 61-years-old among men. Nearly all newly-enrolled women veterans are under age 40 and they are of childbearing age. This obviously means a trend that will create a shift in how we provide the care.

This shift will move primary care and gender-specific care needs of women veterans from the multi-visit, multi-provider model that has been mentioned here, which does not achieve the continuity of care that we desire, to a more comprehensive, primary care delivery model. VA recognizes many current challenges and has initiated new programs, including the implementation of comprehensive primary care, enhancing the health care environment for women veterans, creating a mini residency education program among women's health, staffing every VA Medical Center with a women veteran's program manager, and improving communication and outreach to women veterans.

Most importantly, VA is implementing an innovative approach to women's health care that will address the concerns about fragmented care, quality disparities, lack of provider of proficiency in women's health, by fundamentally changing the experience for women veterans in VA.

To achieve the goal of providing comprehensive primary care, we have designed three models to promote the delivery of optimal primary care, and we recognize that more than one model might be needed, even within various facilities in order to meet the needs to deliver comprehensive care to women veterans.

All three models ensure that every women veteran, wherever she comes to VA, has access to a VA primary care provider who is capable of meeting all of her primary care needs in the one-stop shop model that we have described. A site-level evaluation will also begin so that we can be certain that this program is effective, and we are going to start that in FY10.

All women veterans need to feel welcomed in their VA setting. The health care environment directly and indirectly affects the quality of the care that is provided to women veterans, and a part of redefining our comprehensive care to be delivered means that we have to have improvements in the health care environment which are being made in order to support dignity, privacy, and sense of security.

VA recognizes many primary care providers need to update their women-specific, clinical experience. VA is offering many residencies in women's health across the country. Early results from this program indicate success

in increasing competencies in 12 areas of women's health care.

As of June 2009, 216 participants from 90 VA Medical Centers in 28 community-based outpatient clinics have completed the program. In order to ensure improved advocacy at the facility level, VA has mandated that all medical centers appoint a full-time Women Veteran Program manager. These managers support increased outreach to women veterans, improve the quality of care, and develop best practices in the organizational delivery of women's health care.

Effective internal and external communication is also important in terms of outreach and our success of implementing comprehensive care. VA Center for Women Veterans will continue to expand its ongoing outreach and communications plan to ensure not only public awareness of women veterans' service to our country, but making sure that women veterans are aware of their eligibilities and access to VA health care.

Mr. Chairman, VA's commitment to women veterans is unwavering, and while significant efforts are underway, we know that we have to do a lot more to improve the care. A lot more needs to be done. We stand at a really unique moment in time where our actions and plans today will build this system that will provide equal care for all of American veterans regardless of gender.

Thank you once again for this opportunity to testify, and we now are very prepared to answer any addition questions that you may have of us.

[The prepared statement of Dr. Hayes follows:]

Chairman Akaka. Thank you very much, Dr. Hayes.
Mr. Williamson, we will now begin with your testimony.

STATEMENT OF RANDALL WILLIAMSON, DIRECTOR OF HEALTH CARE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. Williamson. Good morning, Mr. Chairman and members of the committee. I am pleased to be here today as the committee considers issues related to VA's health delivery of service to the women veterans.

VA provided health services to over 281,000 women veterans in fiscal year 2008, an increase of 12 percent in just 2 years. Looking ahead, VA estimates that, while a total number of veterans will decline by 37 percent by the year 2033, the number of women veterans will increase by more than 17 percent over that period, thereby putting greater demands on VA's Health Care System to meet the physical and mental health care needs of women veterans.

Women veterans seeking care at VA Medical Facilities need access to a full range of physical health care services, including basic, gender-specific services, such as cervical cancer screening and clinical breast examinations, specialized, gender-specific services such as obstetric care and treatment of reproductive cancers, and mental health care services, such as care for depression and anxiety.

In addition, women veterans from conflicts in Iraq and Afghanistan present new challenges for VA's Health Care System. These women have experienced a greater exposure to

combat than women participating in previous conflicts. VA data showed that as many as 20 percent of women veterans of Iraq and Afghanistan have been diagnosed with Post-Traumatic Stress Disorder. An alarming number have also experienced sexual trauma while in the military. As a result, many have complex physical and mental health care needs.

In my testimony today, which is based on ongoing work for the committee, I will discuss three aspects based largely on the work we did at 19 VA Medical Facilities.

First, the onsite availability of health care services for women veterans at VA Facilities. Second, the extent to which VA facilities are following VA policies for delivering health care service for women veterans. And, third, some key challenges that VA facilities face in providing women's health care.

Dr. Hayes has outlined a number of steps VA is undertaking to fulfill its commitment to provide high-quality health care services for women veterans. VA has taken some bold steps in this regard. However, much remains to be done in some areas to fully implement the new initiatives.

Regarding the availability of services, we found that basic, gender-specific services, including pelvic and clinic breast examinations, were available onsite at all 9 VAMCs and 8 of the 10 CBOCs we visited. All of the VAMCs that we

visited offered at least some other specialized, gender-specific services, such as treatment for abnormal cervical screening test and breast cancer.

Among the CBOCs, the two largest facilities we visited offered an array of specialized, gender-specific care onsite. The other eight referred women to other VA and non-VA facilities for most of these services. Outpatient mental health care services for women varied widely among the VAMCs and the eight vet centers we visits, but were more limited at some of the CBOCs.

Four CBOCs offered women-only counseling groups, and only the two larger CBOCs offered specific programs for women who had experienced sexual trauma in the military. Also, only two VAMCs offered residential treatment programs for women who experienced sexual trauma. None had dedicated inpatient, psychiatric units for women.

Regarding the extent to which VA facilities are following VA policies for delivering health care services for women veterans, we found that none of the VAMCs and CBOCs we visited was fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied.

For example, many of the outpatient clinics we visited did not have adequate visual and auditory privacy in their check-in areas. Further, the facilities we visited were in

various stages of implementing VA's new initiative to provide comprehensive, primary care for women veterans.

Finally, officials at facilities that we visited identified challenges they face in providing health care services to the increasing numbers of women seeking VA health care. One challenge involves space constraints.

For example, the number, size, and configuration of exam rooms, as well as limited space for women's bathrooms, sometimes made it difficult for facilities to comply with VA's privacy requirements.

Officials also reported challenges in hiring providers with specific training and experience in women's health care issues, including treatment for women veterans with Post-Traumatic Stress Disorder and those who had experienced military sexual trauma.

So, overall, Mr. Chairman, while VA has taken important steps in many areas to improve health care services for women veterans, some areas still require attention.

Mr. Chairman, that concludes my remarks.

[The prepared statement of Mr. Williamson follows:]

Chairman Akaka. Thank you very much, Mr. Williamson.

Dr. Hayes, thank you for your testimony.

VA is poised to make some important changes to how care is delivered to women, but, in fairness, we seem to have a bit of a disconnect between mandates and what is actually happening. I am going to ask you a series of questions about this.

First, VA has mandated that all VA Medical Centers appoint a full-time, women veterans program manager.

Does every VA Medical Center have one in place?

Dr. Hayes. VA has reported, as you know, that there are 144 out of the 144 sites that have a full-time, women veteran program manager. I am actively now in the process of verifying that.

What we do know is that my office, over the last three months, has held three different trainings. We trained 142 women veteran program managers over the last 3 months, and we think that it is very important to train folks, to take these brand-new folks and make sure that they know what they are doing in terms of this plan to develop health care for women.

Chairman Akaka. Dr. Hayes, hopefully, you have read the testimony of the second panel.

Jennifer Olds details her battle with PTSD and specifically makes a case for cognitive therapy. Congress

passed a law last year requiring that these state-of-the-art therapies be available to all veterans.

I suppose this is something you need to take for the record, but are all veterans with PTSD able to receive this kind of treatment?

Dr. Hayes. You're right, Mr. Akaka, that I will have to take that specifically for the record in terms of the issues about access to PTSD treatment. But I think that one of the things that was pointed out in the GAO report about where there is access, it is very important that we first ask veterans what they need, and that is why it is important to hear from veterans about what their struggles are and to, I think, make sure that we are addressing what that veteran needs in terms of her care.

So, for example, there has been a lot of question about residential treatment, and I think when we look at women veterans, we have to be aware that, for example, women with children are not necessarily interested in going off, leaving their children, and going to a residential site. So that every time we look at we have available, we have to make sure we have available for each veteran what she might need, whether it is intensive outpatient, residential, or these telehealth-telemedicine. Some of our veterans have rated that as very highly successful for them to be in that type of treatment.

So, we will take the question for the record in terms of the exact issue of where PTSD treatment is available, but I think that it needs to be a constant issue of asking the veteran what they need, and that particular issue for this veteran, I think, is very important.

Chairman Akaka. Thank you.

Mr. Williamson, your testimony lays out that none of the facilities reviewed fully implemented VA's policies for women's health care.

Could you determine the reasoning behind this noncompliance? Was it funding, lack of training, or anything else?

Mr. Williamson. Thank you, Mr. Chairman.

It is very difficult sometimes to understand the reason.

The area you referred, for example, in assuring privacy of women veterans, part of it is due to facilities in terms of the layout that currently exists and is trying to convert and modify that. But, also, I think part of it comes down to commitment at the local level.

There is no doubt, I think, that the Secretary, Dr. Hayes, and others at the top are very committed to implementing VA policies and improving overall health care for women, but, as we visited the facilities, simple things that are easy to do like placing exam tables so the foot is

away from the door, putting sanitary products in bathrooms for women, those things are easy, and if they're not being done, part of that reason may come back to is there a commitment at the local level to make sure these policies are done?

Chairman Akaka. Several witnesses on the second panel are quite critical of VA care for women. Let us take these one by one.

DAV is most concerned that some service-connected, women veterans are without access to VA health care. Ms. Williams detailed a lack of understanding on the part of VA providers.

Ms. Christopher found that community care is easier to access than VA care.

And Ms. Chase finds that, generally, VA is playing catch-up to meet the needs of women veterans.

Dr. Hayes, what is at the root of all these issues, and how can we rectify them?

Dr. Hayes. I think that what is at the root of these issues really is at a system that has not been responsive to the needs of women veterans.

I came a year ago and launched an initiative specifically to make VA more inclusive of women veterans, to establish primary care that meets their needs so they do not have to come for multiple visits, to make sure that we reach

out to those who do not have health care.

One of the things that research has shown us over and over again is that women do not know that they have VA services available, but it is not good enough if we reach them, but we do not have the right care when they get in our front door.

And, so, we have a very intensive effort going on, which started, as you saw last year, but is rolling up August 1 with every facility, giving us an implementation plan for how to fix primary care for women veterans, how to make the facilities respond to the environment of care issues, and to develop services going forward that will meet women veterans' needs. And I think that until we do that, until we make sure that it is right, then we begin to reach out to our women veterans and welcome them back. We will have a specific initiative which we identified the need for service-connected, women veterans to get their health care, and that is the first on our list, when we can be assured that there is primary care available for them when they walk in the door.

Chairman Akaka. Thank you.

Senator Burr, your questions?

Senator Burr. Thank you, Mr. Chairman.

Dr. Hayes, I want to give you an opportunity to clarify something for me from a statement.

In your testimony on page 7, you state, "As of June 2009, each of the VA's 144 health care systems has appointed a full-time Women Veterans' Program manager," but I thought I heard you say in the response to Senator Akaka that you were in the process of confirming if you had 144 women veteran program managers. Which one is accurate? Do we have them or are you in the process of verifying that we--

Dr. Hayes. I am personally in the process of verifying, and because I want to make sure that I can tell you what is accurate when we say that we have 144 in place.

Senator Burr. How long does that take?

Dr. Hayes. We have a list out now. For example, there is one site. It is really a question sometimes of are they in place or not. The 144th was--

Senator Burr. But your testimony says, "As of June 2009, each of the VA's 144 health care systems has appointed a full-time Women Veterans' Program manager."

Is that a correct statement or an incorrect statement?

Dr. Hayes. That is a correct statement in terms of appointed a person to be in that job. I think that we want to make sure that that person is full-time and that they are able to do the job. That they have been trained, that they are the person that is in place to do the work that we need them to do to advance this program.

Senator Burr. But what--

Dr. Hayes. Some of them had just been hired--

Senator Burr. This is under an architecture put out by VA leadership that you are going to have 144 individuals and 144 facilities, and I would take for granted that listed in that dictate is permanent, full-time. It spells out exactly what these program managers are going to do.

Dr. Hayes. That is correct.

Senator Burr. So, I guess what I am having difficulty clarifying is if you say they are "in place," but you have to verify they are in place because you want to make sure that they are full-time folks, that they are this, does that mean that you have had individual facility managers who have hired somebody different than what the leaderships dictate was?

Dr. Hayes. No, sir. I do not want to indicate that.

For example, we had sites where a Women Veteran Program manager was half-time, and--

Senator Burr. But is that allowable under--

Dr. Hayes. No, excuse me. I do not mean new, I meant that she was doing half-time, she was performing duties serving women veterans in a clinic setting, and she has been appointed as a full-time person. We want to make sure that veterans have been transferred appropriately to other people so that her full-time can be devoted to the Women Veteran Program manager job.

We are still in a transition phase. I'm making sure that we are fulfilling what we said we're fulfilling, which is making sure those folks are available to do this work for us.

Senator Burr. Okay. You said on page 9, "The VA plans to have gynecologists available at each of the VA's 144 health care systems by 2012."

Why is it 2012 and not 2009?

Dr. Hayes. Maybe I should explain. We have gynecologists onsite in approximately 70. And, again, I do not have an exact number for the record on that. At the other sites, we have gynecology services available largely by-fee basis.

As we developed and the number of women increases, we anticipate that we will need to bring those services in-house, and we want to move towards that by FY12.

Senator Burr. Well, do you agree with the statement that I made that we've actually had a decrease in the number of women seeking gender-specific health care services at the VA from last year to this year?

Dr. Hayes. I do not actually think that we have had a decrease. I think that the way that we were accounting from the numbers for gender-specific health care has changed, and that, in fact, masked some of the gender-specific care. We've changed from having women go just to pap clinics to

having women go to comprehensive primary care clinics, and the cost of that were all rolled into together so that we actually on paper look like we decreased our gender-specific care, when, in fact, we believe that it has increased.

Senator Burr. What percentage of gender-specific care does the VA purchase in the community? Has it increased or decreased?

Dr. Hayes. I do not know the answer to that.

Senator Burr. In your testimony, you mentioned the disparity in quality between male and female veterans in the VA System. You specifically noted the disparity in prevention measures such as colon cancer screening, depression screening, and the immunizations.

What are you doing to address these issues?

Dr. Hayes. We are quite aware that there have been quality differences with women. The quality for performance measures in women has been significantly lower than that for men, and we have data now consistently showing that trend from 2006 forward.

We have launched with the Office of Quality and Performance efforts which are identifying the quality measures at each site. That data was not available to facility directors until very recently, so, we knew there was a national problem, but we did not know exactly how people were doing. So, we have asked the facilities now as

we roll out this data just this last week to address specific areas at their facility where the gender performance scores are lower for women than men, and we are helping them as we develop mechanisms to look at patient factors, provider factors, and system factors.

And, again, it goes back to the issues about are we providing care that women can access in a way that once we say, for example, come back for your fasting lipid test, that that is even possible for that woman to conveniently do. So, we need to look at all of it. We need to look at it at a facility-specific level, and we need to address these gender disparities very actively, and we are doing that.

Senator Burr. You noted the recently-released report Provisions of Primary Care to Women Veterans, and you point to it as a roadmap for improving service to women veterans. The report's recommendations, I think, have been well-received throughout the veterans' community.

Let me ask you this: Does the VA have a timetable for implementing the report's recommendations?

Dr. Hayes. We have a timetable for the implementing of comprehensive, primary care to women veterans. The first part, the comprehensive plans, are due by the facilities in August, and that is a five-year plan. Not to say they have five years to get it done, but they must have immediate

actions, interim actions, or midterm actions.

Senator Burr. Does that plan encompass all of the recommendations in that report?

Dr. Hayes. That plan does not encompass all the recommendations in the report. There are many recommendations that are still being developed in terms of a timeline.

Senator Burr. Whose responsibility will it be for implementing the recommendations in the report?

Dr. Hayes. It is ultimately the responsibility of the undersecretary for health. The workgroup was set by the undersecretary for health, but I consider the responsibility largely on my shoulders and my office.

Senator Burr. Great. I thank you and thank you, Mr. Chairman.

Chairman Akaka. Thank you, Senator Burr.

Senator Murray?

Senator Murray. Thank you, Mr. Chairman.

Let me follow-up on Senator Burr's question on the report on Provision of Primary Care for Women Veterans.

I thought it was a good report, and it did a good job of detailing some of the most pressing challenges. But it was sent out not mandatory, it was just sent out to the VA Facilities.

If it did not include any mandatory requirements or any

accountability, how do we expect it to be implemented?

Dr. Hayes. There are two factors that actually help us move forward immediately with the recommendations of the report. As I mentioned, there were these mandatory implementation plans, which started in January, and there was a gap analysis that was mandatory and required in March and a resource request that was submitted in May, which was also required.

The other part of the policy though is that we have the policy for Health Care Services for Women Veterans formally known as 1330.01, which has been revised and is now in the concurrence process. That policy handbook, it will be known as 1330.01 when it is finally released. It does detail mandated policy changes, including the one-stop type model for Provision of Women's Health Care and Primary Care. It also continues to mandate the privacy standards and the other environment issues that are required.

Senator Murray. Okay. Well, sometimes when things are sent out, it is informational; they're not implemented, so, I am concerned that there is not any mandatory requirements, but we will continue to follow that.

Dr. Hayes, as you know, the military currently bars women from serving in combat. We all know, however, in today's wars that there is no frontline on the battlefield. We know that women are serving right alongside their male

colleagues and they are engaging in combat with the enemy. But, unfortunately, the new reality of this modern warfare is not well understood here at home, including by some in the VA. This knowledge gap obviously impacts the ability of women veterans to receive health care and disability benefits from the VA.

What are you doing, Dr. Hayes, to ensure that all VA staff, both in the VHA and in the VBA, are aware that women are serving in combat and that they are getting the health care and benefits that they have earned?

Dr. Hayes. We have initiated a number of efforts. In addition to training of providers, we know that that is not enough just to train the providers in terms of women's health. We need to train all of the staff, and we have a staff module, sensitivity module, which is under development in order to get across and make sure that everyone who comes into contact with women veterans appreciates that extensiveness of her service and some of the complex issues that she may face.

As you know and are well aware that many of our women veterans have the effects of combat and are serving--there is not, I do not think, anyone who is serving today who is not under significant stress.

Senator Murray. Right. But we have people who say well, you were not in combat. You are a woman.

Dr. Hayes. I am distressed that those reports have come forward, and we are educating our mental health people and our other staff about the significance of women's service.

Senator Murray. Are you working with the Defense Department to make sure that the experience of women veterans is properly documented in their DD214s?

Dr. Hayes. Dr. Trowell-Harris?

Ms. Trowell-Harris. I serve as an ex-offico on the Defense Advisory Committee on Women in the Services, and the director for that committee also is an ex-officio on the VA Advisory Committee on Women Veterans.

This issue does come up frequently, and we are attempting to educate everybody. I am talking about within DoD and VA, and currently we are exploring an option of working with DoD and VA through the White House Project on, it's called the Interagency Council on Women and Girls. But, in this case, we are looking at women veterans and service members.

We are interested in an outreach communications model to exploring that and that could help educate because the education is not just to women veterans, the women service members--

Senator Murray. But you are talking about outreach in general. I am talking about the problem if women are

finding on their DD214s it's not that combat because nobody wanted to say they are in combat, and they come home and then they cannot get service.

And Mr. Chairman and members of the committee should know that we do have the Defense Bill on the floor right now. I am going to be offering an amendment to make sure that the Defense Department properly notes the combat experience on the DD214s so that when women come home, they are not fighting somebody saying but I was in combat. Well, you can't be.

Ms. Trowell-Harris. Right.

Senator Murray. So, I hope that I get the support of this committee to do that.

Ms. Trowell-Harris. And that issue was raised in a roundtable we had recently, and we were told during that session that the military documents the location and they do not use the word of combat. So, we did take that back to the DACOWITS Committee, and they had somebody who is going to be looking at that.

But this is probably an area where you all could really help us with that though because the documentation needs to be there. That would make it really easy for VA to deal with those particular cases.

Senator Murray. Okay. Well, I plan on offering that. I will have more on the second round, but, for this round, I

hear so often from women veterans that you can provide all the service you want, but I have got to take care of my kids. There is no childcare available.

Are we looking at the issue of making sure women have childcare so that is not the obstacle to them getting the treatment they need?

Dr. Hayes. As you mentioned, we are very much aware that women and men with children and grandparents with children need childcare in order to access VA services. The Secretary has us actively examining the issues, and we also are looking at the opinion of general counsel.

We may need Congress's support on this in terms of authority to provide childcare, but we are actively exploring it with the task force. We do have some pilots--

Senator Murray. You need authority from Congress to be able to provide childcare? Did I hear--

Dr. Hayes. General counsel may advise us. We will have to get back with you on the record because there is concern about the authority to provide childcare by VA.

Senator Murray. Well, do you expect to have that soon?

Dr. Hayes. Yes. Yes, ma'am, we do.

Senator Murray. Okay.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you, Senator Murray.

Senator Begich?

Senator Begich. Thank you, Mr. Chairman. Thank you very much for your testimony.

I apologize I was not here when you gave your verbal testimony, but I have a few questions. I do want to follow-up on several of the questions by the Chairman and the Ranking Member in regards to the Veterans' Program Managers.

I have a friend of mine, Joelle Hall in Alaska, who's a female veteran, two kids, and a husband in the Guard, and has given me kind of a shopping list the minute I told her that you all were coming in front of me. She quickly gave me a list of questions to ask, but before I kind of work down that, this is actually one of them.

And I know there is a lot of discussion of what the 144 is or is not, and I am going to ask you this, then with a timeline.

Can you provide the list of the positions that will be occupied and by who full-time, part-time, and when they will actually be working full-time?

Dr. Hayes. We can provide that for the record.

Senator Begich. And your timetable to do that?

Dr. Hayes. We can provide that very soon to you for the record, yes.

Senator Begich. Okay, I think that will answer the questions that we are all asking around this specifically.

And, in that process, making sure that we know where they are going. In other words, where they are going to be assigned to so that would help us understand the 144 and what they mean and what they are going to be doing.

Also, in regards to the Women's Veteran Program Manager, is there discussion of expanding this requirement to the CBOCs?

Dr. Hayes. We currently require that there be a liaison named at each CBOC, a VA employee who is the liaison to the women's Veteran Program Manager. We are not requiring that the CBOCs. They are facilities that are looking particularly at the very large CBOCs as to whether that would be an appropriate placement, but we do not have a requirement for that at the CBOCs.

Senator Begich. Let me ask you personally. Do you think that it is something that we should strive to do? I mean, it is easy to have a task force and a group, but what do you think? You are running the program.

Dr. Hayes. I think that if the person is full-time at the facility and they are doing their job to involve everyone in taking care of women veterans, then we do not necessarily need one at a CBOC. I think if the person has the ability to go out to that CBOC, to make sure what is going there, and to provide active coordination through other means, telephone and other means with that site.

So, I think if we make that they are able to do their job, that the CBOCs do not necessarily have to have one onsite.

Senator Begich. Okay. Let me ask, and I do not know who would answer this, Dr. Hayes or Dr. Harris. I am not sure which one, Dr. Harris, if you would be. Whichever one.

In regards to the design of the facilities, we know based on some of the other facilities, the design is not there really to take into account women veterans.

What is the process now to expand the facilities for that purpose? And then I have a couple of additional questions. Whoever wants to answer that.

Dr. Hayes. In part of the implementation plan, which, as I said, could expand as long as five years, we have asked facilities to name where they need space, where they need construction monies to be able to fix the situation in terms of women veterans. And, so, they are able to submit those longer-term requests right now.

Also, my office is working with the Office of Construction and Design so that new construction appropriately has designs for women veterans' exam rooms, appropriately has requirements for bathrooms, et cetera, in the new design process.

Senator Begich. In the Office of Construction Design, other than your office, do they actually have clients that

sit down with them on a regular basis reviewing the designs? Do people actually use the facilities?

Dr. Hayes. I do not know. We would have to get back with you. Get back to you on that.

Senator Begich. I would suggest just as a former mayor who dealt with many designs of buildings that the users need to be part of the equation. If they are not, they should be, to be very frank with you, because, no offense to your office and anyone else, but I know construction people, I used to be in the business. They build to facilitate, they work off of budget, and then they are done. I really think it would be highly recommended that you establish your work with the Office of Construction that they have an advisory of actual clients who utilize their facilities currently or have utilized their facilities to give advice on how those should be constructed.

Because, I mean, some of the issues that you brought up, Mr. Williamson, are small, but they are significant. And design is part of it because I can tell you if you do not design the bathroom the right size, those extra items that you want in there are not going to fit. Just if you would take that under at least some advisement, I would appreciate that.

Mr. Williamson. If I may add also--

Senator Begich. Sure.

Mr. Williamson. We have heard the same thing in terms of there needs to be good communication between Dr. Hayes' office and others with the construction people because, again, we are dealing with a cultural change here, and it is really important that the design people and the people who do specifications have incorporated the needs of women veterans in terms of the facilities.

Senator Begich. Well, thank you very much for echoing that. Again, if you could report back to the committee on just kind of what your plans are. I cannot stress enough, I have seen projects turn from good projects to excellent projects because of the client involvement. It does not matter if it is health care facilities or anything, but, in this case, health care.

And I will just end on this one question.

To follow-up on Senator Murray's comments in regards to how do women veterans understand what care is available, you had mentioned or I am not sure who mentioned it, but there were veterans that are not necessarily aware of the benefits.

How big would you say that universe is if you could measure it in volume of people? Is it a few thousand? Is it tens of thousands?

Dr. Hayes. I think it might be on the level of about 1 million women veterans.

Senator Begich. One million women.

Dr. Hayes. We have an active plan now to utilize the VA call centers to reach out to women veterans and advise women veterans about the benefits and the access. Again, that is going to be phased in. We will start with the service-connected women veterans, but we want to make sure that that does not start until at least this fall because we want to make sure the clinics are available.

Senator Begich. Okay.

Dr. Hayes. And we have been told that there may be in the neighborhood of 1.5 million women veterans altogether, including those who use us.

So, there are about 450,000 enrolled women veterans right now. So, there are about 1 million women veterans who have not enrolled in VA. To the extent that they do not know about us, we can only hope that we can reach out and tell them.

Senator Begich. And where do you think they get health care coverage now?

Dr. Hayes. We do not know that.

Senator Begich. Or do they?

Dr. Hayes. We do have a study underway by Dr. Donna Washington, and the results of that study will be available approximately September. She has done research on this for us, a stratified random sample of women, women who use VA,

women who do not use VA, who are veterans, and those who use this and do not come back. And that study is going to help us understand how women veterans who do not use VA access health care.

Senator Begich. Great. If you could share that with us, that would be great.

Mr. Chairman, I apologize for going over, but thank you very much.

Chairman Akaka. Thank you very much, Senator Begich.

I have one remaining question to you, Dr. Hayes.

As part of my oversight responsibility, I learned that some veterans at the Austin, Texas, clinic were inappropriately being charged for services related to military sexual trauma. As you well know, such care is provided at no charge. It is quite difficult for women to seek such care to begin with, let alone to be presented with a bill for such care. One woman told me she found this emotionally draining and an insult to all women who served.

Is it your belief that this situation at Austin is an isolated incident or are veterans nationwide being charged for care for military sexual trauma?

Dr. Hayes. I can only let you know that personally having been in the field for 25 years, I was actually involved in the initial attempts to rollout the eligibility for military sexual trauma for free counseling. It should

not be "free;" it is without-charge counseling for veterans who have undergone such trauma. So, it is personally distressing when I see all these years later that there are veterans who have I think inadvertently been charged, but, nevertheless, been charged for their counseling services.

After the incident in Austin, a mental health group that oversees the Military Sexual Trauma Program not only educated the persons there at Austin in eligibility, but have done a nationwide search and should have a report very soon about any other cases that were uncovered. But we believe it is an isolated type of occurrence.

They have had an effort to retrain the eligibility clerks through some online information that has gone out, but they will have a report as to whether they discovered any other sites where veterans were being charged for these services.

Chairman Akaka. Thank you very much.

Let me call on Senator Murray for any second round questions.

Senator Murray. Thank you, Senator Akaka. And I just have two additional.

One is about homeless, female veterans. The number of women veterans who are ending up homeless has nearly doubled over the last decade. One out of every 10 homeless veterans under the age of 45 is now a woman. Many of these homeless,

female veterans have kids.

According to Pete Dougherty, who is the Director of VA's Homeless Veteran Programs, he said, "While the overall numbers of homeless vets have been going down, the number of women veterans who are homeless is going up."

I have introduced legislation to expand and improve the services and care for homeless, female veterans and their children through the VA Grant and Per Diem Program in the Labor Department's Homeless Veteran's Reintegration Program.

Dr. Hayes, tell me what you think what else we should be doing that we can do currently and are you aware of this challenge that we have?

Dr. Hayes. Yes, I am very aware of the challenge, and I think it is in part an unfortunate side effect of what is going on in terms of the number of new women veterans, but it is a particular challenge I think in a system that we have not done as I think we need to do with screening for the things that underlie the problems of homelessness.

Right before women become homeless, I think, again, they are largely invisible so that we need to do more to screen for risks of homelessness in our primary care setting. We need to do a better job of screening women for substance use, asking women about whether they have enough to get by, and having earlier interventions to avoid the final decline into homelessness.

So, that is what I think that we need to do in our system, and, again, when we organize the primary care better to comprehensively serve women and not just say well, we will take care of your pap smear, we will take care of your mammogram, but we will take care of you as a whole person. Part of our goal is to make sure that we have adequate mental health and social work in our primary care setting for women.

I applaud and thank you for your efforts to put more into the Grant and Per Diem Program. As you know, there have been barriers because of the issues of children and women with children have been the most difficult group to place whether they are veterans or non-veterans, and, so, I think certainly applaud that effort because that is clearly what we need in expanding the services that are available to women.

And I think it is another area where we have to continue to do the education to our homeless outreach workers and our homeless placement folks in areas where we may underserve the women homeless so that they clearly ask a homeless person whether they are a veteran and a homeless women whether she is a veteran to make sure she gets in the VA services.

Senator Murray. Which goes to my last question. When a man tells you they are a veteran, you immediately say yes.

Women do not perceive themselves to be veterans. The general public does not perceive women to be veterans, even if the woman says I served in the military.

How are we going to overcome that sentiment and make the VA and the general public really respect the service of women and for women to perceive themselves as veterans? I mean, may we should not call them "veterans." I do not know. It is just a real problem.

Have you thought about that? Do you have any advice for us? What can we do to change that?

Dr. Hayes. I may turn to Trowell-Harris. A major effort of her office to tackle this problem.

I, myself, believe that the kind of effort that you are putting in to raise the awareness goes very far in helping to identify that women proudly served, and women have always served as volunteers. I think we have to continue to get that message out in the media, in the Internet, any way that we can, and turn to our partners who are here, the veterans who are here to help us with that message.

But Dr. Trowell-Harris' office is dedicated also to this outreach effort.

Ms. Trowell-Harris. We participate in all of the major women's policy groups, the Veteran Service Organizations Convention, minority groups, roundtable hearings, we work with DoD, so, we try to get the education out there, but my

opinion is it is a matter of changing the culture, getting everybody to understand that women are veterans.

So, you may recall that, years ago, the census used to ask women are you a veteran? They would say no. But the census question changed to ask have they ever served in the armed forces? Then women would say yes.

But, still, the education is needed for everybody, as Dr. Hayes, said. The media, the women veterans, VA staff, Congressional members. It takes all of us. And, again, this is one way that you can help us.

We are doing extensive outreach with the State Department of Veterans Affairs. Each State Department of Veterans Affairs does have a female assigned, a designated female to work with women veterans, and we do have conferences and send them tons of educational material. Again, we work with various committees, such as the Homeless Committee, the Minorities Affairs Committee, and the Research Committee. I

I have a report which some of you seen. I had 20 recommendations for women veterans, and, as part of that, the program managers that were part of that committee, getting Dr. Hayes' office raised on the VA organizational chart is one of the recommendations, and that has been done.

So, all of these things we are trying to do to improve the outreach. But, also, working with the Honorable Tammy

Duckworth, who was just employed with VA. She has a major outreach effort, and we are meeting with her staff looking at some creative ways of getting the message out not just to the women veterans, but to everybody.

Senator Murray. I appreciate that. I think we really have to focus on that as communities, as the media, as everybody so that we, as a country, recognize that women who serve in the military are veterans, deserve the benefits that they have earned, and the respect of this country.

Ms. Trowell-Harris. Thank you.

Chairman Akaka. Thank you very much, Senator Murray.

Senator Begich?

Senator Begich. Mr. Chairman, if I can just ask a couple more quick questions. I know I went over time last time.

Can you give me in the sense of making people aware as women who are getting into the military, what kind of relationship does the VA have with the DoD in ensuring that knowledge of what is available specifically for women is available once they become a veteran?

Who could answer that? Just what kind of relationship is there?

Ms. Trowell-Harris. Our Secretary works with the Secretary of Defense, and, also, there is a designated person at DoD that works on benefit issues and also on

health care issues. And I did mention before about being on the DACOWITS Committee.

We do have some printed material that we use at all major conventions, forums for women veterans. We do have open forums. Women do site visits to the field with our advisory committee. So, we're trying multiple ways of getting the word out.

We do have numerous media interviews, also, and we really appreciate those because they help us get the word out to the veterans nationally.

Senator Begich. And recruitment centers? Same thing, information available at the recruitment centers?

Ms. Trowell-Harris. You mean military?

Senator Begich. Yes.

Ms. Trowell-Harris. I am not sure about that. We can get back to you on that.

Senator Begich. I mean, when the doors open, that is the first opportunity to educate on what the benefits are on the back-end. So, if you could let me know on how when the recruitment centers are operating and people are doing the recruitment, what is there also? Is there any special effort, especially for women on what is available and what could be available to them?

So, if whoever could do that, that would be great.

Ms. Trowell-Harris. Sure. Right. Right, we will get

back to you on that.

Senator Begich. And I guess whoever would be, again, the right person to answer this.

From a funding level, and I started to ask this question on the facilities and you talked about the construction facilities, is there enough resources for what you need in some of the leasing of the space that is occurring as well as future construction of what will be necessary to expand these facilities to meet the women veterans' needs? And, if not, is that part of the five-year plan or tell me how that all works.

Dr. Hayes. We have been working very closely with the Office of Budget and with the Secretary's Office to help define the resource needs for this infusion of infrastructure, and we understand the support of the Secretary that VA will have the resources needed to enhance the care to women veterans.

Senator Begich. That is good. Very good.

And at what point will you have kind of the strategic plan of expansion of facilities that this committee could at least see at some point? In other words, that would kind of show here is our game plan for the next five or so many years on where highest priority based on demand, based on facility structure, and so forth?

Dr. Hayes. Okay, that will not be my office

specifically, although, the plans are coming back through the VISN level office and the Offices of Construction, but we can get back to you regarding the Secretary's response on how the Secretary's office would see these priorities.

Senator Begich. That would be great. And that is just so I can get a sense of kind of where and kind of in preparation. I know when I sat on the Armed Services Committee, we sometimes focused just on the year. The problem with that is that year will have ramifications for the next following years.

Dr. Hayes. Yes.

Senator Begich. And it just kind of helps. And I know there is a big commitment from the president in regards to dollars for the Veterans Administration, which is great. I just want to make sure we are in the right tow here.

Dr. Hayes. I also want to clarify, a lot of the issues, as Mr. Williamson said, are really issues of being able to put some renovation costs and not would be on the priority list for construction, but rather needing the ability to plan and put together a space that would really be renovation costs and local costs.

Senator Begich. If I can add, so, will the renovation costs then not be in the long-term capital improvement?

Dr. Hayes. Oh, no, I did not mean to confuse that.

Senator Begich. Oh, okay.

Dr. Hayes. I am just telling you that the process in one in which we are looking at both short-terms in terms of some renovation where places are putting in new projects. That is already part of other processes that you would be aware of.

Senator Begich. Okay. Very good.

Mr. Chairman, I am going to end there. I do have some additional questions, but I know I exceeded my time the last time, and I have a feeling I have about 30 seconds left I'll burn up that very quickly, so, let me end there.

Thank you.

Chairman Akaka. Thank you very much, Senator Begich.

I want to thank the first panel for your testimony and your responses.

As we know, we are facing a huge surge of an issue here that has been important to our country, and some of the problems that have been noted. We want to work together as closely as we can to move it and provide the health care services that our women veterans expect and will have.

So, we look forward to working with you. Thank you very much.

Ms. Trowell-Harris. Thank you.

Dr. Hayes. Thank you.

Chairman Akaka. I welcome now a second panel this morning. Members of this panel are five women veterans,

each working in the field of advocacy in its various forms.

First, I welcome Joy Ilem, Deputy National Legislative Director for Disabled American Veterans.

Next, we have Tia Christopher, who is an Iraq Veteran Project Program Associate and Women Veteran Coordinator for Swords to Plowshares.

Next, welcome to Genevieve Chase, Executive Director for American Women Veterans.

We will hear testimony also from Kayla Williams, a Veteran of the U.S. Army.

And, finally, we have Jennifer Olds, also a U.S. Army Veteran. I am grateful to VFW for making it possible for Ms. Olds to join us today.

Ms. Ilem, we will begin with you and then move down the table in order.

Ms. Ilem?

STATEMENT OF JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. Ilem. Thank you, Mr. Chairman and Ranking Member Burr. Thank you for inviting the Disabled American Veterans to participate in this timely hearing on women veterans.

The changing roles of women in the military, increasing numbers of women coming to VA for care, and the impact of war on women's health present a number of new challenges for VA in meeting the unique needs of women veterans today.

Ensuring equal access to benefits and high-quality health care services for women veterans is a top priority for DAV. We have a longstanding resolution that calls for review of VA's Health Program for Women to ensure they have access to the same high-quality health care and specialized services that male veterans receive.

It is apparent from the recently-released report of the VA Undersecretary for Health Workgroup on Women Veterans that VA is aware of the shortcomings in its Women's Health Program and making a concerted effort to systematically address the significant challenges it faces to bring care provided to women veterans on par with male veterans.

The report outlines the most critical challenges VA faces in caring for women veterans, and, more importantly, provides a roadmap for change. Some of the most critical issues identified in the report include significantly

increasing utilization rates of younger women accessing VA care, the systemic fragmentation of primary care delivery for women, too few proficient, knowledgeable providers with expertise in women's health, and a number of identified outpatient quality disparities for women veterans.

Additionally, VA researchers report a number of access barriers for women veterans, including lack of childcare services, privacy, safety, and comfort concerns, and unique post-deployment mental health reintegration issues for newly-discharged women veterans who have served in Operations Iraqi and Enduring Freedom.

The workgroup states its primary objective is to ensure every women veteran has access to a qualified health care provider who can deliver coordinated, comprehensive, primary, women's health care inclusive of gender-specific care, preventive, and mental health services.

It plans to achieve these goals through a number of key policy recommendations to reform and enhance women's health delivery in VA. These recommendations thoroughly address quality, efficiency, access, and equity of care for women who use VA services.

And we congratulate the Women Veterans Health Strategic Health Care Group for an extraordinarily forthcoming report in a highly-detailed series of goal-orientated recommendations an 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 health, VA's Advisory Committee on Women Veterans, and the independent budget.

If implemented, these reforms will change the face of health care delivery for women veterans in the VA health care system, and, in turn, improve the health of women veterans.

Without question, VA has a lot of hard work ahead to achieve these goals it has set out for itself, but we are hopeful with the attention, oversight, and collaboration of this committee, that an implementation plan can be expeditiously carried out.

A number of events focused on women veterans have been held in recent months and all are essential to 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 report on women's health and to support VA's efforts for change.

Although this groundbreaking report represents progress, we question if the Women's Health Program directors have the resources to build adequate infrastructure and program capacity and the internal support necessary at the very highest levels to make the reforms it

says are necessary.

One final concern we bring to the committee's attention, although it appears VA has been making a good faith effort to move forward on its plans for improving women's health care services and implement the principles outlined in the report, it does not appear VA has issued a formal policy or directive to the field to address the gaps identified in the report. Therefore, we seek assurance from VA that its implementation will be, in fact, faithfully executed.

Mr. Chairman, again, we thank you and other members of the committee for your leadership and continued support on women veteran's issues, and we appreciate the opportunity to participate in this important hearing.

Thank you.

[The prepared statement of Ms. Ilem follows:]

Chairman Akaka. Thank you very much for your testimony. I want you to know that your prepared remarks will be, of course, made part of the hearing record.

So, now, let me call on Ms. Christopher.

STATEMENT OF TIA CHRISTOPHER, IRAQ VETERAN PROJECT PROGRAM ASSOCIATE, WOMEN VETERAN COORDINATOR FOR SWORDS TO PLOWSHARES.

Ms. Christopher. Thank you, Mr. Chairman and members of the committee for allowing me to speak.

My name is Tia Christopher. I'm a U.S. Navy Veteran, and Woman Veteran's Coordinator for the Veteran non-profit Swords to Plowshares. I speak before you today both in my professional capacity and from my personal experience as a woman veteran.

I am 70 percent VA-rated disabled veteran for PTSD and military sexual trauma. My experiences have given me the passion and perseverance to do advocacy work on behalf of Swords to Plowshares. I mention this to illustrate that I am VA consumer, as well as a community avenue for my peers to seek and access care.

The VA has made notable strides in the care of our nation's women veterans. I would not be the person I am today without the young, woman veteran PTSD groups established at some VA Medical Centers.

Even as we acknowledge the amazing strides that have been made, it must be noted that services and support for women remain insufficient both in quality and accessibility. More women are serving in the military than ever before. No one entity should be expected to provide the breadth of

services and support needed for female veterans. There needs to be a coordination and collaboration between the DoD, VA, and community providers in order to delivery adequate care.

Community providers, such as Swords to Plowshares, are on the frontlines everyday serving veterans from all our nation's conflicts. Because of the historical lack of gender-appropriate services, it is critical that no door be the wrong door to accessing care.

Resources are stretched. We all know that, both for the government and non-profits. Women veterans may seek assistance in the community, which do not address their underlying health issues, but address their pragmatic needs in the moment.

For example, I had a young woman Air Force veteran come in initially asking for help finding a job, but, at the end of our conversation, it became evident she was homeless. This young women who honorably served her country divulged that she was now selling her body just to get by. It broke my heart that this sister veteran of mine had been reduced to this.

Because of the specific employment and training services that Swords provides and the fact that she was able to speak with a fellow female veteran, she felt comfortable asking for help. In this case, she needed mental health

attention, as well. Services need to reflect the myriad, co-occurring issues surrounding our female veterans and care providers need to be versed in how to appropriately and comprehensively address these issues.

This veteran is not unique in her experience. Female veterans frequently access community care rather than VA care, which is often times less of a hurdle to navigate, as well as less intimidating. Swords to Plowshares conducted focus groups of female veterans in San Francisco, during which many participants noted barriers to VA services.

One stated, "If you do have benefits available through the VA, you have to be very persistent, you have to want to get your benefits, and you have to fight for them. If the benefits are there, you're entitled to them, and you just have to find the right person in the office that's going to help you fight for them."

Women need not only more gender-specific care, but also care that is appropriate for their needs. The gender of a mental health provider does not necessarily qualify them to treat that woman veteran. It is essential that women who do need inpatient treatment for PTSD, whether combat or sexual assault-related receive care in a safe treatment space. A co-ed environment can truly be the worst thing for a woman suffering from military sexual trauma and PTSD. We need more woman-veteran-only inpatient VA programs.

Just having the resources is not enough. Again, the quality, quantity, and accessibility of that care is vital. For those who are uncomfortable receiving treatment at a VA facility for whatever reason, funding needs to be allotted for culturally-competent care within the community.

Both government and community entities need to be educated on the specific needs of women veterans. I regularly speak during the community panel portion of the National Center for PTSD's Clinical Training Program. Sharing my story and experience navigating the VA System and receiving treatment has helped these clinicians better understand their patients.

The Iraq Veteran Project to Swords to Plowshares is primarily composed of staff who are veterans. We provide foundation-funded, free panel representations for VA clinicians at community behavioral health providers on issues such as prevalence of PTSD, TBI, MST, military terminology clarification, triggers, cultural obstacles to care, and effective outreach approaches. This has led to greater dialogue and collaboration among community and government entities treating veterans, as well as help the veterans themselves feel that they are understood by their caregivers.

Thank you very much for your time.

[The prepared statement of Ms. Christopher follows:]

Chairman Akaka. Thank you, Ms. Christopher. Now Ms. Chase.

STATEMENT OF GENEVIEVE CHASE, EXECUTIVE DIRECTOR FOR AMERICAN WOMEN VETERANS

Ms. Chase. Mr. Chairman and members of the subcommittee, thank you for inviting us to testify today.

My name is Genevieve Chase, and I am a Founder and Executive Director of American Women Veterans. On behalf of my peers, I would like to thank you for your commitment and dedication to serving the growing number of women veterans.

I am a veteran of combat operations in Afghanistan. While serving in the Army Reserve, I volunteered for a 32-month, active-duty tour, which included deployment in support of Operation Enduring Freedom.

On April 7, 2006, our vehicle was attacked by a suicide, vehicle-borne, improvised, explosive device. The car that hit our truck nearly disintegrated. Although I suffered minor external injuries, the impact of that explosion has continued to this day, and I now know that we were not adequately informed of the services available to us after our service.

The Reserve soldiers I served with were discharged from active service with a five-minute out-briefing. A single sheet of paper listing Web Sites to access for VA health care and services. What I recall from that time was that being focused on overwhelming issues, like finding a job and figuring out how I was going to make it in a civilian world

that had become somewhat foreign to me, not on service-related health issues I would face in the months to come or how I would seek care for those issues. I was not and am not alone in this.

Weeks after returning home, I began to experience additional symptoms that I now know to be characteristic of Post-Traumatic Stress and Mild Traumatic Brain Injury, such as extreme guilt, anxiety, panic attacks, memory loss, hyperactivity, and bouts of deep depression, in addition to periods of consecutive days where I suffered exhaustion from insomnia and lacked the energy to leave my apartment or speak to anyone.

During the past two years, I have gone to the VA web site repeatedly and called the VA to pursue an assessment and screening for TBI and other related issues. After attempting to navigate through the bureaucracy, I gave up, frustrated by an unclear web site and unfriendly service on the other end of the phone.

I looked to the VA for help when I most needed it, but never succeeded in completing my enrollment, let alone actually receiving the care that I needed. In communicating with other veterans, I have found that I am hardly alone in this, as well.

While the VA struggles to catch up and provide adequate, gender-specific care to previous generations of

women veterans, the total number of women veterans is projected to double in the next 10 years. It is vital that this nation proactively address immediately the broad spectrum of treatment needs for this significant increase in the women veterans' population.

VA resources for women must expand to meet the growing number of combat-experienced women and women dealing with PTS, military sexual trauma, and TBI must be able to find easily-accessible and concise information and guidance about these vital services when needed. Veterans should not need a third party to help them navigate the VA system.

AWV believes that women veterans of all generations are entitled to VA services that include women-only clinics, women providers, holistic care, extended service hours, offsite care, PTSD and MST peer support groups, and the availability of childcare during clinic visits. But even with all of these services, women must know they are eligible, they must be enrolled, and they must have access to the VA.

Despite the VA's efforts and claims of educating and reaching out to today's veterans, the message is not getting through. Even minor changes in the delivery of this message can have a huge impact.

As just one example, women veterans from all eras have expressed to me that they would prefer to receive immediate

e-mail updates on VA benefits and services rather than periodic, automatic mailings, which do not always get forwarded through the postal system. AWV believes the best way to improve access to the VA is for service members to be educated and enrolled into VA services while they are still on active-duty.

Briefings, workshops, and enrollment for VA benefits must be mandatory and should be conducted by knowledgeable representatives from the VA. Reaching out to all veterans prior to their discharge from active-duty would address several issues to include raising awareness and knowledge of eligibility of benefits and care, allowing continuity of care and eligibility from hospital to hospital, and offering immediate availability of physical and mental health care when needed rather than after lengthy and unknown waiting periods.

Veterans getting the care they need when they need it can help prevent a number of extended issues to include extreme depression, which contributes significantly to the risk of homelessness, substance abuse, and suicide.

In closing, our nation's veterans from all eras answer this country's call to service, and the VA has the unique and rapidly-growing challenge of ensuring easily-accessible, quality services for women veterans across the spectrum from childbearing years to well beyond retirement.

On behalf of American women veterans, thank you for working to honor and repay the service of all veterans through this inclusive dialogue, and we thank you for your commitment to ensure the quality and scope of physical and mental health care that today's American women veterans have earned by their service.

Ladies, gentlemen, and Mr. Chairman, I thank you for your time and consideration and welcome your questions.

[The prepared statement of Ms. Chase follows:]

Chairman Akaka. Thank you very much, Ms. Chase. Now we'll hear from Ms. Williams.

STATEMENT OF KAYLA WILLIAMS, U.S. ARMY VETERAN, GRACE AFTER FIRE

Ms. Williams. Mr. Chairman and members of the committee, thank you for hearing me speak today. On behalf of women veterans, I would like to thank you all for your commitment to meeting the changing needs of our nation's veterans.

My name is Kayla Williams. I sit on the Board of Directors of Grace After Fire, a non-profit dedicated to helping women veterans.

As a soldier with the 101st Airborne Division, Air Assault, I took part in the initial invasion of Iraq in 2003, and was there for approximately 1 year. As an Arabic linguist, I went out on combat foot patrols with the infantry in Baghdad.

During the initial invasion, my team came under small arms fire. Later, in Mosul, we were mortared regularly. I served right alongside my male peers. With our flak vests on during missions, we were all truly soldiers first.

However, it became clear upon our return that, as Senator Murray noted, most people do not understand what women in today's military experience. I was asked whether, as a woman, I was even allowed to carry a gun, and I was also asked whether I was in the infantry. This confusion about what role women play in war today extends beyond the

general public. Even VA employees are still sometimes unclear on the nature of modern warfare, which presents challenges for women seeking care.

For example, since women are supposedly barred from combat, they may face challenges proving that their PTSD is service-connected. It is vital that all VA employees, particularly health care providers, full understand that women do see combat in Operations Iraqi Freedom and Enduring Freedom so that they can better serve women veterans.

Many of the other problems that women face when seeking to get health care through the VA are by no means exclusive to women. The transition from DoD to VA remains imperfect, despite efforts to improve the process, lost records and missing paperwork are frequent complaints. Despite a growing number of community clinics and vet centers, many veterans face lengthy travel times to reach a VA facility, which is a particular burden during these tough, economic times. Often, other barriers may disproportionately affect women.

For example, since women are more likely to be the primary care givers of small children, they may require help in getting childcare to attend appointments at the VA. Currently, many VA facilities are not prepared to accommodate the presence of small children. Several friends have described to me having to change babies' diapers on the

floors of VA facilities because the restrooms lacked even the most basic changing tables.

Another friend, whose babysitter canceled at the last minute, brought her infant and toddler to a VA appointment. The provider told her that it was not appropriate, and that if she could not find child care, she should not even bother to come in.

Facilities in which to nurse and change babies, increased availability of telehealth or telemedicine, and/or childcare assistance or at least patience with the presence of small children would ease the burdens on all veterans with small children, especially women.

Women in the military are also far more likely to be married to other service members. These women veterans must worry not only about their own readjustments to civilian life, but also the challenges their husbands may be facing. The VA must consider the dual role that women veterans may be balancing as both givers and seekers of care.

My husband, for example, sustained a penetrating, traumatic brain injury in Iraq, and was medically retired from the military. This impacted my decision not to reenlist because he needed assistance that he simply was not getting. It was years before I realized that, as both a caregiver and a veteran, I needed to not simply suck it up and drive on as the military taught, but rather had to reach

out for help and support.

When struggling to cope with invisible wounds of war, such as PTSD or in simply facing challenges readjusting post-combat, peer support can be vital. However, there are things about women's experiences in war zones that our male peers simply do not understand.

They cannot truly know what it is like to fear not only the enemy, but also sexual assault from your brothers in arms. They may be aware of, but not fully able to empathize with the challenges of facing regular sexual harassment, and they certainly do not understand what it is like to feel invisible as a veteran, as many women veterans do. It is, therefore, vital that the VA provide times and/or places where women veterans, especially those who may have experienced military sexual trauma, can feel safe and comfortable in seeking help in a community of their peers. These are all challenges that I am confident every VA hospital can meet and overcome.

In 2006, I went to the VA Medical Center in Washington, D.C. My visit was uncoordinated, stressful, and confusing. The facility did not smell clean and was crowded with veterans who seemed to have poorly-managed mental health concerns. I was not given clear information about what services were available to me.

My husband also went to that VA in 2006. He was

regularly told that he was at the wrong clinic and sent from one office to the other. Doctors gave him the impression that he and his issues were an inconvenience at best. My husband's inability to schedule timely, well-coordinated appointments eventually made him give up on getting care from the VA at all.

We both began relying exclusively on TRICARE for all of our medical and mental health needs, even though civilian providers we see are less familiar with combat injuries and Post-Traumatic Stress.

My visit to the VA Medical Center in Martinsburg, West Virginia, last month, however, was a stark contrast to both my previous experience and the experiences that I have heard about from other women veterans at some facilities.

There was a women's restroom clearly visible in the lobby. It was clean. There was a changing table available. I was treated as a veteran at all times, asked about my combat experiences, and sensitively asked if I had experienced sexual harassment or assault in the military. Providers carefully coordinated my visit, ensured that I was aware of all available resources, and followed-up promptly and thoroughly.

Their OEF-OIF integrated care clinic and newly-opened women's clinic are models worthy of emulation, and I truly believe that with continued advocacy and oversight, all VA

facilities can provide that same standard of care.

In order to best meet the needs of all veterans, I also urge the development of enhanced relationships not only between the DoD and VA, but also with those community organizations that are ready and willing to fill gaps in services. Public-private partnerships can allow all of us to come together to meet the needs of our veterans in innovative and exciting ways. I strongly urge that all legislators support as 597, which will help better meet the needs of women veterans.

Thank you, all, so much for working to assess VA's health care services for women veterans and for your efforts to improve care for all of our nation's veterans.

[The prepared statement of Ms. Williams follows:]

Chairman Akaka. Thank you very much, Ms. Williams. Ms. Olds?

STATEMENT OF JENNIFER OLDS, U.S. ARMY VETERAN ON BEHALF OF VETERANS OF FOREIGN WARS

Ms. Olds. Mr. Chairman and members of the committee, I would like to thank you and the VFW for the opportunity to testify today.

My name is Jennifer Olds, and I served in the U.S. Army during the first Gulf War from 1990 to 1992.

During my time in the military, I experienced multiple incidences of military sexual trauma. As a result of my experiences in the military, I suffer from severe and chronic PTSD.

Some of the health conditions that resulted from that severe and chronic PTSD involved both physiological and psychological effects. Some common to psychological effects that have been stated before are flashbacks, nightmares, insomnia, distrust of society, constant fear, depression, and becoming suicidal. I also suffered from physical ailments because of the PTSD, which include things like nervous issues, anxiety attacks, panic disorders, dizzy spells, ulcers, and I had shingles twice in my 20s.

As I look back over the treatment that I have received from the VA, I find a list of things that I think has comprehensively helped me to recover to the place that I am today, which is significantly much better than I was 15 years ago. Among this list include the availability of

counseling from the vet centers in the Portland, Oregon, VA, and, also, being assigned a psychiatric nurse practitioner who tried to provide medications to help me with sleeping because getting sleep can help improve your ability to handle all the other effects of PTSD.

Eventually, about 10 years after my initial start in the VA system, I finally allowed them to provide anti-anxiety medications, which, in combination with other things, seemed to help me improve quite a bit.

One of the things I believe that had a severe impact on turning my life around was my admittance into the vocational rehabilitation program. That gave me a reason to stop being suicidal or at least to start fighting my suicidal ideations and allowed me to look forward to my future.

Not long after, a few years later, I was given the opportunity to participate in some PTSD research. It was a research study at the VA comparing cognitive studies, cognitive therapy against exposure therapy. I was randomized into the exposure therapy program and participated in it, and it was a 10-week, intense, grueling program that asked me to recollect and discuss a traumatic event.

So, it is not a program that is easy for people to get through, but, if you can, and you are like me, you benefit significantly.

As I also look back, I realize the importance of having holistic care. Because I suffered not only psychological issues, but physical issues, being able to get the support from both sides of the coin was very helpful, as well.

And, finally, I think most important, as we look at providing care for vets or women vets in particular with the kinds of backgrounds that we tend to have, I think with PTSD and military sexual trauma, having very patient, understanding, good-fit providers is key. If we have someone that we are unhappy with or we feel does not understand us, we are not going to go. So, finding people that have the patience and endurance to stick with us until we are able to sort of work for ourselves, I think, is very important.

As I look forward to the future for things that I think would be helpful for the VA System to implement, the first thing that comes to my mind is the location.

I spent an hour-and-a-half driving each way to my counseling appointments, not to mention the amount of time I spent in my counseling appointments, and that combined ended up being at least four hours a day, three to five days a week. That does not bode well for working.

And, also, as I think back on my original discharge, I, again, was not given any information. I had no idea that there was stuff available for me, and really, there was not,

as I look back for PTSD and women specifically.

But I had gotten so suicidal that I sought my own care from a private institution where I utilized my own private insurance. That only covered two weeks at the most. It only covers a portion of that amount. So, my family had to take on the burden of the additional costs. So, my point of this is getting acceptance right into the VA System immediately is important.

I also think that we need to think about women veterans as individuals. I do not think there is a one-size-fits-all. I have listed a number of things that I felt were extremely beneficial to me, but there were other options that came up that were available to me that I did not take advantage of because they were not good fits for me.

An example of this is a counselor that tried to provide EMDR, another type of therapy for PTSD. While it has been proven to be very effective, it was not a type of therapy that I felt was fitting for me at the time.

So, being able to look at the individual and examine what they them self need and providing a variety of options to allow them to pick from, I think, is important, as well.

One of the other things I think that we need to provide, education for everyone really, for providers, for women vets, and for the public on what the VA can offer and

how the VA provides care for the women. Sort of this around the world picture for everyone.

I also think, as I have looked at the care that has been offered for women vets, I have come up with a conclusion that what some of the other people have said also, is I believe that if we have some what I call information sessions for women or for vets by vets in helping them to understand how to navigate the system and to move forward with the different kinds of options is important, as well. If I had had that, I may have started some things earlier on in my treatment plan. And I would be one to volunteer to do that for other vets because I feel it is important to help others get their life back sooner than some of us have.

And, finally, I think we need to reduce the stigma that the VA has in the system in general. I think while I go out and I speak positively about my experiences from the VA because I have had numerous, wonderful experiences from the Portland, Oregon VA, there are other people who do not, and we need to reduce the amount of incidences like this that prevent the VA system from getting the good reputation that it can deserve.

I understand there are differences from VA to VA, but, in general, reducing that stigma, I think, will help encourage vets to use the system.

So, Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or the other members of the committee may have. Thank you for your time.

[The prepared statement of Ms. Olds follows:]

Chairman Akaka. Thank you very much, Ms. Olds, for your testimony, and all of you here.

Several of you mentioned the importance for VA providers to understand and acknowledge that women can experience combat while serving in the military.

How would you recommend VA and women veterans educate their providers about this in order to help them provide better care for women veterans?

Ms. Chase. Senator, I think--

Chairman Akaka. Ms. Chase?

Ms. Chase. --in terms of recognizing combat and raising awareness about that, there are several military occupational specialties with the Army and across the services that have women who are engaging in activities outside of the wire. Some of these include our intelligence teams, our medics, our truck drivers, our civil affair soldiers, our military police, and even sometimes our finance and supply sergeants and NCOs and officers.

I think the best way to get people to understand and to pay attention is to connect the two, and I think if we could provide or somehow get together statements and maybe even personal testimony or a team of people that go and address the Veterans Affairs directly on some of these service providers and some of these clinics in their local areas and say I am a real person and I am standing in front of you to

tell you that I served in combat, and I need you to hear me. I think that would be more impactful than anything else that we could give them on a memo or an e-mail.

Chairman Akaka. Yes, Ms. Williams?

Ms. Williams. Another option that may help people understand a little more viscerally would be to have viewings of the Lioness documentary about women serving in combat available at VA facilities perhaps over lunch hour or in some way that providers would have a chance to watch that.

Chairman Akaka. Ms. Ilem?

Ms. Ilem. I would just note I think the Lioness documentary probably most exemplifies a great opportunity for them to really see and hear in their own words. So, either that or other shortened videos that VA has done on a number of issues related to TBI and OEF-OIF population and mental heath issues, reintegration issues. One on women veterans specifically would be an excellent opportunity for them to see something short, but in women veterans' own words for them to be able to connect.

Ms. Chase. And, Senator, I would like--

Chairman Akaka. Ms. Chase?

Ms. Chase. --to caveat that. Sorry.

The Lioness documentary is a phenomenal and fantastic documentary. However, it is specifically about a particular

team of women called the Lionesses who were embedded with combat teams and infantry teams, but we also need to recognize and make sure that they are aware that there are very many jobs out there and there are a lot of women every day on different jobs in different capacities, in different branches of service that are serving outside the wire in combat every day, and not just that one specific team specific to that movie or documentary.

Ms. Christopher. Mr. Chairman?

Chairman Akaka. Ms. Christopher?

Ms. Christopher. I agree with the fellow panelists on what they're suggesting. The one thing that I would like to note though is, to be quite frank, trainings can be very boring. I mean, whether you are watching a PowerPoint or a video or listening to someone talk, I mean, I think that in order for it to be truly effective, there needs to be dialogue, and it needs to be interactive.

And I think a Q and A portion--when we do our trainings through Swords to Plowshares, we open ourselves up for questions. We actually refer to it as an uncomfortable questions panel, and we encourage the clinicians to ask us, to clarify MOSs and military terminology and to ask us our opinion on treatment that has worked for us and that has not, and we make it extremely candid, and I think that it has helped immensely, and the feedback has been so positive.

So, I just definitely stress the interactive component for a successful training.

Chairman Akaka. Thank you.

We will have a second round of questions. So, let me call on Senator Murray for her questions.

Senator Murray. Thank you very much, Mr. Chairman.

First of all, thank you, all, for your service to the country. I really appreciate what all of you have done, and going beyond the service now to come and talk with us about the important issue that we are talking about today, and I just want you to know that I really do appreciate that.

While it is the official policy of the military that women can not serve in the combat, but, yet, many of you talked about your experience, whether it is Traumatic Stress Syndrome, being close to IED explosions, being injured.

Given the fact that women are serving in combat roles, have you found that this combat experience is reflected in DD214s?

Ms. Williams. My own certainly was reflected in my DD214. It shows that I was awarded the service medal for my time in Operation Iraqi Freedom, and, also, if it ever were to become a question, I also received Army medals and the paperwork that support those details of what experiences they were earned for, and that is another way that people can show their experience. But I know that that is not

universally the case. I was just lucky enough that that was true for me.

Senator Murray. How about others of you?

Ms. Chase?

Ms. Chase. When we get our DD214s, it states in there whether or not you served and in what theater. And it also states your job, and I was also awarded the combat action badge. However, that is not an automatic award. It's not an automatic entitlement. It is something that is submitted by your chain of command, and if it is not submitted or the paperwork gets lost or it does not go through, then you do not have that, as well.

And it also is not a qualifier. A lot of people do not perceive it to mean that you were actually in combat or directly engaging the enemy. So, that policy needs to be changed or reworded to reflect that women are, in fact, serving in combat and they are, in fact, on missions outside of the wire, and regardless of whether or not they are going outside the wire and they are inside a FOB or a PRT, when you have mortars that are incoming daily and you have no idea where they are coming from, that is combat, and the perception, I think, needs to be changed and I think that would be helped if the wording in the policy was changed, as well.

Senator Murray. Ms. Williams, you mentioned that you

were both a caregiver and a care seeker. Your husband was in the military. I assume that that is fairly common for a woman to be married to a fellow military officer and be in the same position.

What can be done to help us better care for women veterans who are not only dealing with their own readjustment issues, but are dealing with spouse or children, as well?

Ms. Williams. I think that it is important that care be more comprehensive. And you are right, the percentages are very high. Among active-duty, enlisted, married, female service members, over 50 percent are married to other service members, compared to only 8 percent of their male peers. And my husband and I were both enlisted.

I know that the VA is trying very hard to do outreach. I once got a call, for example, asking if I had sustained a traumatic brain injury as part of their outreach effort to make sure that they are catching everybody, and I said, no, I did not, but I am glad you called because my husband did and our family is in shambles right now. I do not know how to hold myself together and my family together and keep my job, and I am struggling really hard here. And he said, well, I cannot really help you with that. I am calling to ask if you have suffered a brain injury.

And that is the way that I think we can try to make

sure that we are addressing entire family needs. If you have a service member who has sustained an injury both while they are in the DoD and once they have transitioned to VA care, making sure that their family is being taken care of is an important step.

I know the VA does not cover care for family members, but if they learn that the spouse is also a veteran, it is important that they take extra step and reach out and contact them proactively and ask if they need help as a caregiver. And, of course, this does apply to both male and female spouses; just the number of female spouses are much higher.

Senator Murray. I hear a lot from women about the access of childcare being a barrier to go to the VA. Several of you mentioned this in your testimony, and I do not think a lot of people realize that if you tell a woman that there is no childcare, they just simply do not go. That is it. They do not get their health care.

For all of the panelists, do you think that the VA providing childcare services would increase the number of women who go to the VA and get the care that they need?

Ms. Ilem. I would say definitely. I think researchers have repeatedly shown this as a barrier for women veterans, and that is the frustration. How many research surveys do you have to do when women keep repeatedly saying this is a

barrier for them to access care? And I think it was Kayla who mentioned an experience of someone who was told it is inappropriate for them to bring their child with them, and some of these very personalized appointments for mental health or other things, it may be very difficult, but they have no other choice.

So, I think it would definitely be a benefit and we would see an increase in the number of women veterans who would probably come to VA.

Senator Murray. Ms. Williams?

Ms. Williams. I definitely think that user traits of the VA would increase if women knew that they had childcare available. There are a variety of innovative ways that we could try to address the problem of women having to balance their needs for childcare with their needs to get services. Among them would be increasing the availability of telehealth or telemedicine, where women do not have to necessarily go all the way to a remote facility and spend four hours trying to get to and from and then be in care.

There are also opportunities for innovative programs.

For example, the VA has small business loans available. If they could provide loans to women veterans who want to provide childcare at facilities near VA facilities, that would be a great way to try to marry these two needs.

There are also a lot of community organizations that

stand ready and waiting to help that would be happy just given a small office to staff it with volunteers and be able to help provide that care for the time that a women has to be in an appointment.

And I think as many others have said, the specific solutions may vary by location, but there are a lot of innovative ways that we could forge public-private partnerships to try to meet these needs.

Senator Murray. Okay. Excellent.

Mr. Chairman, I have gone way over my time. I need to get to another committee for mark-up, but I love the video idea of showing the Lioness documentary at VA facilities. I think it, at the very least, opens peoples' eyes to the fact that women have served in very important roles and will maybe open that little door in their head to think oh, wow, women really have served our country in amazing ways and they do need the care and the respect and the services that they have earned.

I would love to see another documentary about all the other things that women have done and start helping people everywhere really recognize the important service that women have provided.

So, thank you to all of you. And, Mr. Chairman, thank you so much for having this hearing today.

Chairman Akaka. Thank you very much, Senator Murray.

Senator Begich?

Senator Begich. Thank you very much, Mr. Chairman.

Like Senator Murray, at around 11:30, I am going to have to depart for a meeting, but this is a very interesting panel, and I want to thank you for your service, but also for your insight in the day-to-day utilization of the VA services and what can be done, and I have a couple of questions.

I am going to look through my handwritten notes here and try to reread my handwriting, as each one of you were going, but I am going to make a couple of comments. It is not necessary for you to respond.

But I am kind of looking at Dr. Hayes, if you could follow-up with at least me and if the committee so desires on a couple of things. One is the childcare issue.

I remember a circumstance as of Anchorage, Alaska, my wife and I had our first child, one-years-old when I got elected. In my office, we had if it was not a crib in there at any given point, there was probably toys scattered throughout, and I can still remember a colonel from the Army coming over and introducing himself to me with his spouse and their two-year-old, who also came into my office, and I think because I created an environment that showed that to happen that that was okay, it made a big difference. I would not ever imagine that five years ago, a colonel from

the Army bringing their two-year-old to the mayor of the city that they are being stationed, and that would never probably have happened. But we created an environment to do that.

So, you had mentioned the childcare, each one of you, as critical.

The question I would have, Dr. Hayes, you had mentioned legal counsel may have some issues with this. I would like to get whatever they write up if they do on childcare. I would like to see that because the one thing I know about attorneys, and, no offense, I am not one, but they will always tell you why something cannot happen versus why something should happen. And, so, if you approach them in a way that when they give you the answer why it cannot happen, which is probably the likelihood, can you ask them what can change to make it happen?

That is what I think many of us are talking about or are going to be interested in because I agree with you, if the facility does not have childcare, facilities for both women and men, it is a problem. And, so, if you could do that, that would be fantastic.

A couple of you mentioned training and successful training, and I agree with you. It is "boring." The trainings I have had to go to and how they are interactive.

And I'll look to you first, Ms. Christopher.

In your interactions, how do the clinic folks come to you? In other words, do they volunteer to come to your training? What happens? How does that work? Does the VA require it? I would say no to that, but it is a set up question. But how does it work? How do you get folks to participate from the clinical side, the professionals?

Ms. Christopher. Honestly, we have been very lucky. Actually, the DoD liaison to the Palo Alto Polytrauma Center actually invited me and my colleagues to join the National Center PTSD Clinical Training Program. He actually cut his time in half to develop a community panel because he thought it was important. And, honestly, I found that the DoD liaisons have been extremely instrumental in bridging the gap between the VA and the community, which I think is fantastic.

When it comes to the VA clinician trainings that we have done, honestly, we have approached them and we have gotten really good feedback, and I think in the Bay Area, there is some really good dialogue, but, no, we--

Senator Begich. No outcome yet?

Ms. Christopher. To suggest it.

Senator Begich. Okay. Do you have something, again, you could share at least with me in any written document that is kind of here is what you would like to propose to the VA?

In other words, what I see, we did this with community police training in Anchorage when we saw an opportunity because we had a lack of understanding within our police department in regards to the cultural diversity of our city. We have 90-plus languages spoken in our school district, a very diverse community, so, we integrated that into our training. We kind of forced it at first because it was a structure, and police are paramilitary, so, they have similar structures and procedures and processes and changes not necessarily high on the list.

And I would be interested in both you and I think was it Ms. Williams? You also talked about training. I can not remember which one did. But any of you that have some suggestions, I would be very interested in getting that, of how to then have a discussion with the VA on how they can make that a little better. I would be very interested in that, if you could.

Ms. Christopher. Yes, Senator.

Senator Begich. And whoever else would be willing to do that.

In connection to that, again, I am going to kind of veer through you to Dr. Hayes.

I would be very interested if the VA actually surveys their clients for results of VA clinics because I am just guessing, even though in theory they are all same, they

operate differently.

The example you gave, Ms. Williams, I think it was your positive experience in the last clinic you had gone to was very positive, and there are some good things that occurred there. But that varies clinic to clinic, and I would be curious if, Dr. Hayes, you could do that. But, also, from Ms. Williams, if you could tell me again where that was. I did not write it down quick enough. The one you had a very good experience in.

Ms. Williams. Yes, sir. I have had negative experiences at the D.C. VA, and, just on my way here this morning, I chatted with a woman in uniform that I was coming here, and she said she is in the process of retiring, she just went to the D.C. VA, and had the same experience that I did and the fact that it seemed unclean to her and very disorganized and there were people there clearly struggling to cope, and it can be nerve-racking when you are seeking care to worry that that is your future. And I said, go to the one in Martinsburg, West Virginia.

We live out near Dulles Airport, and from there, it takes just as long to get into D.C. as it does to go all the way out West Virginia based on the lovely traffic we all face. And the Martinsburg facility is doing great.

There are obviously areas that they could improve on, as well. They are undergoing construction. So, currently,

the OEF-OIF Clinic is collocated with the mental health outpatient clinic, which I first found a little off-putting, but when they said that that was because of the ongoing construction to improve the facility, I thought that that was great and it is really a wonderful model.

Senator Begich. That is great. Thanks for telling me which clinic that was and that helps me get a little better understanding.

The last think I will just mention, especially the discussion of telemedicine. Alaska, because of our rural and remoteness that we have there, telemedicine is a very powerful tool, and it is very valuable in a lot of ways, and, so, I know we have had very positive comments and conversations with the VA about telemedicine and their interest in expanding that.

I know from my state, it is a critical path to delivery because we do not have a VA hospital, for one. We have clinics. And then, in remote areas, we have nothing. And it is very difficult because there are no roads to get from one place to the next. So, I appreciate your comments on telemedicine from another perspective. You know, I see it from a rural perspective. I appreciate your comments from women veterans, that it is another access point that is a positive one so thank you for that.

Mr. Chairman, I will end there, and just it is a very

enlightening panel in a lot of ways because of your direct contact and utilization and work with other folks. So, thank you very much for this insight.

Chairman Akaka. Thank you very much, Senator Begich.

Hearing what has gone on here, I just want to inform everyone that the committee's legislation S352 has provisions making childcare more available by using an existing childcare programs and providing reimbursement to those getting care. So, that is in that bill and this is something, of course, as we have discussed, that certainly can be used here with helping all women.

One of my major goals is to create a seamless transition for service members as they leave the military and become veterans.

As women veterans, what do you perceive as a major gap in this transition process, and how would you recommend we fix it?

Ms. Williams?

Ms. Williams. Sir, I think one thing that will go a long way towards fixing some of the problems, and it is my understanding it is at least in the trial process now in some locations, would be electronic medical records.

Having to hand-carry your own medical records when you leave the DoD System and take them to the VA System, and the fear that some piece of paper will get lost, a vital piece

of paper proving what has happened to you in the past, is very difficult and stressful, and may be even more of a challenge for veterans who may have sustained a traumatic brain injury or be struggling with mental health concerns. So, I think that the implementation of universal electronic medical records will go a long way towards fixing that problem.

Also, there can be big challenges in terms of benefits.

When my husband was medically retired from the military, there was a gap between that time and when he started getting his VA benefits, and during that time, we were so financially insecure that both of us ended up going on unemployment, which was a deeply humiliating experience for two proud and honorable combat veterans to be reduced to that while we were waiting for his VA benefits to start coming in, and I was waiting for my job to get started.

So, trying anything that can help smooth and ease that transition, I think efforts to get VA exams done for those service members who have been injured in the military so that they can have a more seamless transition in terms of benefits is another step in the right direction.

Chairman Akaka. Thank you.

Ms. Chase?

Ms. Chase. Senator, as a reservist, when you come off of active-duty, which can be multiple times during your

military career, especially if you have been activated several times, one of the biggest issues is that we are handed our records, and then it comes on you to keep and maintain those records throughout the duration for however long you will need them.

Once you are handed your medical records, that is it, and that documentation does not flow from what is or may have been put into a computer system at a care facility that you were at even to another care facility while on active-duty orders from base to base, much less from when you are on DoD and then into the VA System.

So, that enrollment period in enrolling where the records directly transfer from your active military service and they follow you throughout your VA service or throughout your VA eligibility time, it is important, it is significant, and I cannot stress enough and I cannot say enough how vital it is to have that also to prove combat service if a woman or any veteran has served in combat and has been seen or treated by a physician or a physician's assistant while on active-duty, then it would flow right into their VA eligibility and into the computer system. So, it will alleviate so many of the other issues that we are seeing.

Chairman Akaka. Thank you very much.

Are there any other--Ms. Olds?

Ms. Olds. Mr. Chairman, thank you.

I want to follow-up with the medical records thing.

That was one of the biggest problems with me getting care when I first got out back in 1992. To this day, no one has found my records, and, of course, that caused a significant delay in getting benefits from the VA. It took almost three years and Councilwoman Furse to get involved. So, having access to our medical records, having them transferred without anyone having an opportunity to lose them, I think, is significantly important.

And, also, giving information to people about what benefits they can get, I was not given any. I had no idea I had benefits coming until I met with someone at the PVA and they asked the right questions.

So, information and medical record availability, I think, are kind of the two big ones as far as us getting our access into the VA System when we get out.

So, thank you.

Chairman Akaka. Thank you.

Ms. Christopher?

Ms. Christopher. Mr. Chairman, when I got out of the military, I did not think that I had any benefits. And it was due to a volunteer writing an op-ed in the Seattle Times that I found out about the Military Sexual Trauma Program, and that I might be eligible.

Needless to say, when I arrived, I had to fight for my eligibility. I have an honorable discharge, but the circumstances are a bit more complicated, and, so, it was the clerks that I really had to fight with to get treatment, to get seen.

Once I did finally prove that I was a veteran and that I was entitled to treatment for MST, I got great care by the doctors that I got there. But it was an uphill battle, and having to prove again and again my trauma and that I am a veteran has definitely affected me. And, let me tell you, it was very validating to finally be rated by the VA.

I have seen with having OIF-OEF advocates and case managers nowadays that process is so much easier for new veterans, and I am so glad that the VA has those. However, most veterans, newly-separated service members are not always aware that these positions exist.

So, again, it has been back to the community when veterans come into my clinic or when we are doing briefings, I tell them, hey, do you know about this office in the VA or I hand out a business card and personally introduce them to my VA counterparts. And, so, my point is that the community is still just a really integral tool in access to VA health care.

Chairman Akaka. Ms. Ilem?

Ms. Ilem. I would just say things have changed a lot

since I got out of the military in the mid-80s when there was little-to-know information. I definitely did not recognize myself as a veteran, did not know that I had access to the VA, and did not even recognize that I was entitled to service connection for disabilities incurred during service until I met DAV folks.

So, I think VA is on the right track now in terms of a number of outreach efforts when people are coming back from deployments, trying to outreach with them then, get them enrolled in VA care at that point, giving them information, but also then doing follow-up letters, follow-up phone calls.

The unfortunate thing, as we heard from Ms. Williams, when somebody does call, if they do not have the ability to just change a little bit and take into account that they were calling on this particular veteran, but others need help to be able to refer them and to be able to just go ahead and take care of these people. That is going to be key in terms of continued follow-up over a point of time when people are ready and may catch them at a point when they are going to then realize they have access to these benefits, and they are needed for them.

Chairman Akaka. Thank you very much, Ms. Ilem.

I want to thank all of you for being here today, but, first, I want to thank you for the sacrifice you have made

to our country and also to the kind of help you are giving us in trying to help our women problems in the veterans.

We have heard about a lot of good initiatives VA is undertaking to increase the quality and access to care for women veterans. However, we also heard that there is much more that could be done, especially in the areas of outreach and education about these services, and you mentioned about records and also the electronic shift that needs to come.

All our nation's veterans, both men and women, deserve the best quality of health care and I will continue to work to make sure that they receive it.

I look forward to working with VA and others to find solutions to the gaps in care for our women veterans.

Thank you, all, again for being here today. You have been very helpful.

This hearing is now adjourned.

[Whereupon, at 11:10 a.m., the hearing was adjourned.]