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CARING FOR ALL WHO HAVE BORNE THE BATTLE: ENSURING EQUITY FOR WOMEN VETERANS AT VA

HEARING

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APRIL 10, 2024

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CARING FOR ALL WHO HAVE BORNE THE BATTLE: ENSURING EQUITY FOR WOMEN VETERANS AT VA

WEDNESDAY, APRIL 10, 2024

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:30 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Brown, Blumenthal, Hirono, Hassan, King, Moran, Boozman, Cassidy, and Tuberville.

OPENING STATEMENT OF HON. JON TESTER, CHAIRMAN, U.S. SENATOR FROM MONTANA

Chairman TESTER. I'm going to call this meeting of the Veterans' Affairs Committee to order. I want to welcome everybody to today's hearing to ensure the Department of Veterans Affairs is meeting the needs of women's veterans.

Today, women make up more than 11 percent of the veteran population. The number's projected to be 15 percent by 2035, with women making up 17 percent of the active-duty military force, and 21 percent of the reserve component. We know that these numbers are going to grow.

With that in mind, the Committee has worked in recent years to ensure the VA is providing equitable, high-quality care to women veterans. In 2021, the Deborah Sampson Act, a bill, which I led with Senator Boozman, was signed into law. It continues to help eliminate barriers to healthcare and services faced by women veterans, including survivors of military sexual trauma. MST impacts both men and women. I hope today's hearing will address what the VA is doing to improve care and benefits provided to survivors of MST.

I'm encouraged by VA's improvements to its MST claims process since the passage of the Deborah Sampson bill, but I won't stop fighting until all MST survivors have access to fair claims process and high-quality care that they have earned. That is why I continue to push for passage of my bill with Senator Murkowski, the Servicemembers and Veterans Empowerment and Support Act. This bill would expand the evidentiary standard for MST survivors, applying for VA disability benefits.

Today, I also look forward to hearing updates from the VA on another critical law, the MAMMO Act, another bill led by Senator

Boozman to expand veterans access to breast cancer screening and care. That law includes a pilot program on telescreening mammography services that will give us information on how to best streamline care in rural states like Montana, where the VA doesn't offer in-house mammography services.

The MAMMO Act and Deborah Sampson Act represent great strides in improving healthcare and benefits provided to women veterans. We know that our work is far from done, and that's why we're lucky to have a second panel with us today made up of entirely women who have served our country, including Dr. Alissa Engel from the great State of Montana.

We'll hear from these women about where the VA is succeeding in meeting the needs of women veterans and where they need to improve. Women veterans, including rural women veterans, and those with specific needs like spinal cord injuries need our support. So, I do want thank all the witnesses that are here today. And with that, I'll turn it over to my friend and colleague, the Ranking Member, Senator Moran.

OPENING STATEMENT OF HON. JERRY MORAN, RANKING MEMBER, U.S. SENATOR FROM KANSAS

Senator MORAN. Chairman. Thank you. I'm pleased to be here today, and this is an important topic and I'm glad we're having this hearing. I welcome our witnesses and everyone who's gathered here for this hearing on the needs of women veterans.

Women have made immense sacrifices and honorable service to their country since the American Revolution, but far too often, their contributions go unrecognized and often underappreciated. A single hearing is unlikely to fully capture the complexity of this topic, but conversations like the ones we will have this afternoon are important pathways to make certain that women veterans, and their service are recognized, appreciated, especially when they need access, benefits, and services from the VA.

Our witnesses will share with us in a few minutes, I'm sure, that the VA has made strides to be more welcoming to women, to make gender-specific services to women more accessible. As you said, Mr. Chairman, the work is never over. We say that frequently, perhaps every hearing, every topic that we're involved in. But I would indicate that's true today in this hearing, and it's particularly true when it comes to women serving and who have served, who are now living in rural areas, and aging women who have unique needs the VA must proactively address.

In preparation for today's hearing, we reached out to women veterans in Kansas to learn about their experiences. These women told me how grateful they are for the VA, and that they have seen VA change for the better over the last several years.

Each had similar stories, however, about the challenges that still exist for women. One told me that the only time she hears from the VA is when they're reminding her to pay a bill. Although this woman is an active user of the VA healthcare system, she has still not had toxic exposure screening and had to seek out on her own information about the PACT Act.

Because Kansas is such a rural state, women veterans either rely on community care or have long distances to travel to a VA, which

they sometimes cannot do because of family and professional obligations or poor health. Each veteran we talked to said the VA has made accessing community healthcare difficult, even for services like maternity care, which is only provided in the community. One woman had to find a new doctor for her third pregnancy because her prior one was no longer willing to work with the VA.

Though hearing directly from advocates is certainly valuable, and I look forward to that today. I hope today's hearing will shed light on how the VA, and perhaps this Committee, and the Congress can do more in moving forward for women everywhere. Our duty is to make certain that they receive the support and care they deserve, and I thank you, Mr. Chairman. I thank our witnesses.

Chairman TESTER. Thank you, Senator Moran. I want to welcome our first panel witnesses to this afternoon's hearing. I'll introduce you right now. From the VA, we have Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services at the Veterans Health Administration. She is joined by Dr. Sally Haskell, Acting Chief Officer for VA's Office of Women's Health, and Dr. Amanda Johnson, Acting Deputy Chief Officer for the Office of Women's Health.

Also from the VA is Kenesha Britton, Assistant Deputy Under Secretary in the Veterans Benefits Administration, Office of Field Operations. And finally, last, but certainly not least, from the VA Office of Inspector General. We always appreciate having the Inspector General here. We're joined by Dr. Jennifer Baptiste, Deputy Assistant Inspector General in the Office of Healthcare Inspections.

Dr. Scavella, we'll start with you. Know your entire written statement will be a part of the document. We'll try to hold it to five minutes. Thank you.

PANEL I

STATEMENT OF ERICA SCAVELLA, MD, FACP, FACHE, ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY SALLY HASKELL, MD, ACTING CHIEF OFFICER, OFFICE OF WOMEN'S HEALTH; AMANDA JOHNSON, MD, FACOG, ACTING DEPUTY CHIEF OFFICER, OFFICE OF WOMEN'S HEALTH; AND KENESHA BRITTON, ASSISTANT DEPUTY UNDER SECRETARY, NATIONAL CONTACT OPERATIONS, OFFICE OF FIELD OPERATIONS, VETERANS BENEFITS ADMINISTRATION

Dr. SCAVELLA. Thank you, sir. Good afternoon, Chairman Tester, Ranking Member Moran, and Committee Members. My name is Dr. Scavella, and I'm the Assistant Under Secretary for Health for Clinical Services at the Veterans Health Administration.

Joining me today are Dr. Sally Haskell and Amanda Johnson, respectively, the Acting Chief Officer and Acting Deputy Chief Officer within the Office of Women's Health. I'm also accompanied by Ms. Kenesha Britton, who is the Assistant Deputy Under Secretary for Benefits for National Contact Field Operations within the Veterans Benefit Administration.

Thank you for the invitation to testify before you today. Addressing the unique needs of women veterans is crucial. Since 2001, the number of vet women using veteran services has tripled going from 158,000 to over 625,000 enrollees within the last calendar year. As we wrap up our 100th year of providing women's healthcare, we aim to set a higher standard of care and become a national leader in women's healthcare.

We proudly provide comprehensive care for our enrolled women and gender-diverse veterans, including preventive, acute, and chronic disease management, reproductive healthcare, and mental healthcare. To address gender-specific health concerns, we have developed several primary healthcare policies, one of which includes assigning a woman to a trained woman's health primary care provider. Should she choose to have that.

As of September 2023, all healthcare systems have at least three primary care providers who are specializing in women's health. A major component of the comprehensive care that we provide includes a range of essential reproductive health services, including contraception, pregnancy-related care, fertility counseling, sexually transmitted infection screening, and specialty medical and surgical management of gynecological conditions.

VA provides comprehensive and specialized gynecological care through a network of skilled professionals at state-of-the-art facilities. Initiatives like the Gynecology Community of Practice and Virtual Grand Rounds to enhance the equality of care access to essential reproductive care, including abortion care, is vital for our patients if they are experiencing a condition that may affect the life of the veteran.

VA is dedicated to supporting women veterans' mental health needs and well-being through a range of initiatives. This includes expanding access to evidence-based services, increasing awareness of gender-specific resources like women-only therapy, and women-led peer support groups. Specialized care is offered for conditions like post-traumatic stress disorder, depression, anxiety, and reproductive mental health issues like postpartum depression.

VA additionally offers innovative resources to support clinicians, including a national network of women mental health champions. At each VA Medical Center. VA has trained over 120 clinicians since 2022, specifically in women's health. VA is dedicated to ensuring that every woman veteran receives the benefits she deserves, and continuously expands its outreach and services to better support women veterans.

The department recently organized nearly 140 events tailored specifically to meet the needs of women veterans, and provides a web-based course to enhance that education. Thanks in part to this effort, we have over 702,000 women who are currently receiving disability compensation benefits, setting a record with a 26 percent increase over the past five years.

Finally, we recently implemented various reforms to improve the military sexual trauma or MST-related claims process for both male and female survivors. In fiscal year 2023, we had over 43,000 MST-related claims that were processed, with women receiving 62 percent of the MST-related benefits. Ongoing work is being done to

address under development, examination, and medical opinion-related errors, and improper denials.

To ensure timely decisions for MST survivors, VA is reaffirming its commitment to enhancing workload management strategies, increasing full-time employees at our operation centers, analyzing trends and common errors, and conducting a claims quality stand down day for our MST claims processors.

Our commitment to ensuring that women veterans receive the care, support, and respect they deserve remains unwavering. VA's women-centered programs have made significant strides in improving their well-being, especially as their enrollment with NDA reaches new levels. We must maintain this momentum and protect the progress achieved through our continued collaboration.

Thank you so much for this opportunity to update you on our efforts, comprehensively providing care for women veterans. Chairman Tester and Ranking Member Moran, this concludes my testimony, and we are ready for your questions.

[The prepared statement of Dr. Scavella appears on page 43 of the Appendix.]

Chairman TESTER. To the second. And I assume Dr. Scavella, Britton, Haskell, and Johnson are with you.

And we will now hear from Jennifer Baptiste.

STATEMENT OF JENNIFER BAPTISTE, MD, DEPUTY ASSISTANT INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

Dr. BAPTISTE. Chairman Tester, Ranking Member Moran, and Committee Members, thank you for the opportunity to discuss the OIG's oversight of VA programs and initiatives that focus on serving women veterans.

The OIG's Women's Health Program was implemented to help ensure VA is meeting the healthcare needs of this expanding population. More women veterans are accessing VA at a younger age, underscoring the need for maternity and gynecologic care to be readily available. Access to gender-specific cancer screenings, such as for breast and cervical cancer, and diligent follow-up of test results are necessary. Women often present with unique symptoms for acute and chronic health conditions such as cardiovascular disease.

VA must ensure its care providers are equipped to detect and manage women's distinct healthcare needs. Also, expanding outreach and screening for MST and mental health conditions could make more eligible women veterans aware of the care and benefits available to them.

Our work has found that frontline VA staff are overwhelmingly dedicated to providing high quality care to women veterans. We recognize the commitment VA has shown in increasing the availability of gender-specific resources while working to create a safe and welcoming environment.

As the number of women veterans continues to rise, however, VA faces significant challenges in ensuring access to women's primary care providers and gender-specific care within their facilities and in

the community. Recent OIG reports on VHA women's health providers, the mammography program and reproductive health services highlight several areas for which improvements affecting gender-specific care are needed.

Those reports have highlighted that there is still important work to be done on maintaining a welcoming environment and access to clinicians that are fully supported and trained in treating women veterans. We have reviewed and substantiated allegations of inappropriate conduct by a gynecologist and lack of advocacy by a chaperone. We have also confirmed that a facility's Women Veterans' Healthcare program was under-resourced and largely overlooked.

Failures of the type the OIG has reported can undermine women veterans trust in VA.

Coordinating care that women veterans receive in the community is also critically important because some gender-specific care such as maternity care, is not generally provided within VA facilities.

Women veterans may also be referred to the community for gynecologic care and cancer screenings. Test results, therefore must be timely communicated and medical records returned promptly back to VA.

Program coordinators who support the care of women veterans, including maternity care, MST, and intimate partner violence coordinators largely do so as collateral duties.

They have reported to OIG that they often lack sufficient resources, administrative support, and protected time to effectively serve women veterans. Other related OIG oversight work has demonstrated the importance of appropriate screening and support for victims of sexual violence, as well as the need for MST benefits claims to be processed more accurately and timely by VBA.

We recently released a report that found approximately half of the veterans who reported sexual assault to DoD while on active duty, did not use VA healthcare, and a third had not received a service-connected disability rating, suggesting the need for better outreach to veterans and ensuring a welcoming environment for those veterans to receive care.

In closing, the OIG's portfolio work to date highlights the challenges VA must overcome if they want to engage more women veterans who will rely on and trust VA for their care. The OIG Women's Health Program is currently conducting a national review to assess maternity care coordinators workloads and fulfillment of their duties, with a follow-on review that will include the experiences of veterans who have received maternity care coordinated by VHA.

Additionally, the OIG audit staff continue to monitor the processing of MST claims for VA benefits that have disproportionately affected women veterans. We will continue to monitor VA's progress on addressing the needs of women veterans and to provide practical and meaningful recommendations for improvements.

We appreciate the opportunity to participate in this hearing. It is fitting that this hearing falls during the month VA highlights sexual assault awareness and prevention. The OIG is committed to being a voice for survivors and providing VA with information to improve its efforts.

Chairman Tester, Ranking Member Moran, and Members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.

[The prepared statement of Dr. Baptiste appears on page 49 of the Appendix.]

Chairman TESTER. Dr. Baptiste and Dr. Scavella, thank you both for your testimony. We appreciate it. Appreciate your work. I will turn to the dean of this Committee for your questions. Senator Murray.

HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you, Senator Tester. Thank you, all of you. Really appreciate it having this hearing on really an important topic because we all know that women are the fastest growing demographic within the veteran population.

In my home State of Washington, the Puget Sound VA saw a 7 percent increase in women veterans who are using their services over the past two years. In February, I met with women veterans in Seattle who told me about the barriers they are facing in receiving healthcare through the VA. I heard from a veteran who—she was looking for care at American Lake VA which was very close to where she lived, but the women's clinic was completely full. So she had to go to the Seattle VA to get care—close but not close. And I know alot of other women veterans are facing the same stories. Her story is not unique. I hear that all the time. Many women are having the trouble getting the care that they need.

And additionally, mammography services are an important part of healthcare for women veterans. But right now, VISN 20, which covers Washington, Oregon, Idaho, and Alaska is the only VISN without in-house mammography. And that is really not acceptable. So Dr. Scavella, does the VA have plans to expand their in-house mammography services to VISN 20?

Dr. SCAVELLA. Thank you for that question. We are always aiming to provide services at the point of care where veterans find it most convenient and most accessible. We do face challenges just like the rest of the United States in having qualified employees to provide these services. So that is a challenge for us, but we will continue to work to make sure we have services that are accessible within your systems.

There's also a quality-of-care component related to providing mammography in that you need to make sure that the mammographers, the persons performing the procedures, are adequately trained and are able to keep their skills. So, I can look specifically into any of the demographics there. I would like to ask Dr. Haskell if she has any specific information to answer your question.

Ms. HASKELL. Yes. Thank you, Senator Murray, for your question. VA currently has in-house mammography at 78 sites, and it's really been increasing very rapidly over the last number of years. And we are looking at additional ways of providing mammography, as you probably know, through teleradiology, as well as potentially looking into more mobile mammography services.

So these are some things that the National Radiology program is working on. I think as Dr. Scavella says we are limited in that we want our mammography programs to be very high-quality care. And in order to do that, we need to ensure that there are certain number of women at a facility.

There are requirements both for the radiology technologist and the radiologist themselves, that they need to do a certain number of cases per year in order to be qualified and certified. So we look carefully at those numbers.

And we are also—I do want to say that we're very aware of that VISN 20 gap, and I know that the radiology program is looking at it very carefully——

Senator MURRAY. Okay. If I could just ask——

Ms. HASKELL. Yes.

Senator MURRAY [continuing]. Can you take a look and get back to me and tell me if you're not going to do it, or if you are, when it's going to happen. And I want it to be the answer to the second question not the first there, so.

Ms. HASKELL. Absolutely. Thank you.

VA Response: Like any other clinical service, we consistently look at a variety of options as we address changes with our enrolled Veteran populations. According to most recent data, American Lake and Seattle have sufficient women Veteran populations to support adding mammography, though the population is dispersed along I-5 corridor and east/west with minimal fixed density. We currently accommodate the needs through Community Care (CC) requests for this service and follow-up diagnostic services as needed. Wait times for mammograms do not appear to be a barrier in most locations in the Puget Sound area.

Depending on the review of updated data, with emphasis given to the preferences of women Veteran enrollees, there are many options to consider, including continuation of the current CC referrals. In addition:

- VISN leadership is actively involved in reviewing this issue with Puget Sound leadership, along with our Women's Health Coordinator and the National Program Offices for Women's Health and Radiology. We consistently monitor growth, interest, and demand as demographics continue to change and shift with regard to women Veteran enrollees. (This has been an ongoing, regularly discussed topic throughout the years and will continue to be as Puget Sound strives to meet the needs at current and future sites of care.)
- The VISN 20 team is working with the Puget Sound team to review feasibility of a VA/DoD partnership with Madigan.
- There are several options to consider for a VA-directed mammography program if deemed appropriate and consistent with the women Veterans' preferences, including telescreening mammography and a traditional screening mammography program at a local VA site of care.

Senator MURRAY. Thank you. Earlier this year, DoD announced that it's going to expand its IVF services to single and unmarried service members, and will allow service members to utilize donor gametes. I was really excited to hear that the VA is following DoDs footsteps in its IVF expansion. This is really great news for active-duty service members and veterans, and I know we have a lot of work to be done to make sure everyone has the access they need. Which is exactly why I introduced the Veteran Families Health Services Act, which will expand IVF services to more service members and their families. And I'll be working very hard to get that passed.

But Dr. Scavella, if you can just talk about how this recent expansion will help more women veterans and speak to why IVF care is so crucial for veterans who cannot conceive naturally.

Dr. SCAVELLA. You know, thank you for that question. It's fitting, again, that we're having this hearing one month after Women's Health Women's History Month. And it's one year and one month post the Secretary providing a new mission statement, which includes women in the mission statement.

We now can offer IVF services to women veterans who may be unmarried, veterans in same sex marriages and other non-marital unions. And we can also now use the gametes, the embryos and eggs and sperm from donors as opposed to previous legislation and rules and regulations. So it has expanded the opportunity for us to provide that care. We're really excited by the release that the Secretary signed last month, as well as the entry into the federal registry.

Senator MURRAY. Well, thank you. And Mr. Chairman, I'll just say that when we ask our men and women to serve our country, we tell them we will take care of them when they go home. To tell them that doesn't include having a family to me is outrageous. So I think this is really important and I appreciate the work you're doing on it, and we will continue to do everything we can to make sure we get this done for families.

Chairman TESTER. I agree with you, Senator Murray. I also appreciate your work. Senator Moran.

Senator MORAN. Dr. Scavella, one of the women that my staff spoke to, women veteran, in preparation for this hearing is being reassigned a new primary care provider as her current one is retiring. She is concerned she will be assigned a male physician. On the other hand, on my way to the airport on Monday, I stopped unannounced at a VA clinic in Kansas City, Kansas, and visited with the veterans in the lobby.

And this female veteran was telling me that she's getting good care, but she'd prefer just to be treated as a veteran, not a woman veteran. My staff tells me that's not an unusual circumstance. And in the view of this woman, she believed that she was not offered that opportunity. She was only eligible for care on the women's clinic side of the VA.

So one, my understanding now is that that's not the case. I don't know what the educational or comments were made to this veteran in the waiting room, but in each instance, they're looking for a specific kind of provider. One, just the general VA, and one would really like to have a woman doctor. Tell me how this works at the VA.

Dr. SCAVELLA. Yes. So, thank you for that question. Ranking Member Moran. I am a 25-year-old year veteran of working within Department of Veterans' Affairs, and I took care of women and men in Baltimore and was very proud to do so. I had some women who wanted to see whomever they could and did not have a preference. And I had some women who specifically wanted a specific gender, whether it was a male physician or a female physician. And it is their choice.

We are currently in the—in this current day, we are required to offer women veterans the opportunity to have the clinician of their choice. They can choose a woman, they can choose a man. And we

continue to do that. It is their choice, and so we find some who really feel really safe in those sex concordant relationships for their provision of care, or there are some that don't have a preference. We just need to make sure we meet their needs.

Senator MORAN. Doctor, this Committee has been attempting to help the VA solve its provider shortage. We just heard about that in mammography. Is there a shortage in doctors who are female at the VA? So, if you ask for a doctor who's a female, is that a given?

Dr. SCAVELLA. So, I think we do reflect the U.S. population for women who are in medicine. We may be a little still discordant as far as having how many women? I'm going to actually ask Dr. Haskell. She knows that number, but I don't think so.

Ms. HASKELL. I did want to say that in regard to—well, first of all, let me answer your question, which is that I do believe that more than 50 percent of the providers in VA, at least in primary care, and in mental health, I believe are female. So we don't have a shortage of female providers, but I didn't want to say in regard to women being able to have a choice of providers that we require that all women are offered assignment to a women's health provider.

But our goal is really to have at least 85 percent of all women assigned to women's health providers. So it means that we are taking into account the fact that there will certainly be some women who prefer to be assigned to a regular primary care provider, not in a specific women's clinic.

Senator MORAN. I didn't know exactly how to ask that question, what the right words were, but I can assure this, this testimony will assure the veteran I visited with that she has the choice. And even if it's offered, it doesn't have to be accepted.

Ms. HASKELL. Exactly. That's correct. Thank you.

Senator MORAN. Let me talk a moment about a kind of a common complaint, and that is the community care. And it's, at least the veterans we visited with are concerned that the doctors, the providers are not being paid in a timely fashion. They're leaving, they're taking away the opportunity to provide community care to veterans. In many places we need to be growing community care in particularly rural places and with maternity care only being provided within the community.

Are we cognizant of the fact that we need to make sure that community care works for the provider and for the veteran? In other words, are we caring for the timeliness of payment those kind of things that make community care still a viable option in places across the country for maternity care and for places across rural America for veterans and their wide array of need for medical services?

Dr. SCAVELLA. So, thank you for that question. Since I see we're out of time, I'll actually defer to Dr. Johnson for that answer.

Senator MORAN. Dr. Johnson?

Ms. JOHNSON. Yes. Thank you very much. I think that's an important concern and a critical concern, and absolutely our maternity care is provided entirely in the community. And the reason for that is we cover about 7,000 deliveries across our large integrated healthcare system. And in order to provide high quality maternity

care, we really require enough volume to provide that care in a safe manner.

So, if we're doing 7,000 deliveries a year across a large integrated healthcare system, we just don't have enough volume to build that infrastructure within VA, which would include neonatologists, NICUs, neonatal intensivists, all of those things that we need to have in place to provide safe maternity care.

And I, as an OB-GYN, who actually works in a rural area am well aware of the needs of women in those states and what we have as a healthcare system is a priority to ensure that our community care networks are adequate so that we are able to provide that care to the veterans we serve no matter where they live.

And then, also leverage our telehealth ability that we have within our healthcare system to provide our veterans with tablets that have broadband access. So even those folks in rural areas are able to connect with their providers remotely if that's possible.

Now, for some OB care, that has to be done face-to-face, and we're aware that for folks living in rural areas, they may need to travel for some of that. One of the programs that I'm very proud of is our Maternity Care Coordination program. And Dr. Baptiste mentioned a little bit, we work quite closely together when we look at whether our Maternity Care Coordination program is meeting the needs of veterans we serve.

But that program was developed to recognize that we have veterans who are using maternity care who are automatically getting dual care. Meaning, they get care in VA for their mental health care, their primary care, and they must be getting care in the community. So it's really critical to have that care coordination piece that works to center the veteran and their needs with both their community provider and their VA providers.

Senator MORAN. Dr. Johnson, thank you. You've testified before us before, and I appreciate your testimony. Senator King, I'm sorry that that Senator Tester allowed me a third question, and then I'm leaving to return to Intelligence Committee where you and I came from.

Ms. Britton, the 2018 VA Inspector General Report found that 49 percent of military sexual trauma claims were not properly processed. The result of that was that veterans, according to the Inspector General, were being prematurely denied benefits they were owed.

In 2021, the IG followed up with recommendations and found about 57 percent of denied MST claims were still not being properly reviewed. It doesn't seem that the VA has this right yet. Can you explain how the percentage of MST claims being improperly processed increased by such an alarming percentage after the 2018 IG report and what actions VBA is taking to make sure that doesn't continue?

Ms. BRITTON. Thank you, sir. First and foremost, I would like to say that we do recognize the declination in the accuracy rate of the MST claims processing. As a result of the 2021 IG report, we did centralize our claims processing to specialized sites to process our MST cases. With those cases being centralized we provided specialized training to those claims processors to ensure that they have

the necessary technical knowledge to be able to process those MST cases.

We started out with five sites to process those cases, and we most recently centralized to one location under one senior executive with those specialized claims processors. We have within our receipt the special focus review that yielded a 71 percent accuracy rate for FY '23 for MST teams claims processing.

What centralizing the claims has done for us is it's allowed us to really hone in on the errors that we've seen in the claims process. With the special focus review, we took a deep dive into that and we are revamping how we're doing quality.

So we generally look at our employee quality, which is 97 percent. With the 71 percent that was achieved on the special focus review, we actually took a step back and we modified how we're assessing our MST cases. Now we will begin looking at those MST cases in the accuracy level of those on a monthly basis as opposed to an annual basis, which is what we've traditionally done as directed in the OIG report. This would allow us to do three reviews at the employee level which also expands the number of reviews that we're doing annually.

So, with that special focus review, we did a little bit over 200 reviews. This would give us the opportunity to look at 15,000 of those MST cases to make sure that we're assessing the accuracy of those in flight. So, we'll no longer be waiting until claims are completed to look at whether or not they are done right. We will do in-process reviews along the way, and instead of doing that at the claim level, we will do that at the employee level to make sure that those employees are being trained properly.

We are looking at our top error trends. We are developing targeted training to make sure that those claims processors have that training. And I am happy to report that even though we have seen that 71 percent accuracy rate, we have seen an increase in the grant rate for our MST survivors. So we've seen a grant increase in the grant rate from 2011. It was at 56 percent, so we're now looking at 62 percent for our grant rate for our MST survivors.

Senator MORAN. Ms. Britton, it'd be unfair to my colleagues to ask any follow-up questions, but perhaps we can—after the hearing my staff and you can have a conversation and/or we can have a conversation elsewhere. We'll follow-up with you. Thank you.

Ms. BRITTON. Absolutely. Thank you, sir.

Senator MORAN. You're welcome.

Chairman TESTER. Senator Angus King.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. Thank you, Mr. Chairman. I'd like to thank the Chairman and the Ranking Member for this hearing. I think it's such an important topic and important for our focus.

Ms. Britton, I've heard a lot of testimony. That answer you just gave is one of the best and most clear, concise, and informative answers that I've ever heard in this Committee. So, thank you for that.

Dr. Scavella, I think it was Dr. Baptiste had mentioned only half of the MST victims use VA care. It seems to me that just cries out

for outreach. Talk to me about how do we increase that number because it's a tragedy if there are people who need care that cares available, but they never asked, they never knock on the door. What are we doing about outreach?

Dr. SCAVELLA. Thank you for that question, Senator King. So, one of the things that Deputy Secretary Bradsher is very concerned about is making sure that the women veterans feel that they have a place within VA to receive their care, and that they are coming to us for that care. We know——

Senator KING. Is there a perception among women veterans that the VA is male dominated, it's a service mostly for male veterans?

Dr. SCAVELLA. I would say from the perspective of many, including some anecdotes, that I've heard from her and others that some women who have served don't see themselves as veterans. They don't see themselves as having a place here or deserving of receiving the services that we can provide both through VHA, VBA, and NCA through the cemetery services.

Senator KING. Let's go back to outreach.

Dr. SCAVELLA. So back to outreach. We are involved with the TAP program that takes place within the one year post- and preseparation from the service.

Senator KING. When it happens. Sometimes it doesn't happen.

[Pause.]

Dr. SCAVELLA. That's correct.

Senator KING. That's between me and the Defense Department.

Dr. SCAVELLA. Yes, since I can't comment on what's happening at the Department of Defense. But the VA is actively engaged with trying to improve the TAP program to make sure that we have a presence. The Women's Veteran Services programs and things that are available to women as they're separating, are presented at that. There's a separate session for them to hear about what we have. So, we are actively trying to make sure that they know that they have a place here.

The other thing I will say is that we do know that approximately one in three women veterans have experienced military sexual trauma, approximately one in five calling——

Senator KING. It's an appalling number.

Dr. SCAVELLA. Correct.

Senator KING. And it's probably underreported,

Dr. SCAVELLA. Correct. Probably underreported. Approximately one in five have experienced intimate partner violence. So between those two and just the burdens on women in general, we are working really hard to make sure that when they do come into our system, that we are proactively screening them, bringing them in for services, connecting them to mental health care, which can be either a risk factor for those two, or they could be things that develop after having experienced it.

Senator KING. I would hope that you might develop an additional special outreach over and above the TAP program, just a letter or some kind of communication even before mustering out so that women veterans know that there is a place that they can go.

Let me move on. We're dealing with particularly MST and other issues that are involved with mental health issues; stigma, PTSD. I guess the first question is, do we have the capacity in terms of

mental health professionals to deal with these issues? Because I know in my State of Maine, there's a problem of mental health professionals generally let alone in the VA. Where do we stand on that on that score?

Dr. SCAVELLA. Thank you for that question. So we do have specific women mental health coordinators at each facility that can help our veterans with that. We also do have a variety of outreach programs that women's health office is actually leading. So we are doing all of those things to make sure that they are receiving the care. I'd love to allow Dr. Haskell and Johnson to add to my answer.

Senator KING. Well, one thing I hope behavioral health lends itself to telemedicine and we found in the private sector that it increases people's attendance at their appointments, less stigma. They don't have to sit in an office and worry about who's next to them. So, I hope that's one of the options that's being pursued.

Dr. SCAVELLA. We are using telehealth, yes. Thank you.

Ms. HASKELL. Yes. If I could just make a few more comments about outreach. We do have a very robust outreach program through the Office of Women's Health through our Women Veterans Call Center, where we make outgoing calls to women veterans to actually—and women veterans who are not using VA, to inform them about benefits and services that are available. And that's been in existence since 2013, and I think we've called over 2 million women veterans or made over 2 million phone calls. So that's a very effective program.

And then you were talking about the TAP program. So there's a women's-specific module called the Women's Health Transition Training. It was actually developed by our Office of Women's Health in conjunction with DoD and VBA, and has now been taken over by VBA and it's available to all women. And that's a session that's fully devoted to educating them about the benefits and services that are available specifically to women.

Senator KING. I'm going to have a suggestion. Dr. Scavella, when I was Governor, I used to occasionally call the state's 800 numbers. My chief of staff called it scaring the staff, but it would be informative for you to check just—and also, to have kind of a secret shopper, you know what I mean? So that we don't have to wait for complaints to come in.

Let's see what feedback there is in the community that we're serving, and actively seek that kind of information, because there may be very simple blockages that we don't know. So, I would urge you to do that. My final question, I'm invoking the Moran rule here, Mr. Chairman, sorry.

[Laughter.]

Senator KING. This won't be the first time. Dr. Baptiste, is the VA listening to you? That's my basic question. You've made a lot of recommendations. Your work, the IG, has done a lot of really good work, and I just want to be sure that it's being implemented and that somebody's paying attention. Are you satisfied with implementation?

Dr. BAPTISTE. So in our reviews, we do make recommendations and follow——

Senator KING. That's my question.

Dr. BAPTISTE. Yes.

Senator KING. Are they following your recommendations?

Dr. BAPTISTE. And then we follow the action plans and actions that VA takes to ensure that the improvements are sustained and effective. And in addition what we would expect is when we conduct an inspection at a particular facility, that leadership at other facilities review our recommendations, review our findings, use that as a tool to review their own programs and make improvements.

Senator KING. I hope you will follow up, because doing reports and studies doesn't matter unless the recommendations are implemented. So I think that should be very much a part of your mission.

Dr. BAPTISTE. We do have a robust follow-up process.

Senator KING. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Senator Boozman.

HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you very much. Mr. Chairman, thank you for holding this hearing you and Ranking Member Moran. It's so, so very important.

I want to thank the members of both panels for being here today. Your expertise on the issues facing our veterans across the country enables Congress to do our jobs more effectively. You're making the VA and veteran experience better, not just for women, but for all veterans.

We need to create a culture at the VA that welcomes women veterans, and makes them feel like they belong. It's long overdue that we update the belief that when a woman seeks care at the VA, it's because her husband is the veteran. The great State of Arkansas is home to over 19,000 women and veterans, and I couldn't be prouder to represent them here today.

And also, I want to thank all of you all for the great job that you do, representing them in your own way. Women are currently the fastest growing demographic in both our active duty and veterans' populations. Breast cancer is the most diagnosed cancer among women in the United States. The Committee worked hard. We especially want to thank Senator Tester for his championing the SERVICE Act. It requires the VA to conduct mammograms for all women who served in areas associated with burn pits, other toxic exposures.

Dr. Scavella, can you update us on the implementation of the SERVICE Act at the VA and what issues, if any, you're seeing on the ground?

Dr. SCAVELLA. Yes, thank you for that question. So we are really proud that we have fully implemented the SERVICE Act. We are providing updates on all of the different sections in the SERVICE Act to make sure that we are responding and meeting the needs of our women veterans.

I want to turn it over to Dr. Haskell, who was intimately involved in that work to provide some details.

Ms. HASKELL. Yes, thank you, Senator Boozman. So we have been implementing the SERVICE Act actively since I guess last

year. And essentially the way we are implementing it is offering all of the women who served in these areas where they may have had potential toxic exposure a breast cancer risk assessment, and then we would order mammograms for those who it's felt to be clinically appropriate based on their toxic exposure as well as their personal and family history.

So what we've done is we have created a templated note in the electronic health record where the providers can conduct that breast cancer risk assessment. And then the note actually guides the provider about whether they should order a mammogram or whether they should, or refer the woman to some more extensive evaluation and testing, such as seeing a high-risk breast oncologist or another specialist.

And so we've not only created the template, but we've also created a dashboard that's available to the field so that the providers in the field can see all of the women in their panels who are eligible for the SERVICE Act, breast cancer risk assessment.

So, it's progressing nicely, and many sites are doing active outreach where they're actually making phone calls to women on those lists in the dashboard to encourage them to come in for their breast cancer risk assessment.

Senator BOOZMAN. Oh, good. That's a very good story.

Ms. HASKELL. Thank you.

Senator BOOZMAN. Also working with Chairman Tester, we got signed into law the MAMMO for Veterans Act, which is a little bit different in that it requires the VA to develop a strategic plan to improve breast imaging services, create a pilot program for veterans in areas where the VA does not offer in-house mammography, expand veterans access to clinical trials to partnerships with the National Cancer Institute. It also required the IG to report on mammography services furnished by the VA.

Dr. Baptiste, I was pleased in your testimony that your investigation did not identify concerns related to access and use of mammograms at the VA. Could you please speak to the findings and recommendations we should expect to see in this report as it will be published soon?

Dr. BAPTISTE. Our review found concerns that frontline staff were not aware of the Women's Oncology System of Excellence. I believe VA refers to it as the Breast and Gynecologic Oncology System of Excellence. And so that was one of our concerns and part of our recommendation.

The second is regarding the cancer registry. We found that data on veterans with a cancer diagnosis were not being entered into that cancer registry.

Senator BOOZMAN. Okay. Very good. So with that, I'll yield back.

Chairman TESTER. Senator Blumenthal.

Senator BOOZMAN. I started to be like Angus and ask a question that ran over, but I'm going to defer.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. You should always try to be like Senator King. [Laughter.] Thanks to the Chairman and Ranking Member for having this hearing. Very, very important topic. Thank you for

all of your great work on it. We're going to have a witness from the DAV, which recently did a report on women's mental health. Some of their findings are pretty disturbing. I'm sure you're familiar with them.

That report found that between 2020 and 2021, suicide rate among women veterans rose 24 percent. It also found that women are twice as likely to attempt suicide than male veteran. They're three times more likely to choose a firearm as a means of suicide. And more than 50 percent of deaths for women veterans are by self-inflicted firearm injury. Why is that? What can we do about it?

Dr. SCAVELLA. So, thank you for that question, Senator Blumenthal. Each time we hear of a tragic case, we are devastated, especially when it's our women veterans. We have done a lot of research and continue to do a lot of research into the area. We do have a Women's Health Research Network that does a lot of the analysis post-event to try to help us to inform.

We understand that women veterans do have a unique set of mental health conditions, including PTSD, depression, anxiety that could contribute to this. They typically have a slightly different burden with regards to taking care of families. That also adds to that. We find that our women veterans are younger which is also a risk factor for some of the things associated with both military sexual trauma and intimate partner violence. They tend to be younger and that may be the reason why they may be in more financial turmoil and not as established. So all of these things contribute to their mental health concerns. That's one issue.

The other is because of their training in the military. They are adept with using firearms they have access to. Approximately, 38 percent of our women veterans have firearms available to them, and they are using those. So we do have, within the Office of Suicide Prevention and the Office of Mental Health, we are looking at managing the mental health issues.

And then with suicide prevention, in addition to community partnerships, we have a Lethal Means Safety Initiative where we are trying to put time between a thought and an action by having firearms locked. We continue to work with women veterans who have either had suicidal ideation and have not committed an act to try to understand what would help them to potentially not be successful if they have those thoughts again. We're continue to do many, many research efforts to look at this.

Senator BLUMENTHAL. So, they're younger, perhaps more likely to be in financial trouble, victims of sexual assault or other similar trauma, and you're doing more research? How systematic is the research? In other words, you have ongoing specific studies, or is it a case by case?

Dr. SCAVELLA. So, I'll start, but I will turn it over to my colleagues. So, the research is not just looking following an event. We do have REACH VET, which is using analytics tools to take a look at risk factors for women to proactively reach out to them before they may even know that they may be, you know, at risk. So we're using both real-time tools. This is all on top of an ongoing, very intensive mental health care that they're receiving within either their women's health clinic program or within their mental health clinic. We have integration of mental health in primary care. So

there are many things that are going on and these are things we are doing on top of that but I want to see if either Dr. Johnson or Dr. Haskell would like to add to my answer.

Ms. HASKELL. I think that was really a pretty thorough answer Dr. Scavella. But I did want to say that we are very concerned especially about the use of firearms. And that we have formed a work group between the Office of Women's Health and the Office of Mental and Suicide Prevention. And we are looking at several specific ways to really focus in on this and one is the training about lethal means safety and the gun locks. And training not only for veterans but also for their providers. To ensure that all of our women are actually screened for firearm ownership and given a gun lock if they would like to have one.

We also have for all of our veterans in primary care—they do get suicide screening and depression screening. So that's available as well. And then the other thing that the work group is focusing on is really ensuring that all of our care in the VA is what we call trauma-informed care. And that's just sort of ensuring that that our providers are aware that any veteran who comes to the VA may have had a trauma experience and that may impact their engagement with healthcare. And we know that when veterans use VA, they are less likely to commit suicide than those who are not using VA services. So we want to really encourage our women to be engaged in and follow through.

Senator BLUMENTHAL. Can I interrupt you——

Ms. HASKELL. Yes. Go ahead

Senator BLUMENTHAL [continuing]. Because my time's about to expire. The numbers of women using VA services has increased over the recent past. Do you have numbers as to what percentage of the women veterans are taking advantage of VA services as compared to the percentage of men, and what the trends are in increased use by women of the VA, those overall numbers?

Dr. SCAVELLA. Yes. Thank you for that question. So there are approximately over 6 million active veterans using our services. Of those, approximately 10 percent, 625,000 to 630,000 are women veterans. We do find that the women veterans who are coming into our system tend to be younger. They're also, you know, of all different ages, but they're younger. They're in this cohort that we're concerned about.

Senator BLUMENTHAL. But what percentage of all the women veterans are taking advantage of the VA as compared to what percentage of all the men? Do you understand my question? In other words, perhaps 6 million is what percentage of all the men—male veterans out there and 625,000 is what percentage of all the women veteran?

Dr. SCAVELLA. Yes, I can talk about the enrolled. I'll ask Dr. Haskell if she knows about the total in the U.S. population.

Ms. HASKELL. We do follow those numbers. We call it market penetration, would be the, you know, sort of percent that are using the VA compared to the percent that are available in the market. And I would have to get back to you on the current exact number, but I believe it's somewhere around 40, 42, or 45 percent for women veterans and slightly higher for men. But again——

Senator BLUMENTHAL. Could you get back to me? I don't want to take the——

Ms. HASKELL. Yes.

Senator BLUMENTHAL [continuing]. The Committee's time——

Ms. HASKELL. Yes.

Senator BLUMENTHAL [continuing]. With it now, and I appreciate your letting me——

Chairman TESTER. Before we get to Senator Hirono. Just to be clear, you're saying 45 percent of the eligible women veterans are in the VA?

Dr. SCAVELLA. I believe that's true, but again——

Chairman TESTER. Okay, that's fine. You could be off a percent, or two, or five.

Dr. SCAVELLA. We need to get back to you with the exact——

Chairman TESTER. We've got a ballpark figure——

Senator BLUMENTHAL. And if you could get us—if you could confirm those numbers and get us the most current ones, and then the similar percentage for the men—male veterans. Thank you.

VA Response: As of September 30, 2023, according to the most recent data, the market penetration for male Veteran enrollees was 46.5%, and for female Veteran enrollees, it was 44.4%.

Chairman TESTER. Senator Hirono.

HON. MAZIE K. HIRONO,
U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman. I'm glad that Senator Blumenthal focused on the incidents of women veterans committing suicide. Whenever any veteran commits suicide, in fact, whenever any enlisted person commits suicide, that is a matter of concern to us. But in particular, it's very distressing that the incidents of women veterans committing suicide is going up not down. Is that right? That's what it sounds like to me.

Dr. SCAVELLA. Correct.

Senator HIRONO. Yes. So, thank you for citing some of the reasons or some of the circumstances that could lead to their suicide rates. But some of these conditions do not happen once they separate from the military. Are they not experiencing sexual trauma while they're in service? So, what is happening within them while they're still in active duty that, you know, will help when they get into the veteran status in terms of the support that they get once they're in veteran status,

Is there some continuity of services that we provide to women when they're in active duty as well as when they transition to veteran status?

Dr. SCAVELLA. That's a great question, Senator Hirono. I think we would need to look at some of the DoD data related to the penetration. We did see similar trends in women active service members, but I cannot compare our 24 percent to theirs.

I think there are some concerns that women—some of the things that actually do help them are the connectedness that they have with each other and those bonds that help to actually reduce the risk. But we do need to look at that. I don't have the answer to

that particular question. I want to see if Dr. Haskell or Dr. Johnson does.

Ms. HASKELL. No, I don't think I have anything to add to that.

Senator HIRONO. So, but my question is, is there some kind of a programmatic or other ways that you are already connecting to women service members before they reach veteran status? Is there a program like that?

Dr. SCAVELLA. I'll turn it over to Ms. Britton who has some information based on the work she's doing.

Senator HIRONO. Please.

Ms. BRITTON. Thank you, ma'am. So for our VA Solid Start Program, we actually target veterans that received a mental health exam within their last year on active duty. In FY '24, so far, we've successfully connected with over 136,000 women veterans—actually, veterans.

But of those veterans, 32,000 of them were identified as priority veterans. There are three calls that are made to those veterans within the first year of them exiting active duty. So, one within the first 90 days, the second one within 180 days, and then a final call before the one-year anniversary of their release from active duty.

So that is a connection that we're able to make with the VA Solid Start call agents. Those are personalized conversations. We keep them with the same representative for the entire year so that they can gain a level of trust as it relates to the engagement.

We do track the referrals that we make to the crisis hotline, and in FY '22, we had a total of 9 female veterans that we connected to the crisis hotline. And in FY '23, we connected 4. So far in FY '24, and this does not contradict the increases that Dr. Scavella talked about, but we have not received any crisis calls from women veterans in FY '24 that have needed to be referred to the crisis hotline.

Senator HIRONO. This is not a criticism, but do you—because I think you're doing your best, but do you think that more needs to be done in terms of connecting with the female service members while they're in service?

Dr. SCAVELLA. Yes. I think we need to explore this to see if there is some type of transition. We do know just based on other work we're doing, that that one year of transition between being an active service member to being a veteran, that there is a lot of instability during that one year. And it's possible that even though we have implemented several programs to perhaps—there's something or some things that we are not providing in support.

Senator HIRONO. So, every service except for the Air Force is having recruitment issues. So I would imagine that there is an increasing number of women signing up, and I think that we can see those numbers get even higher as the recruitment efforts to produce more female recruits. So I think that what you-all are doing to identify—well, I'm talking about the people who are in service, but I do see continuity of service kind of an issue that needs to take place. So whatever you're doing in that regard. Thank you.

I know that historically that the medical studies have not particularly focused on the particular healthcare needs of women. And to the extent that VA has particular programs or healthcare pro-

grams that reach female veterans, can the VA be a leader in ensuring gender equity in terms of producing the kind of research that would be useful in providing healthcare to women or particularly female veterans?

Dr. SCAVELLA. Yes. So, thank you for that question. We do have an active Women's Health Research Network that is doing a variety of research projects, looking at all things that affect women veterans, the unique needs that they have as they separate, the unique needs that they have as far as different mental health conditions, reproductive health concerns, and all of the things that surround that, as well as those who may have been exposed to toxins, et cetera. So we do have a robust number of research projects ongoing and being published.

Senator HIRONO. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Hirono. When I first got on this Committee, veterans never talked to me about their doctors. They could always request the doctor they got. That changed sometime half a dozen years ago. I think I got a complaint from a veteran that said, "I want to see the same doctor I saw last time I was in, and they wouldn't let me do it."

There was a question asked earlier that talked about you could have your clinician of choice for women, and I assume that applies to men. And is that a new policy or is that—by the way, I applaud it. I think it's the right thing to do. I think the veteran should be able to stick with a person that knows in the VA. When did this change?

Dr. SCAVELLA. So, we've always tried to take the considerations and requests of our patients into consideration. There are times when we cannot adhere to the requests.

Chairman TESTER. Yes, because you're busy.

Dr. SCAVELLA. It could be unethical, et cetera, but we do try to make sure we're providing our veterans with——

Chairman TESTER. Well, I applaud that. Okay, Dr. Baptiste, I'm going to tax your memory for a second. The ranking member talked about what I believe he talked about was an OIG report and how the VA was addressing those OIG recommendations.

I think the follow up he wanted to ask, and the follow up I'm going to ask is, Ms. Britton talked about what they were doing. I want to know your opinion about what they were doing. Did they address the challenges? And look, I don't want you guys to get into a fight there on the panel. I know you are friends. But the truth is, is that the OIG provides our eyeballs into the VA. And if what they're doing isn't addressing the problem, I really want to know, and if it is, I really want to know.

Dr. BAPTISTE. Sure. So, as you pointed out, our audit division has issued two reports reviewing MST claims, and we recognize that VBA has set up these MST operation centers to centralize the processing of those claims. There is one recommendation still open from our 2021 report regarding the review of some denied claims. And we are concerned that there may still be some inappropriately denied claims. Our audit group is planning to review that again in the near future.

Chairman TESTER. And this is a question for you then, Ms. Britton. The review of denied claims, are you guys in process at doing that before they review your review?

Ms. BRITTON. Yes, sir. So my staff and I, we actually have met with the OIG staff several times over the last year to review the recommendation as well as the centralization of the MST cases.

As it relates to the 9,700 reviews, there were a little over 90 cases that were identified by the OIG that we needed to re-review. Based on the overturn rate of those 90 plus cases, we actually expanded the review and we reviewed 9,700 cases.

Chairman TESTER. The bottom line is, did it result in any of those denied claims being undenied?

Ms. BRITTON. Yes, sir. We have a 62 percent overturn rate of the re-reviews that we've done, which has resulted in over $69 million.

Chairman TESTER. And has there been a process put in place to make it so that those denial of claims that are bona fide claims don't happen to begin with?

Ms. BRITTON. That is the increased training that we've done. So we've done training on the markers which is an area where we know that specialized experience is required.

Chairman TESTER. Okay. I talked about the Deborah Sampson Act earlier in my opening statement. And we talked about some of the things it could do. From your eyeballs, Dr. Scavella, what tangible improvements has the VA seen as a result of the measures in the Deborah Sampson Act, and does Congress need to do anything else?

Ms. SCAVELLA. Thank you for that question. So I do want to turn that over to Ms. Britton because she has been predominantly working on that.

Ms. BRITTON. So with the Deborah Sampson Act, we have implemented those recommendations. For Section 5205 which is the recommendation that speaks to the women's veteran service coordinators, we do have those coordinators at all of our regional offices. For 5501, which is the military sexual trauma conditions, that is related to the MST processing site and the improved training that I spoke about with the markers.

We do have implemented as part of a mandatory requirement for our MST, for our examinations, that all veterans are given the option in the examination notification letter to select a gender-specific examiner.

And then also with 5503 which is the piece that speaks about the OIG and their review, we did receive over 48,000 claims in FY '23. We've completed over 43,000. As I stated earlier, that grant rate has improved over the past few years from 2011 up until to date. We've seen a significant increase in the grant rate.

Chairman TESTER. Okay. I mean, I think the bottom line is here is we all need to be on the same page when it comes to women's health, in particularly, military sexual trauma.

And in the end, statistics are really good, except I get lost in them. I just want to make sure that the women veterans are getting what they need when they go to the VA and they're not being turned away. They're not being hit with red tape. They're being accommodated with the challenges they have.

With that, we're going to get to the second panel because they're very, very important also. But I want to thank all of you for your testimony and you are dismissed, as I would say when I was a school teacher, and we'll bring up the second panel.

Ms. SCAVELLA. Thank you.

Chairman TESTER. I'm going to start introducing reintroducing the second panel now. First up that's going to testify first is going to be Dr. Alissa Engel. Alissa is a Montanan, wears many hats. Dr. Engel is a veteran, a therapist specializing in military and veteran community, a volunteer mentor coordinator for Montana's Eighth Judicial District Veterans Treatment Court, and she is a current member of the Montana International Guard.

We also have Julie Howell that is an Associate Legislative Director at PVA, that's Paralyzed Veterans of America. We have Dr. Kirsten Laha-Walsh, who is a Government Affairs Specialist for the Wounded Warriors Project. And Naomi Mathis, the Assistant National Legislative Director for the DAV, Disabled American Veterans.

And we want to thank all four of you for being here today. And as I said, we will start with you Dr. Engel, thank you for making the trek from Montana. It is good to see you again, and you may proceed. No, this Great Falls, Montana, one of the most beautiful places on earth.

And the four of your entire written statement will be part of the record. I would like to ask you to keep your verbal statement within five minutes. Thank you.

PANEL II

STATEMENT OF ALISSA ENGEL, PHD, LCPC, LMFT, MENTAL HEALTH THERAPIST, VETERAN

Ms. ENGEL. Good afternoon, Chairman Tester, Ranking Member Moran, and Committee Members. Thank you for the opportunity to speak with you all today.

I'd like to focus on military sexual trauma and the claims process. It is crucial that MST claims be processed accurately and in a timely manner. The consequences of an incorrect denial are catastrophic. When we have an MST claim filed, we are being handed the opportunity to right a wrong for that veteran. This is a privilege that they don't have to give us because by that point, they've already been through hell.

I touched on the topics of institutional betrayal and moral injury in my written testimony because both play a role in the nature and type of PTSD we see with MST. The inclusion of one or both often results in the development of what we call complex PTSD.

A denied MST claim is a just another layer of institutional betrayal. Many victims wait to report, if they report at all, until they are discharged from the military, assuming it will be safer or because they desperately need the resources. When their claim is denied and they're left feeling betrayed, worthless, abandoned, and unsafe all over again, and the institution that should be helping and protecting has just further complicated their trauma.

Conversely, having a claim approved is a powerful healing tool. It's the equivalent of a guilty verdict in court. It doesn't eliminate the trauma memory, and it doesn't heal the trauma reactions, but it also doesn't compound the trauma, and it lays a priceless foundation for healing.

A validated disability claim tells the victim, we believe you. What happened to you wasn't your fault, and it shouldn't have happened on our watch. It tells the victim that as a Nation, we truly are grateful and that we will stand beside them.

Given the current MST claims processing procedures, we cannot look at our women vets in the eye and honestly tell them that be we believe them and will provide them with the services they need to heal. We must enact the necessary changes to create an impeccable trauma-informed claims processing procedure.

When I accompanied the marine veteran that I referred to in my written testimony to her claims appointment with the VSO, she couldn't focus. She froze. She didn't remember what was discussed in the meeting. This just illustrates how complicated and terrifying the process is; how trauma instinctively throws the veteran into survival mode and shuts down the brain's ability to manage such a complicated process.

It's also very difficult to prove MST when most victims don't report, they don't seek medical care and they don't tell anyone for years. Neither of the women veterans I spoke about in my written testimony, reported their assaults to the military. They do not have DoD documentation to substantiate their claim. They have their story that they've told, maybe one or two people in a fragmented memory. That's how sexual trauma works.

If you sit with someone who trusts you enough to tell you their story, the pain and betrayal are palpable. But earning this level of trust takes time. The current claims process doesn't allow examiners the luxury of time. They see a veteran who enters the exam room in pure survival mode one time. The examiner might be a male, they're in a sterile and foreign meeting space, and they're asking questions about the worst moments of that veteran's life. It's impossible to get an accurate determination under these circumstances.

The VA must find a better way to substantiate MST claims. Why do we presume dishonesty until proven otherwise? What if we created our processes based on research, which gives us an overwhelming amount of evidence that victims tell the truth? The consequences of denying a valid claim are far greater than the consequences of approving the very rare false claim.

In addition to improving MST claims processing, we must also fix the referral and authorization system. When a woman veteran is ready to engage in mental health care or care related to other MST injuries, it is imperative that they have easy access to a network of highly trained professionals.

In grad school, I invited the dean of the law school and the director of the Veteran Law Clinic to sit on my dissertation defense committee. It's pretty risky business to invite a lawyer to ask you as many questions as they want about your research, but she only asked me one, and it will haunt me forever.

She told me that her high school-age daughter was interested in going to the Air Force Academy and that she had a very competitive application. And then she asked me if I thought she should encourage it. And my answer was, "I don't know." Which is also the answer you really don't ever want to give in a dissertation defense. But it was the honest answer with the MST epidemic raging and the aftercare lacking.

I can't in good conscience encourage anyone to send their child to basic training. My hope is that in the very near future, thanks to the good work of so many, I'll be able to say, "Yes, absolutely. The military is a wonderful career path for your daughter."

Thank you for your time, and I welcome any questions.

[The prepared statement of Ms. Engel appears on page 65 of the Appendix.]

Chairman TESTER. Doctor, thank you. There will be questions. Julie Howell.

STATEMENT OF JULIE HOWELL, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Ms. HOWELL. Chairman Tester, Ranking Member Moran, and Members of the Committee, Paralyzed Veterans of America, thanks you for the opportunity to present our views on the current state of care for women veterans.

Few veterans understand the full scope of benefits offered by VA better than PVA members. Ensuring the women members of PVA have timely access to quality care will help VA be better positioned to deliver care for all veterans, particularly those with complex illnesses and injuries.

We've all heard that women are the fastest growing demographic or the fastest growing cohort of veterans using the VA accounting for nearly 30 percent of all new VA enrollees. It is our obligation to ensure that all women veterans encounter barrier free access to healthcare and benefits.

We commend Congress on several legislative victories for women veterans over the past few years, such as the MAMMO Act, the SERVICE Act, the MST Claims Coordination Act, and the Deborah Sampson Act. Collectively, these bills represent a huge investment in women veterans. However, as we all know, there's still plenty of work to be done.

In our written statement, you will find several topics that we believe need additional attention. But in the interest of time, I'd like to focus on a few areas that are of the utmost concern to PVA. The Deborah Sampson Act was a major achievement that became the vehicle to draw attention to the deficiencies encountered by women veterans when accessing VA.

While many women veterans have benefited from its passage, it's had little impact on PVAs women members. VA still lacks critical accessibility accommodations that our members rely on. Barriers for our women members that they encounter when accessing gender-specific care are an issue and VA needs to take them seriously.

It starts with parking lots with limited disability parking, check-in counters that are too high, waiting in exam rooms that are too small, limited ceiling lifts, and a general lack of accessible medical

diagnostic equipment. This is why we support the Veterans Accessibility Advisory Committee Act to ensure that VA prioritizes accessibility for all of our disabled veterans.

I'd also like to take a minute to discuss the very sensitive issue of military sexual trauma. MST is pervasive, and we must do everything we can to treat survivors with the utmost care and respect. Mr. Chairman, in a 2021 survey of our women members, nearly 40 percent of them reported that they had experience with MST. Forty percent know a provision within the DSA mandate that survivors could pick the preferred gender of the providers they engage with. However, we are hearing from our service officers that that is not always offered and that is not standard across the board.

Many of our members are filing their MST claims decades after their experience. And for SCI/D veterans, some of those physical long-range symptoms of MST are incapable of manifesting. However, that doesn't make their trauma or their experiences any less real. VBA staff need to understand the nuance that comes with working claims for veterans with complex injuries.

We thank Chairman Tester for the reintroduction of the Service Member and Veteran and Empowerment and Support Act of 2023, which we believe may help address some of these concerns. Finally, when people imagine a disabled veteran and their caregiver, most people imagine an older male veteran with his wife by his side. So in contrast, I would like to introduce the Committee to Ann Robinson. Ann Robinson is an army veteran, a PVA, a national vice president, a wife, a mother, a grandmother, and my friend.

Ann was injured in a military vehicle accident in 1999, and Harry has been her dedicated caregiver and loving husband ever since her injury. Ann's level of need is significant, and while Harry has constantly been by her side, they need additional help. Recent expansions of the Veteran-Directed Care Program have provided Ann an opportunity to hire direct care workers. However, it hasn't been that easy.

The VDC Program only allows Ann to pay her workers around $19 an hour. And after more than 100 interviews, the few folks that were qualified and hired left for higher paying jobs. In her home of San Antonio, the staff she needs generally earn upwards of $35 an hour.

The lack of direct care workers is a nationwide crisis, one that hits disabled veterans with the greatest support needs quite hard. Our Nation must increase efforts to grow this workforce, and VA needs to help by ensuring veterans with a catastrophic injuries and illnesses are able to secure needed direct care workers in line with market demands.

In closing, we commend the Committee for working toward the passage of the Elizabeth Dole Home Care Act. PVA members are eager to see this bill become law. We urge Congress to pass this as soon as possible because our Nation's most vulnerable veterans should receive care in the comfort of their home should they choose.

Many argue that this level of care costs too much. However, in recent years, we've talked a lot about the true cost of war and in many like her have earned their benefits. The lifelong supports

that they need are the true cost of military service. Thank you to the Committee for giving PVA this opportunity to share our views, and I'm happy to answer any questions.

[The prepared statement of Ms. Howell appears on page 73 of the Appendix.]

Chairman TESTER. Thank you, Julie. If we can't take care of our veterans when they come home, we shouldn't send them off to begin with. Kristen, you're up.

STATEMENT OF KIRSTEN LAHA–WALSH, PHD, GOVERNMENT AFFAIRS SPECIALIST, WOUNDED WARRIOR PROJECT

Dr. LAHA-WALSH. Good afternoon, Chairman Tester, Ranking Member Moran, and distinguished Members of the Committee. On behalf of Wounded Warrior Project, I want to thank you for the opportunity to speak before you today about how Congress, VA, and the wider community can better support women veterans.

Since 2003, Wounded Warrior Project has been working to transform the way America's injured Post-9/11 veterans are empowered, employed, and engaged in their communities. For the past 20 years, we have supported warriors through and beyond their transitions to civilian life with services in mental health, physical health, peer connection, career counseling, and financial wellness. We currently offer these services to over 200,000 veterans across the country, and we are welcoming hundreds more every month.

And as key context to today's hearing, I want to briefly highlight how we are serving more than 35,000 women warriors. We have taken deliberate steps through our Women Warriors Initiative, which supports these veterans through tailored programs and services such as women only peer support groups, or culturally competent mental healthcare that can be offered in gender-specific cohorts.

Through our physical health and wellness program, we offer female-focused opportunities such as multi-week courses that provide education on topics such as perimenopause and postmenopause challenges and experiences. And in fiscal year 2023, more than 5,000 women participated in our connection programming to build bonds with other veterans in their areas, and over 130 women stepped up to serve as warrior and peer leaders in their local communities.

Most notably for today, I am pleased to share insights we gained through the development of our "2023 Women Warriors Report." The report serves as a beacon shedding light on the experiences, struggles, and triumphs of our women veterans. While our written hearing statement includes more perspective, I'd like to highlight three of our key focus areas in the Women Warriors Report, and to provide insight into the policy recommendations we develop through our data.

First, the report highlights the critical importance of mental health support for women veterans. Anxiety is the number one injury or health problem reported by women warriors, and like PTSD and depression is reported at a higher rate than males. But while women warriors are also more likely to report moderate or severe

mental health symptoms, they are also more likely to seek support and care than male warriors.

It is incumbent upon us to expand access to mental health services to meet the warrior where they are, de-stigmatize seeking help, and foster a culture of care and compassion within our veteran community. Congress should continue to help VA retain, recruit, and train mental health providers and continue oversight to ensure VA is creating community referrals for care if it cannot provide timely services itself.

We also encourage the Committee to consider broader issues such as women veterans not feeling respected within their communities, which can lead to feeling isolated, left out, or lonely, all of which were reported as top issues for women warriors.

A second central focus of the report pertains to healthcare access and quality. Women warriors are more likely to navigate the VA system with three in four using VA medical centers for primary care. However, only 61.9 percent use VA for women's healthcare-specific services.

In recent years, women veterans have often cited feeling harassed at VA medical facilities, which has dissuaded use by many. But VA has worked hard in recent years to ensure women veterans feel safe and appreciated while accessing healthcare.

Another challenge presented was that more than half of our women warriors reported delaying or putting off getting healthcare, with barriers including, a lack of cultural competency from providers and staff. This issue is especially important for individuals who have survived MST.

With over two-thirds of our women warriors experiencing sexual harassment while in service and more than 2 in 5 reporting having experienced sexual assault, it is imperative that VA support services through the benefits process as well as through healthcare. More broadly, from accessing gender-specific care that is culturally competent, to feeling listened to by providers and staff, there is a critical need for tailored, comprehensive benefits and healthcare initiatives that prioritize the well-being of our women veteran population.

A third focus centered around the financial wellness for women warriors, which included topics such as career advancement and leadership opportunities for women with a military background. Despite being more educated, women warriors face greater struggles with employment than males. With 1 in 10 women warriors reporting unemployment, we've heard many stories about adverse factors like a lack of professional mentorship, difficulty translating military skills to the civilian workforce, and finding employers who are supportive.

Congress can help take proactive steps to address issues like these by continuing to invest in workforce training and education initiatives such as the Edith Nourse Rogers STEM Scholarship and VET TEC programs. Both have a high potential to benefit women warriors, specifically.

In the coming days, weeks, and months, we look forward to continued discussions with leaders, VSO partners, and the broader community, along with opportunities to translate the insights and finding of this report into tangible initiatives and concrete action.

We are steadfast in our commitment to our women warriors, ensuring that they receive the respect, recognition, and support they so rightfully deserve.

Thank you, again, for the opportunity to testify before you this afternoon. I look forward to answering any questions you may have.

[The prepared statement of Dr. Laha-Walsh appears on page 82 of the Appendix.]

Chairman TESTER. Kristen, thank you for your testimony. Naomi, you have the floor.

STATEMENT OF NAOMI MATHIS, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. MATHIS. Thank you, Chairman Tester. We appreciate the opportunity to discuss DAV's new report, "Women Veterans: The Journey to Mental Wellness."

Our report comes on the heels of VA's most recent veteran suicide prevention report, which showed overall increased rates of suicide for veterans. However, the most alarming finding was that the suicide rate among women veterans jumped more than 24 percent in 2021. That's nearly four times higher than the increase among male veterans, and vastly higher than the increase among non-veteran women.

Our report looked at the unique risk factors contributing to the staggering rate of suicide among women veterans, and the challenges and obstacles women veterans face on their journeys to mental wellness. DAV offers more than 50 legislative and policy recommendations that have the potential to save the lives of women veterans.

The issue of lethal means safety is especially important as firearms were used in more than half of women veterans' suicide. In fact, the rate of women veterans dying by firearm suicide was nearly three times higher than for non-veteran women. VA has included women veterans in its lethal means safety campaigns. Unfortunately, some women veterans felt the ads did not make clear why it was so important to keep their firearms safely stored.

DAV recommended the VA should conduct additional focus groups with women veterans to determine the most effective secure firearm storage messages and messengers for this population.

We also found that military sexual trauma, MST, and interpersonal violence, IPV, led to an increased risk for suicidal ideation and self-harm behaviors among women veterans. One in three women veterans enrolled in VA care report experiencing MST, and one in five women veterans using VA primary care reported experiencing IPV or domestic assault. For these reasons, DAV strongly recommends that MST and IPV be essential pillars of VA suicide prevention reports.

Research also shows there is a direct link between trauma and substance use disorder, as well as eating disorders, which often stems from an attempt to control chronic pain or to cope with post-traumatic stress. The risk of suicide death among women veterans with active substance use disorder is more than two times the rate of male veterans.

Unfortunately, most women veterans with at-risk alcohol use are not in treatment, citing stigma and discomfort with mixed gender programs as reasons for not engaging in treatment.

We found geography and barriers to accessing mental healthcare can be another risk factor for suicide. Research shows that there is a 20 percent increased risk for suicide among rural veterans. Mr. Chairman, as you know, one in four women veterans who use VA healthcare services live in rural areas. And rural women veterans have higher rates of suicide by firearm than their urban women veteran peers.

Perhaps the most underappreciated aspect of women veterans health is the relationship and impact of reproductive health issues on mental health. During the lifecycle of women; pregnancy, birth, and menopause can bring about significant hormonal shifts and increase the possibility for mental health issues, including increased risk for postpartum depression and poor mother infant bonding.

I know firsthand how dramatically pregnancy can impact a person's mental health. Following my service in Iraq, I was diagnosed with PTSD. Later, I became pregnant and medical complications forced me to give birth to my son two months early. Subsequently, I began experiencing severe postpartum depression. One day while my baby boy was sleeping on the bed, I started having terrible intrusive thoughts that threatened to harm both of us.

This served as a wake-up call for me, and I quickly got the mental healthcare I needed. While I was fortunate to get the right help to get through my crisis, many women veterans are not even aware of the powerful impact hormonal changes can have on their mental health.

In conclusion, the successes and gaps in DAV's report highlight the importance of continuing to invest in VA women-centered research programs and services, and targeted suicide prevention efforts.

Mr. Chairman, this completes my statement, and I look forward to answering any questions the Committee may have.

[The prepared statement of Ms. Mathis appears on page 96 of the Appendix.]

Chairman TESTER. I appreciate all your testimonies. Thank you very, very, very much. And I'll start with Senator King, if you have questions.

Senator KING [presiding]. I do. All of the discussion today has about been treating MST, and it's ramifications and implications, and the terrible toll that it takes. But I'm sitting here saying, "Shouldn't we be doing more to prevent it from happening in the first place?" Am I correct that the figure is 1 in 3 female veterans report military sexual trauma? That's unacceptable.

And I also serve on the Armed Services Committee. We've had a lot of work over the last 10 years led by Kirsten Gillibrand, as you know, on changing the rules and the regulations. But it seems to me we're really talking about a culture change, that this kind of conduct is just unacceptable. But your testimony has been very powerful, and I agree with everything you said about better treatment; more than one interview, more training. But Mr. Chairman, we also—I'm the Chairman. Okay.

[Laughter.]

Senator KING. Well, in that case, no, but we really have to keep—I hope you'll work with us, with my office on dealing with these issues not only here, but in the Armed Services Committee. Because if there's more than we can do, let's do it.

But the hardest thing is culture change. But I remember many years ago when drunk driving was an epidemic in this country, and it became not cool sometime in the '70s and '80s, and now the level is much reduced. It was a culture change. And so, we need to be thinking about that.

Ms. Howell, you talked about outreach, suggestions for improving outreach. You heard my questions of the prior panel. What can we do specifically better contact the TAP? What is it going to take to get more women veterans into the system where help is available?

Ms. HOWELL. Thank you for that question, sir. The work that VA is doing to get the word out in TAP is great. That's also a very small portion of the veteran population. Most veterans engage with VA several years after they've already separated. That's the way this usually works. They engage with all the support services years after——

Senator KING. Yes. One of the most dangerous periods is the——

Ms. HOWELL. Is that transition.

Senator KING [continuing]. Immediate post-separation.

Ms. HOWELL. If I may just take a second, sir. One of the questions you asked to the first panel was, how come such few, like, why such a small percentage of women veterans are actually engaging with VA? What do we need to get them there?

But then you also just answered your own question in that this trauma happens at DoD, and then we expect VA to fix the problem. Women are not going to—many women are not comfortable going to VA because what happens when you run into a bunch of people that you then assume are a danger and a threat?

Like my neighbor commented earlier, women are not a monolith, no veteran group is, we need various channels to be able to create a net so that all of those outreach efforts can align. You can do your standard, let's go have 140,000 touch points with veterans throughout a year, but if you're not engaging with the local communities that those women feel comfortable in, you're going to miss those folks.

We can't spend all of our time—while it, yes, it's absolutely critical to focus on transitioning service members, plenty of MST claims come in decades after these women serve. We don't feel comfortable addressing that concern in the moment. It's a trauma response, as was said earlier. So we can't think that any one outreach method is going to be a in catchment for all veterans.

Senator KING. Well, to the extent you all have ideas along this, we don't have to do it all right here, be in touch with us, with the Committee, with the Chairman, with my office, because the most valuable commodity around here are ideas. And you're in touch with the field to tell us what can be done, what the steps are.

One of my problems on armed services since the very beginning of my tenure here is that I believe that the Defense Department should spend as much time, money, and effort on transition out as they do on recruiting in. And we are looking for all kinds of ways

to improve the handoff, for example, by notifying the state veterans' officer when somebody is going to be coming out and going to their state.

So, a lot of those rules, but please give me as much help as you possibly can. Your testimony has been very sobering.

Dr. Engel, you, you talked about the process. I like the idea that one interview is not enough. Is the process improving? I don't want to be like your dissertation.

[Laughter.]

Ms. ENGEL. I was thinking that. I don't think so. I don't think that MST reporting process is improving.

Senator KING. Well, tell me how? You don't have to tell me now, my time is expired, but we have this little digital clock in front of us that governs our life. But seriously, don't let your input to this Committee end today. If you have thoughts how to improve it; require two interviews, ensure that there are female intake officers? What should the criteria be? What is the standard? All of those things help us to understand that because we may be in a position to fix it.

Ms. ENGEL. Yes, sir.

Senator KING. Thank you. Thank you all very much. Your testimony is very important. Really appreciate it.

Chairman TESTER [presiding]. Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Thank you, Mr. Chair. And I just want to echo what Senator King just said. Your testimony is really, really important, and it also can be really, really hard. No matter how practiced you get at this sharing personal details and wearing the experiences of so many other veterans who you're speaking for today is a hard thing to do. So we are really, really grateful to you for that.

I wanted to start with a question to Dr. Laha-Walsh. In its "2023 Women's Warriors Report," the Wounded Warrior Project discussed several difficulties faced by women veterans, including a lack of support as they transition from military service to civilian life. So you discussed this in your testimony and you mentioned that many women warriors are more likely to experience loneliness, isolation, and a lack of respect for their military services compared to their male peers.

As more women veterans leave the military and enter civilian life, one of the strongest ties to their service is their connection with the VA. So Doctor, what can the VA do to help address the loneliness, isolation, and other issues that women veterans disproportionately face?

Dr. LAHA-WALSH. Thank you for the question. We have several recommendations in our report that we believe would address certain aspects of connecting women veterans to engage more with their community. We have also made recommendations, specifically, around increasing eligibility for scholarships because we also see a lot of women veterans and women warriors, specifically, that are wanting to pursue higher education.

But I would say, specifically, there is a recommendation in our report that focuses around building out a professional mentorship

network. A lot of women veterans feel that they have to compete amongst other women veterans while in service. So when they get out, they don't have a net to fall socially.

Many women warriors in our focus groups last year also spoke about the, the need to separate their civilian friends from their military background friends. They didn't want to co-mingle or intermix the groups. So, providing a professional mentorship network would allow women veterans who have achieved career milestones to support those in the transition process and it would be facilitated by VA.

We believe that program potentially would not only increase productivity within connectivity, but also would stimulate further conversations about what women veterans can do to support each other on the outside.

Senator HASSAN. Thank you. That's very helpful. Ms. Howell, in your testimony, you discussed some of the challenges that women veterans with spinal cord injury and disease face. You specifically discussed how difficult it is for these veterans to receive gender-specific care through the VA's spinal cord injury and disease system because of the high level of coordination required between this system and the VA's Women health clinics.

You also stated that many women's clinics are not physically accessible for paralyzed women veterans. So, what can the VA do to make care more accessible and more effective for women veterans with spinal cord injury and disease?

Ms. HOWELL. Thank you for that question, Senator. I think what is true of all things within VA, particularly around gender-specific care, is coordination. VA is very siloed. Most of us up here are VA users. One of the very unique things about VA as compared to community care at large is that there is that continuum; your doctors are tracking, everyone's got access to full records. You don't have to necessarily be proactive about that outreach.

However, within VA for women that are using the SCI centers, that coordination is very hit or miss. It relies on a coordinator to be in the SCI center that's willing to take the time to build those relationships. You need a women's health clinic or a gender-specific provider that has the bandwidth to go over to the SCI unit, because more often than not, the women's health clinic is going to lack those fundamental accessibility requirements that keep our women members safe.

And so, that cross team coordination, that takes a lot of bandwidth, and it takes a lot of effort, and sometimes it takes an external pressure to make sure that people are making those connections so that the PVA women members can receive accessible gender-specific care, either in an accessible women's clinic or through the SCI center.

Senator HASSAN. Okay. Thank you very much. And Mr. Chair, I yield my time.

Chairman TESTER. Yes. Thank you, Senator Hassan. I'm going to start with you Dr. Engel. I share many of your concerns about the military sexual trauma claims process and would like your input on a change that may help use the process for survivors.

When so many sexual assaults go unreported in the military, it is my belief that we need to require the VA to consider non-DoD

evidence. Check out those sources when reviewing claims for all MST-related mental health conditions. I'd like you to comment on that. I would like you to tell me if this could potentially change the impact for MST survivors, or if this is not something that's worthwhile.

Ms. ENGEL. Thank you for that question. I absolutely think that that would make it better for survivors. Like we've talked about they typically don't report, or they report after a large amount of time goes by. And when they do report, it tends to be people that they're close to; their spouses, their friends, their family. Not the formal channels.

So if we allow non-DoD proof, it really opens up the door there. The other piece about—that is when we're looking at trauma-informed care, we always want to give the power and control back to the veteran that was taken from them. And right now they're kind of put in a position where I get my disability claim for my MST, but I have to do these things that I don't want to do, or I don't get my claim. By doing what you're suggesting, sir, it gives them more power and control. They get to choose what evidence they want to bring instead of having to produce certain evidence.

Chairman TESTER. Okay. Thank you. I'm grateful for the support all the VSOs that are up here today for the Servicemembers and Veterans Empowerment and Support Act. I appreciate that. It would expand evidentiary standard for MST claims and make improvements in that claims process. So thank you for that because if we want to do right by MST survivors, we need to give them a stronger voice, you, a stronger voice in this process.

So this is for the PVA, and Women Warriors, and DAV. Can you each take a moment to describe the impact this bill would have on MST survivors and their access to VA healthcare and benefits? You can go in any order you want.

Ms. MATHIS. Thank you for that question, sir. DAV strongly supports this legislation. In fact, we did a grassroots campaign on it, which resulted in over 22,000 emails from our members in support of this bill.

And this bill will help ensure veterans are aware of access to care and services for conditions related to their trauma, and they don't face unnecessary hardships throughout the claims process.

Dr. LAHA-WALSH. Again, thank you for the question. We found that women veterans are actually more likely to include more non-direct evidence, which include the word performance records, financial documents, demonstrating unexplained financial situations. So because of that and many other things, we support strongly the SAVES Act.

We also are very supportive of ensuring that all guard and reserve members are able to receive MST-related services, including mental health care, which is also provisioned within this bill. And we very strongly support that.

Chairman TESTER. Julie?

Ms. HOWELL. Thank you for the question, sir. I just want to highlight that nearly 36,000 service members reported sexual assault in FY '22 according to DoD, and as we've already discussed, that's only the reported ones.

I think that your piece of legislation will be critical in making sure that when veterans come forward with their claim, that they don't feel the need to provide the textbook evidentiary support. I think that will provide a comfort level for people that are applying for these claims. That will see an increase in applications.

I also think for PVA, in particular, Section 206, will have a really profound impact. The study on training and processing of claims. PVA believes that critical information can be gleaned from the process by that section in particular.

And as I mentioned in my testimony the complications that come with veterans with complex injuries and comorbidities when they're filing an MST claim, a lot of those long-range physical manifestations don't necessarily manifest with our membership.

So, I think being able to present that case with the evidence that you have will go a long way. And that study will show whether or not VBA is sticking to it.

Chairman TESTER. I'm going to ask a few more questions, then I'll get to you, Senator King, if that's okay.

Naomi, I want to talk to you about something on a personal level and in a more general level. And this deals with mental health. You talked about in your opening statement, the impact of childbirth had and the thoughts that went through your head.

But something happened, and you went and got help. Have you ever thought about why that occurred? Was it because of your association with DAV, or was it the fact that you've got somebody that knows you well enough to understand when there was a challenge, or? Talk to me.

Because sometimes this doesn't happen and you don't get help, and then, you know, it's like any other health that I'm on. If you don't get health help, it gets worse. Talk to me.

Ms. MATHIS. Thank you, sir. I would say at the time I was in acute PTSD. I was in the throes of PTSD after coming back from Iraq as a combat veteran and dealing with that, and then the hormonal changes with having my child along with polypharmacy. I was on several medications. They were trying to figure out how—you know, which medication would actually work for me.

And as that incident happened, it just scared me in what I would potentially do to both of us. And so, it wasn't really anything specific. It was just myself trying to will myself out of it, and really crawl up out of that hole that I was in, and my ability to reach out and say, hey, something's not right. This is not okay. I'm scared.

Chairman TESTER. And you were able to get ahold of somebody that could help you.

Ms. MATHIS. I was able to get ahold of someone, and that's why peer support is so important. And social support, it's really a protective factor when it comes to suicide prevention.

Chairman TESTER. 100 percent. And I think it's one of the reasons you see a 20 percent higher rate of suicide in rural America, because isolation is something that happens automatically if you're living where there is no people.

I just want really quickly, and I'll get to you, Angus, half the suicides committed by women. Did I get this right are done with guns?

Ms. MATHIS. Yes, sir. More than 50 percent, actually.

Chairman TESTER. Okay. And the rate has went up by 24 percent. At least that's what the 2021 study said. I'm a farmer, okay, I'm not a mental health professional at any sense of the imagination, but I have always been told that suicide by guns with women is rare.

Ms. MATHIS. In fact, and I'm not a doctor either, but from what we found, they generally use medication. So overdoses or strangulation is the—usually.

Chairman TESTER. So the question here is, is this something that's outside the norm for veterans?

Ms. MATHIS. It seems to be. Yes, sir. Well, it seems to be that veterans that is the——

Chairman TESTER. For women veterans.

Ms. MATHIS [continuing]. For women veterans, that is the method that's chosen compared to their non-veteran peers.

Chairman TESTER. Yes. And I guess it probably takes somebody, I mean, maybe it's familiarity, but oftentimes familiarity with guns will make it so you don't use it. But maybe not. I could be wrong.

Ms. MATHIS. Which is why it's important, sir. There is a time between the thought of suicide, and having that accessibility, and actually potentially taking their life by a gun.

Chairman TESTER. It's interesting you say that because about a month ago, I had a gentleman in my office, a guy veteran, that tried to commit suicide with a gun, and the bullet didn't fire. And he immediately went and got help.

And he's alive today because it, you know, the blunt instrument didn't work. And he's living a great life, by the way. Living a great life, but he went and got help just like you did. And the problem, it can be fixed. The stigma needs to be taken away so that people understand this. Angus.

Senator KING. I just want to be sure in our discussion here to get on the record, that I suspect there's nobody in this room who wants to fix these problems more than Dr. Scavella. And everyone I've worked with at the VA care deeply. They wouldn't be there otherwise.

And so, I don't want to leave hanging that somehow the VA, they don't care. They're too bureaucratic. The VA people I've worked with at the CBOC in Maine, at Togus, the Veterans Hospital in Maine, they're people who are there by choice. So I just wanted to be sure, Mr. Chairman, that was on the record.

The four women who preceded you care about this issue deeply, and what we need to do is come together to share experiences and find solutions. So, thank you for that. And I want to thank our prior panel as well. Thank you.

Chairman TESTER. The only thing I would add to that is not only the four women who work for the VA, but the woman who works for the IG cares about it too. And thank, thank you all for your testimony today. I very much appreciate you guys taking the time to be here to talk about this very, very important issue.

This isn't the last time, by the way, we are going to deal with this. We are going to have a roundtable that includes more Veterans Service Organizations, more people's perspective because this is an issue we've got to find solutions for because honestly it's a bad deal.

And I would say this, Angus, you talked about training to get out of service. I think if the military started doing that, it would help in the recruitment greatly. I don't think there's any doubt about that.

So, I want to thank the witnesses for testifying. We will keep this record open for a week for comment. This hearing is now adjourned.

[Whereupon, at 5:23 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

STATEMENT OF ERICA M. SCAVELLA, MD, FACP, FACHE,
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VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

"CARING FOR ALL WHO HAVE BORNE THE BATTLE:
ENSURING EQUITY FOR WOMEN VETERANS AT VA"

APRIL 10, 2024

Good afternoon, Chairman Tester, Ranking Member Moran, and Committee Members. My name is Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services in the Veterans Health Administration (VHA). Joining me today are Dr. Sally Haskell, the Acting Chief Officer, and Dr. Amanda Johnson, the Acting Deputy Chief Officer, both within the Office of Women's Health (OWH), and Ms. Kenesha Britton, the Assistant Deputy Under Secretary for Benefits for National Contact Field Operations with the Veterans Benefits Administration (VBA).

Thank you for the invitation to testify. Addressing the unique needs of women Veterans is crucial, especially as they are the fastest-growing group served by VHA today. As we conclude our 100th year of providing women's health care, VA aims to set a higher standard of care and become a national leader in the delivery of women's care. Continued collaboration with this Committee is essential to achieve the comprehensive care they deserve.

I. Health Care for Women Veterans

Over the past 5 years, there has been a significant increase in the number of women Veterans seeking VA health care services, with women accounting for over 30% of the total growth in Veterans served. Since 2001, the number of women using VA services has more than tripled, rising from 159,810 to over 625,000 in 2023. VA provides comprehensive care for women Veterans, encompassing preventive, acute, and chronic disease management; reproductive health care; and mental health care.

To address the unique health care needs of women Veterans, VHA has developed primary health care policies specifically for them. These policies ensure equitable, high-quality care that is sensitive to their gender-specific health concerns and experiences. By emphasizing preventive care, early intervention, and holistic approaches to wellness, VA aims to promote the health and well-being of women Veterans through its primary care initiatives.

One key policy ensures that women are offered assignments to specially trained and experienced Women's Health Primary Care Providers (WH-PCP), who offer general and gender-specific primary care within a long-term patient-provider relationship. With

every VA health care system having at least three WH-PCPs, 87% of women Veterans are assigned to one. In fiscal year (FY) 2023, VA allocated funding for over 1,000 women's health personnel nationwide, including primary care providers, gynecologists, mental health providers, and care coordinators of which 86% are onboarded.

Reproductive Health Policies

All enrolled Veterans can access a wide range of essential reproductive health care services at VA. Examples of these reproductive services provided by VA include contraception, pregnancy-related care, fertility and preconception counseling, sexually transmitted infection (STI) screening and treatments, and specialty medical and surgical management of gynecological conditions.

A. Gynecology. Comprehensive and specialized gynecological care, which may involve complex surgeries and cancer treatments, is provided to women Veterans as part of our commitment to meeting their unique health care needs. VHA provides a range of gynecological services through a network of skilled health care professionals at state-of-the-art facilities to address their specific health concerns. VHA provides compassionate, evidence-based care ranging from routine screenings and preventative measures to specialized treatments and support for gynecological conditions. To further these efforts, OWH has created several initiatives with a focus on clinical excellence, research, and education.

- The Gynecology Community of Practice and Virtual Grand Rounds serve as platforms for collaboration and learning among VA gynecologists, facilitating virtual meetings, webinars, and forums. These initiatives aim to elevate the quality of care.
- The VA Gynecology Virtual Grand Rounds additionally provides expert-led presentations, case discussions, and updates on reproductive health topics for Veterans. This platform enhances the quality of gynecological care for women Veterans.
- The National VA Gynecology Conference convenes health care professionals, researchers, and women's health experts to share research findings, best practices, and innovations in gynecological care. With a special focus on addressing the unique health care needs of women Veterans, this conference serves as a vital forum for collaboration.
- The VA Advanced Fellowship Program in Minimally Invasive Gynecology provides prestigious training in advanced surgical techniques. Through hands-on experience in laparoscopy and robotic surgery, enhancing health care providers' expertise and improving outcomes.

B. Contraception. VHA supports Veterans' reproductive health by offering all Food and Drug Administration (FDA)-approved, -granted, or -cleared contraceptive methods, including oral contraceptive pills, long-acting reversible contraception, and permanent sterilization methods. To improve access, VHA offers a 12-month dispensing of

hormonal contraceptives and allows self-administration of subcutaneous Depo-Provera, alongside education on reproductive health and contraception access.

C. Maternity Care Coordination. VA does not provide the full scope of maternity care and delivery on-site, but provides this care through community providers. VA covered over 7,000 deliveries in the past year alone. The Maternity Care Coordination program supports pregnant Veterans throughout their maternity journey, offering personalized care, education, guidance, and resources, including screening for intimate partner violence and depression. Following its wide success and positive reception, the maternity care program, which is available to all VHA health care systems, has been expanded to provide life-changing, coordinated care for a full 12 months postpartum.

D. Abortion Care. Ensuring access to essential reproductive care, including abortion care in certain circumstances, is vital for protecting the health and well-being of pregnant Veterans. VA provides pregnancy options counseling, which includes abortion counseling, and will offer abortions in cases of rape, incest, or when the life or health of the Veteran or VA beneficiary would be endangered if the pregnancy were carried to term.

E. Fertility Services. Infertility issues can arise due to service-related injuries or medical conditions, impacting Veterans' ability to start or expand their families. VA is dedicated to promoting, preserving, and restoring these Veterans' health and well-being to the greatest extent possible. Most VA fertility services are available to all eligible, enrolled Veterans and encompass a range of options, such as laboratory testing, surgical corrections, intrauterine insemination (IUI), sperm processing and washing, hormonal therapies, and genetic counseling. Additional fertility services such as in vitro fertilization are available to Veterans and their legal spouses who meet specific eligibility requirements under special legislative authority. VA recently expanded eligibility for IVF to single and unmarried Veterans and to allow for the use of donor sperm, eggs, or embryos.

Mental Health

VHA is committed to supporting women Veterans' mental health and well-being through various initiatives. These include expanding access to evidence-based services and increasing awareness of gender-specific resources such as women-only therapy and peer support groups. Specialized care is offered for conditions like posttraumatic stress disorder, depression, anxiety, and reproductive mental health issues, such as postpartum depression. These efforts underscore VHA's dedication to fostering a healing environment tailored to the diverse needs of women Veterans. In addition to patient-centered programs, VHA offers innovative resources to support clinicians who serve women, including:

- A national network of Women's Mental Health Champions at each VA medical center that aims to expand and promote women's mental health resources locally.

- The National Reproductive Mental Health Consultation Program provides expert consultation to support VA clinicians on mental health and reproductive health concerns. Clinicians can access the service through email, expect a response time of less than one business day, and submit follow-up questions as needed.
- The VA/Department of Defense (DoD) Women's Mental Health Mini-Residency enhances clinicians' competency in providing gender-sensitive mental health care through annual training conferences. Since its establishment in 2016, over 850 VA and DoD clinicians have successfully completed this training program.
- Interpersonal Psychotherapy (IPT) for Reproductive Mental Health is an adaption of IPT for women facing mental health challenges related to reproductive stages (e.g., infertility, menopause, etc.), with over 120 VHA clinicians trained in this therapy since 2022.

Continuing Education Initiatives

Continuing education is crucial for clinicians and staff serving women Veterans, keeping them up to date with the latest advancements and best practices in women's health. It enhances their knowledge, cultural competency, and sensitivity towards women Veterans' unique experiences, thus building trust and rapport. It also cultivates a culture of continuous improvement, leading to higher job satisfaction, better health outcomes, and maintenance of certifications and licensures. Since 2008, VA has trained more than 11,500 clinicians in a 3 day update in women's gender specific health care known as the Women's Health mini-residency program, with 1,501 clinicians trained in FY 2023 alone. Notable initiatives include:

- 39 trainings organized by OWH and the Office of Rural Health targeting rural clinical sites, which is crucial for improving women Veterans' care.
- A 12-session course on reproductive mental health for multidisciplinary clinicians, covering various topics like menstrual irregularities, contraception, and cancers. Over 350 clinicians have completed this rigorous course.

II. Benefits and Services for Women Veterans and Military Sexual Trauma (MST) Survivors

VA wants every woman Veteran to come to us for the benefits they earned and deserve. We are committed to informing women Veterans about their available VA benefits and services. VA is committed to connecting them to their earned benefits through more proactive and effective outreach and engagement. Currently, 702,557 women Veterans receive disability compensation benefits from VA—an all-time record and an increase of 180,959 women Veterans (or 26%) over five years ago.

The average woman Veteran who receives disability compensation benefits from VA has a 68% combined disability rating, and they receive an average of $26,809 in earned disability compensation benefits per year from VA. The average grant rate for women Veterans is 89.2%, meaning that 89% of women Veterans who have applied for disability benefits with VA have received benefits for at least one condition.

VA also is working to ensure that women Veterans can get education benefits and well-paying jobs. Despite only making up 16.5% of the Veteran population, Women Veterans received 27.5% of Post 9/11 education benefits and 26.4% of Veteran Readiness and Employment benefits in 2023. These historic statistics are a direct result of our concerted efforts to bring more women Veterans to VA. Despite the significant growth in the number of women Veterans who are accessing their benefits, there is still more work to do, and VA wants every woman Veteran to come to us for the benefits they have earned.

We're constantly working to expand our outreach–and our services–to better serve women Veterans. That's why VA is hosting nearly 140 events this year specifically designed to support women Veterans, which is the largest outreach campaign in VA history to bring women Veterans to VA, and is directly emailing and texting Veterans to encourage them to come to VA.

In addition to our efforts to engage women Veterans after they have left the military, VA strives to provide information to Service members as part of the Transition Assistance Program (TAP) prior to their transition to civilian life. As a supplement to the VA TAP course, VA offers Women's Health Transition Training, a web-based training course that is open to all women Service members and can be taken at any time. Topics include transitioning to civilian life and health benefits (emphasizing women-specific needs), mental well-being, managing health care, eligibility, and transition assistance resources. VA also has implemented the VA Solid Start (VASS) program to ensure Veterans are aware of the benefits and services available. In 2023, VASS agents successfully reached 22,102 women Veterans, equating to a 76.7% connection rate, a 5.2% increase over FY 2022.

VBA front-line employees in public contact teams and national call centers receive training and information to connect women Veterans to Women Veterans Coordinators (WVC), who are the primary women Veterans' contact. A WVC is available at all regional offices. Coordinators maintain extensive knowledge about VA benefits and services, and an awareness of women Veteran issues and concerns, working hand-in-hand with other special emphasis coordinators. WVCs also maintain an effective network and referral system with the local VHA Women Veteran Program Managers coupled with local and state women Veterans' organizations to ensure they are informed about available resources.

MST-Related Claims Processing

We recognize the courage and strength of MST survivors to come forward and file a claim for disability compensation. That's why VA treats all claims, but especially those related to MST, with the utmost respect and the seriousness they deserve.

Over the past several years, VA has instituted a series of reform measures to improve the MST-related claims process for all MST survivors. Some of these reforms

include the incorporation of trauma-informed communications principles and human-centered design into the MST claims process, the appointment of a single senior executive to oversee the MST workload, consolidation of all MST claims processing to a single operations center, and a memorandum of agreement with DoD that allows us unrestricted access to reports of military sexual assault.

These efforts are having an impact on the lives of survivors. In FY 2023, 43,044 MST-related claims were completed, an increase of 22,000 over all MST-related claims completed in FY 2022. Veterans received a grant of MST-related benefits 62% of the time, compared to just 41.8% in FY 2011, and the number of Veterans service connected for MST-related conditions (as of end of month January 2024) and receiving VA disability compensation benefits has doubled since FY 2019 when it was 61,000 to more than 128,000 in FY 2023.

Despite these improvements, we still have work to do to ensure that under-development, examination and medical opinion-related errors, and improper denials are problems of the past. We also want Veteran survivors of MST to receive their decisions in a more timely manner. That's why we are renewing our commitment to MST survivors by improving the workload management strategy of MST-related claims, adding more full-time employees dedicated to the MST Operations Center, and reviewing the trends of the most common errors on MST-related claims to create targeted training for our team, while also holding a claims quality standdown day for MST claims processors to provide additional training on the most common MST errors.

III. Conclusion

I am grateful for the opportunity to update you on our efforts for women Veterans and those who experienced MST. Our commitment to ensuring that all Veterans receive the care, support, and respect they deserve remains unwavering. VA's women-centered programs have made significant strides in improving their well-being, especially as their enrollment with VA reaches unprecedented levels. We must maintain this momentum and protect the progress achieved. Your continued support is vital for delivering high-quality care and benefits to our Veterans and their families.

Chairman Tester, Ranking Member Moran, this concludes my testimony. My colleagues and I are prepared to answer any questions.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF JENNIFER BAPTISTE, MD
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OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
US SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
CARING FOR ALL WHO HAVE BORNE THE BATTLE: ENSURING EQUITY FOR WOMEN VETERANS AT VA
APRIL 10, 2024

Chairman Tester, Ranking Member Moran, and Committee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Department of Veterans Affairs' (VA) programs and initiatives to better serve women veterans. In 2021, the OIG's Office of Healthcare Inspections created the Women's Health Program to increase oversight of VA's efforts to meet the healthcare needs of this expanding population. The OIG recognizes the commitment and focus VA has shown in expanding the availability of gender-specific resources and creating a safe and welcoming environment.

As the number of women veterans continues to increase, VA must work to improve access to women's primary care providers and gender-specific care within their facilities and in the community. More women veterans are accessing VA at a younger age, underscoring the need for maternity and gynecologic care to be readily available. Gender-specific cancer screenings—such as for breast and cervical cancer—must be easily accessible and followed up on diligently. Cardiovascular disease is the number one killer of women, and women veterans are at an increased risk for heart disease, reminding stakeholders it is critically important that VA providers are equipped to diagnose and manage these and other widespread, chronic health conditions.[1]

Women veterans often experience other health conditions, including mental health concerns, at higher rates than their male veteran counterparts. Expanding screening for military sexual trauma (MST) and mental health conditions could help ensure women veterans are aware of the available care and benefits to which they are entitled. VA must also ensure its Intimate Partner Violence Assistance Program is providing the necessary support and assistance veterans require. While the OIG recognizes the efforts of

[1] The Facts about Women and Heart Disease, https://www.goredforwomen.org/en/about-heart-disease-in-women/facts, accessed April 1, 2024; Women Veterans and Heart Health, https://www.goredforwomen.org/en/about-heart-disease-in-women/facts/women-veterans-and-heart-health, accessed April 1, 2024.

the Veterans Health Administration (VHA) to build up its women veterans' services, our work has identified deficient programs that are not adequately supporting the needs of women veterans.

This statement will discuss recent OIG reports on VHA women's health providers, mammography program, and reproductive health services to highlight several areas of needed improvement affecting the delivery and environment of care for gender-specific health care. It will also present the substantial work of OIG teams reviewing the delivery of care and benefits to survivors of sexual violence, including military sexual trauma, and intimate partner violence, populations that include a disproportionate number of women veterans.

BACKGROUND

The Veterans Health Care Act of 1992 authorized VA to provide gender-specific services (such as Pap tests, menopause management, mammography, breast examinations, and reproductive health), broadened the context of posttraumatic stress disorder (PTSD) to include care for sexual trauma experienced in the military, and mandated VHA to assign to each region a women veterans' coordinator responsible for enhancing services.[2] Over the past two decades, VHA has built on that authorization by introducing multiple initiatives to improve the access and quality of health care for women veterans. In 2008, VHA's Women Veterans Health Strategic Health Care Group began redesigning the delivery of care.[3] This initiative shaped existing policies, which require all women veterans are offered assignment to a primary care provider and care team who have experience or received training in the care of women veterans. These specialized teams should have a reduced panel size to allow for longer and more frequent visits, as well as enhanced staffing that accommodates chaperone and care coordination needs.[4]

While military sexual trauma affects both women and men, VA reports that approximately "1 in 3 women and 1 in 50 men" indicate they have experienced MST. Between 2011 and 2021, the number of women veterans receiving MST-related outpatient mental health care increased by 158 percent.[5] MST is an experience, not a mental health condition or diagnosis. Although PTSD is commonly associated with MST, other frequently associated diagnoses include depression and other mood disorders and substance use disorders.[6] Psychological trauma, such as MST, also increases risk of physical health conditions

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[2] VHA Directive 1330.01(7), Health Care Services for Women Veterans, May 14, 2023.

[3] National Center for Veterans Analysis and Statistics, America's Women Veterans: Military Service History and VA Benefit Utilization Statistics, November 23, 2011.

[4] VHA Directive 1330.01(7), Health Care Services for Women Veterans, May 14, 2023.

[5] VA, "Military Sexual Trauma," accessed March 11, 2024, https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

[6] Ibid.

such as cardiovascular disease, stroke, and diabetes.[7] In addition to poorer psychological and physical health, women veterans with a history of MST who receive VA health care report more readjustment problems after military discharge, such as difficulties finding employment.[8] Since 2000, VA requires that every veteran seen for VA health care is screened for MST.[9] Veterans do not need a VA disability rating or documentation of MST experiences to access MST-related care—it is made available at every VA medical center and many community-based outpatient clinics, and counseling is available at vet centers. VA also offers more intensive MST-related treatment in residential and inpatient programs, some of which are gender-specific.

The number of women veterans accessing VHA care has tripled since 2001, growing from about 160,000 to over 600,000 today.[10] Women make up 30 percent of all new VHA patients, despite making up over 10 percent of the overall veteran population.[11] This trend underscores the importance of VA improving the experience and resources available to women veterans.

VHA CAN IMPROVE THE DELIVERY AND ENVIRONMENT OF GENDER-SPECIFIC HEALTH CARE

As VHA has worked to expand the services available to women veterans, the OIG has focused on providing oversight that assesses whether these expanded services are adequately resourced and delivered in a safe environment and in accordance with VA policy. The OIG reports summarized in this section showcase deficiencies in access to care, women's health program management, and adherence to policy that create barriers to the provision of high-quality gender-specific care at VA.

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[7] Harvard Medical School, Harvard Women's Health Watch, Past Trauma May Haunt Your Future Health, accessed March 11, 2024, https://www.health.harvard.edu/diseases-and-conditions/past-trauma-may-haunt-your-future-health.

[8] "Military Sexual Trauma: Issues in Caring for Veterans," VA National Center for PTSD, accessed March 11, 2024, https://www.ptsd.va.gov/professional/treat/type/sexual_trauma_military.asp#two.

[9] VHA Directive 2000-008, *Sexual Trauma Counseling Section of the Veterans Millennium Health Care Act*, Public Law 106-117 (RCN 10-0905), February 29, 2000. This directive was rescinded and ultimately replaced by VHA Directive 1115 that mandates screening for experiences of MST for all veterans seen in VA medical facilities. The National Deputy Director for the MST Team told the OIG that although this policy did not specifically mandate screening, it was issued in the context of the mandate to implement the screening software and the need to screen all veterans for MST and that the year 2000 is typically identified as the initiation of the screening requirement.

[10] The Women's Health Evaluation Initiative, VHA Sourcebook. The Women's Health Evaluation Initiative consists of women's health investigators including VA Health Services Research and Development, Center for Innovation to Implementation, and the Health Economics Resource Center at the VA Palo Alto Health Care System.

[11] About Us - Women Veterans Health Care (va.gov), accessed April 1, 2024, https://www.womenshealth.va.gov/WOMENSHEALTH/about-us.asp; Veteran Population - National Center for Veterans Analysis and Statistics (va.gov), accessed April 1, 2024, https://www.va.gov/vetdata/Veteran_Population.asp.

A Case Example of Deficiencies in a Women Veterans Health Program

An OIG team conducted a healthcare inspection of alleged deficiencies in the Women Veterans Health Program (WVHP) at the VA North Texas Health Care System in Dallas, Texas.[12] This report provides a wide-ranging examination of the problems that can potentially exist at any VHA facility when the women's health program is not appropriately managed or resourced. WVHP policy identifies primary care requirements for all women veterans, including gender-specific care, like basic gynecological care as well as breast and cervical cancer screenings. VHA's current goal is that 85 percent of women veterans be assigned to a designated women's health primary care provider. The OIG determined that the facility had an insufficient number of these designated primary care providers trained to provide gender-specific comprehensive care for women veterans. The shortage of women's health primary care providers in the geographic area made it difficult for VHA to recruit staff. Additionally, WVHP staff reported to the OIG that women's health primary care providers' patient panel sizes had not been reduced as required by VHA and the amount of time allotted for appointments was not sufficient for unique gender-specific care needs.

In addition to shortcomings in healthcare delivery, the OIG determined that the facility had long-standing deficiencies in the availability of equipment, supplies, and space to provide gender-specific health care. One of the roles of the WVHP manager is to ensure that construction and renovation projects comply with VHA policy to meet the privacy and dignity needs of women veterans. The OIG found that the WVHP manager was not fully engaged with this process and did not routinely participate in weekly environment of care rounds as required by VHA policy. The WVHP manager's lack of engagement contributed to a failure to identify resources needed for the provision of women veterans' health care, including the renovation of existing space to ensure women veteran restroom access within the clinical area.

Additionally, the facility had an extended vacancy for a gynecologist, which the facility mitigated by using an advanced practice registered nurse and community care providers. After hiring a gynecologist, the advanced practice registered nurse and the gynecologist shared a licensed vocational nurse from another clinical area to serve as the required examination chaperone. This impeded the ability for both providers to conduct examinations simultaneously, and staff said the advanced practice registered nurse also performed ancillary administrative duties, further reducing her availability for appointments.

While community care provided a vital resource during staff vacancies, the facility did not have a standard operating procedure for tracking and reporting community care results back to the requesting VHA provider. The OIG reviewed the electronic health records of 31 women veterans with abnormal

[12] VA OIG, *Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System, Dallas, Texas*, January 23, 2020.

gynecological test results and determined that medical records were not received for seven of the 11 veterans referred through community care.

The OIG made 18 recommendations, now closed based on VHA documentation, for corrective action focused on staffing for gender-specific care provided by designated women veterans health providers, extended appointment times for these healthcare exams, comprehensive healthcare resources for women, WVHP manager routine attendance in environment of care rounds, support staff to provide gynecology services, and ensuring VHA providers receive records from community care referrals.

National Review of VHA Reproductive Health Services

To understand the availability of reproductive health services across VHA and to further examine the staffing and resource challenges of gender-specific care, the OIG released a national review of VHA's reproductive health services for veterans in the fall of 2023.[13] The review's purpose was to capture a snapshot of the availability of reproductive health across VHA, given the rapid demographic change and the expansion of reproductive health services covered in VA's medical benefits package. Approximately half of the 600,000 women veterans who use VHA for health care are of childbearing age, highlighting the need for VHA to ensure ample capacity of these essential services.[14]

The OIG team selected 26 VHA facilities, which included all Veterans Integrated Service Networks (VISNs), with a range of facility complexities, a mix of rural and urban geographical service areas, and varying levels of state restrictions to abortion services. The team interviewed leaders at the selected VHA facilities to identify concerns and offer candid perspectives. Although informative, the findings cannot be statistically generalized across VHA because quantitative data were not analyzed on patients, facilities, or procedures performed within VHA, and the sampling method was not random. The OIG found that the selected facilities were generally able to provide reproductive health services. For the most part, the challenges reported were not unique to the provision of reproductive health and were consistent with recognized broader challenges for health care, including travel distances to obtain specialty care; limited resources and provider availability in the community; and challenges with VHA staffing and recruitment.

To mitigate these problems, facilities used community care resources to provide reproductive health services. However, some facility leaders identified a lack of access to community care resources for a range of reproductive health services. While the staffing and access challenges identified are not unique

[13] VA OIG, *Review of Veterans Health Administration Reproductive Health Services*, September 28, 2023.

[14] VHA Women's Health Services, Women's Health Evaluation Initiative, Sourcebook: Women Veterans in the Veterans Health Administration, Volume 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution, February 2018. A VHA analysis of veteran population trends from 2018 found that the number of women veterans under age 35 had tripled over the course of sixteen years.

to reproductive health care, the expanding population of women veterans of childbearing age underscores the need for VHA to focus additional resources in this area.

Misconduct by a Gynecologist and Facility Leaders' Failure to Adequately Respond

VHA has instituted policies to create a welcoming and safe environment for women veterans seeking care. However, the OIG has found that at times these policies, as well as the education and training provided to staff, have not yielded a culture that treats women veterans with dignity.

The OIG conducted a healthcare inspection after receiving complaints alleging a gynecologist's conduct and language were inappropriate while engaging with women veterans and a nurse chaperone failed to provide support to these patients at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi.[15] The inspection team substantiated that the gynecologist's conduct toward five women veteran patients was unprofessional, unethical, and insensitive, and this undermined the culture of privacy, dignity, and safety promised to all patients. Specifically, in the written complaints regarding the gynecologist's misconduct, patients said he was disrespectful; made rude, vulgar, and offensive comments and jokes during examinations and appointments; cut patients off or would not let them speak; and spoke negatively of other facility providers' care. The patients said they felt defeated, numb, anxious, sad, angry, traumatized, powerless, violated, afraid, and alone.

The OIG found VHA had not incorporated key strategies, such as trauma-informed care and sensitive examination policies, into training, policy, and practice, to advance health care for women veteran patients.[16] The team concluded that patients, particularly those with a history of trauma such as MST, or a mental health condition such as depression, anxiety, or PTSD, would benefit from care delivered by health providers who use trauma-informed care principles.

The team also substantiated that the nurse chaperone did not provide support to or advocate for the five patients when the gynecologist engaged in misconduct. The nurse chaperone did not view the conduct as inappropriate and defended the gynecologist's behavior by describing a patient as too sensitive.

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[15] VA OIG, *Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi*, February 10, 2021. The OIG also reported on the Montana VA Health Care System's chief of staff, a gynecologist, who practiced without privileges when providing pregnancy care for a patient during her second and third trimesters and did not refer the patient to a community facility equipped to evaluate and manage her obstetric care, placing her and the fetus at risk. The OIG determined facility leaders' oversight did not identify other quality of care concerns, and the facility director twice failed to initiate state licensing board reporting. All 10 recommendations related to ensuring alignment with VHA and facility policies, including those related to privileging, and maternity and pregnancy care; as well as reviewing care deficiencies to identify follow-up needs, processes for ongoing professional practice evaluations, timely completion of administrative actions, and state licensing board reporting remain open. VA OIG, *Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena*, February 6, 2024.

[16] Trauma-informed care emphasizes physical, psychological, and emotional safety; honoring patient voice, agency, control, and choice; and minimizing risk of re-traumatization. A sensitive exam is the "evaluation, palpation, physical therapy for, placement of instruments in, or exposure of a patient's genitalia, rectum or breasts." American College Health Association (ACHA) Guidelines, Best Practices for Sensitive Exams, October 2019.

Although VHA policies require the use of chaperones for all sensitive examinations, the policies fall short in outlining the chaperone's responsibilities, duties, training, or competencies. The lack of specific training regarding the role and expectations of a chaperone may have contributed to the chaperone's unawareness and insensitivity to the patients' distress and subsequent deficiencies in support or intervention.

VHA, the VISN, and the facility concurred with the OIG's six recommendations related to education, tracking patient complaints, reviewing the gynecologist's conduct and care provided, and reviewing the role and training of providers and chaperones for sensitive exams. Five of the six recommendations have been closed as implemented. However, more than three years from the date the report was published, recommendation 2 remains open pending the release of a chaperone directive in development at VHA.

OIG Oversight of VHA's Mammography Program

Since the Veterans' Health Care Amendments of 1983 passed, VHA has provided mammography services to veterans.[17] A mammography program is a distinct subspecialty of the department of radiology functioning within a VA medical facility. According to VHA policy, mammography conducted within VA must meet the requirements of the Mammography Quality Standards Act.[18] Breast cancer is the most diagnosed cancer among women in the United States. Screening and early detection and timely communication with patients may result in improved health and better survival rates.[19]

Delayed Communication of Mammography Results to Patients at the Washington DC VA Medical Center

In 2021, the OIG performed an inspection focused on allegations that patients were not receiving mammography results as required at the Washington DC VA Medical Center.[20] The inspection was requested by members of the House Committee on Oversight and Reform's Subcommittee on Government Operations after receiving information that the facility was not in compliance with the VHA policy on communicating exam results and letters to patients.

VHA requires a "lay summary letter" (a written report summary that uses language clearly understood by a layperson) be conveyed to patients from the facility's Mammography Program within 30 days of a procedure. In addition to lay summary letters, VHA requires that the ordering providers communicate normal mammography results to patients within 14 calendar days and abnormal results within seven

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[17] VHA Directive 1105.03, Mammography Program Procedures and Standards, May 21, 2018.

[18] VHA Directive 1105.03. The Mammography Quality Standards Act sought to ensure all "women have access to quality mammography for the detection of breast cancer in its earliest, most treatable stages."

[19] "Breast Cancer Facts & Figures," American Cancer Society, accessed April 26, 2023, https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html.

[20] VA OIG, *Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center*, February 25, 2021.

calendar days of receiving the results. Communication of test results to patients must be documented in the electronic health record.

Following the facility's own internal review, the inspection team completed an independent review of the patients who received mammography exams during the identified time period and found additional mammography exams not identified by the facility's initial review due to errors in diagnostic coding. Facility staff had not consistently entered the appropriate primary diagnostic code for a mammography exam in the electronic health records as required; these exams were later determined to not be abnormal. During its review, the facility identified two patients with clinically significant mammography exams (breast cancer). In an independent review, the OIG identified two additional patients with breast cancer. The OIG determined that all four patients received timely notification of their abnormal results from the ordering provider, while they may not have received the lay summary letters within the required 30-day period. However, the review of other patients revealed that ordering providers did not consistently document patient notification of abnormal mammography results within seven days as required.

The OIG found that the facility mammography program's clerical and administrative functions were not defined in a standard operating procedure manual, and there was inadequate oversight and quality controls for ensuring the lay summary letters were mailed, one avenue for communicating patient test results. Facility leaders also needed to develop a formalized training program for mammography technology staff to make certain that patients are monitored and tracked when experienced facility staff leave employment. Seven recommendations, all closed, were made to ensure the ordering providers notified patients of mammography exam results, a comprehensive standard operating procedure manual for the mammography program was developed and implemented, and a formal mammography technology staff training program was established.

More Progress and Awareness Is Needed to Support the Women's Oncology System of Excellence

The Making Advances in Mammography and Medical Options for Veterans Act of 2022 required the OIG to report on mammography services and breast cancer care provided to veterans.[21] In meeting this requirement, an OIG team evaluated mammography services delivered through the outpatient settings of randomly selected VA facilities and community providers. The team also assessed the performance of the VA Women's Oncology System of Excellence (WOSE) and breast cancer patients' accessibility to a comprehensive care team, as required by the legislation.

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[21] Making Advances in Mammography and Medical Options for Veterans Act of 2022, Pub. L. No. 117-135, 136 Stat. 1244 (2022) § 106. Currently, this publication is in draft and, consistent with OIG practices, has been reviewed by the Department. This allows VA offices to comment on OIG findings and recommendations, as well as to provide responsive action plans to implement the recommendations. OIG staff are integrating the feedback into the final report before publication. While it is not the OIG's routine practice to testify regarding not-yet-published reports, due to the timing of this hearing and VA having reviewed the draft, the pertinent oversight findings will be generally discussed today.

The OIG evaluation did not identify concerns related to

- patient access to and adequacy of staffing to perform mammograms,
- use of three-dimensional mammography,
- availability and quality of mammogram reports,
- incorporation of mammogram reports into electronic health records,
- timely communication of mammogram results to ordering providers and patients, and
- access to a comprehensive breast cancer care team.

However, the evaluation revealed issues related to WOSE and local cancer registry databases.[22] Most VA facility leaders and staff were unaware of WOSE, and more than two years after its launch, VHA leaders acknowledged there was less progress than they projected. VA facility staff were not entering oncology data into local cancer registry databases in a timely manner.

VA MUST IMPROVE THE DELIVERY OF CARE AND BENEFITS TO SURVIVORS OF SEXUAL VIOLENCE AS WELL AS INTIMATE PARTNER VIOLENCE

Although anyone can experience sexual violence, women make up the overwhelming majority of those targeted.[23] Research estimates that nearly one in two women and one in four men in the United States experience some form of unwanted sexual contact in their lifetime, and approximately one in four women and one in 26 men have experienced completed or attempted rape.[24] Research also suggests that individuals who experience sexual violence are "at risk of a wide range of physical, mental, reproductive, and other health consequences over their lifetime" when compared with those who have

[22] In October 2020, VA introduced the Women's Oncology System of Excellence to provide "oncology patients with cutting edge care and access to potentially lifesaving clinical trials." "VA Creates National Women Veterans Oncology System of Excellence in Fight against Breast Cancer," October 20, 2020, accessed February 22, 2023, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5549.

[23] The term "sexual violence" encompasses a range of unwanted sexual contact, characterized by the use of force, manipulation, or coercion, to commit acts of a sexual nature without consent or against a person's will. Forms of sexual violence include rape, sexual assault, unwanted sexual touching, sexual exploitation, and sexual harassment.

[24] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2016/2017 Report on Sexual Violence," accessed September 18, 2023, https://www.cdc.gov/violenceprevention/pdf/nisvs/nisvsReportonSexualViolence.pdf.

not.[25] Even those statistics may be understated as sexual violence is often not reported.[26] Survivors may be reluctant to report sexual violence to law enforcement, seek medical care, or disclose it to family or friends. Commonly cited reasons include fear of not being believed, shame, embarrassment, fear of retaliation, pressure from others, and distrust of law enforcement.[27]

In addition to advancing the services available to women veterans, VA has taken actions to better assist veterans who have experienced MST or intimate partner violence (IPV).[28] Recognizing that sexual assault and IPV often go unreported and that veterans are more likely to disclose having experienced MST or IPV if asked directly, VHA actively screens veterans about these experiences.[29]

The OIG has focused on the importance of appropriate screening and support for victims of sexual violence and IPV, as well as the need for MST benefits claims to be processed accurately and timely by the Veterans Benefits Administration (VBA). Similar to work on women veterans' health care, recent oversight reports have identified the need for additional resources, training, and adherence to existing policy to better support and serve the needs of survivors.

An OIG Study on the Use of Health Care and Benefits by Veterans Who Reported Sexual Assault During Military Service

Last month, the OIG released the results of the first population-based, longitudinal review of VA healthcare and benefits utilization by veterans who reported sexual assault to the Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) during military service or who later disclosed having experienced MST to a VHA healthcare provider.[30] The OIG assessed the population of

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[25] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report," accessed February 24, 2022, https://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2016/2017 Report on Sexual Violence," accessed September 18, 2023, https://www.cdc.gov/violenceprevention/pdf/nisvs/nisvsReportonSexualViolence.pdf.

[26] US Department of Justice, "Criminal Victimization, 2020," accessed February 24, 2022, https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cv20.pdf.

[27] National Sexual Violence Resource Center, "About Sexual Assault," accessed February 24, 2022, https://www.nsvrc.org/; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report," accessed February 24, 2022, https://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf.

[28] VHA defines IPV as violent behavior by a current or former intimate partner that includes physical and sexual violence, psychologically aggressive or coercive acts, and stalking. VHA Directive 1198, *Intimate Partner Violence Assistance Program*, January 24, 2019.

[29] VHA Directive 2000-008, *Sexual Trauma Counseling Section of the Veterans Millennium Health Care Act*; Pub. L. No. 106-117 (RCN-10-0905), February 29, 2000, rescinded March 25, 2005.

[30] VA OIG, *Transition to VA Health Care and Utilization of Benefits for Veterans Who Reported Sexual Assault During Military Service*, March 14, 2024.

approximately 1.2 million veterans who were discharged from active military service from October 1, 2015, through September 30, 2020.

The data revealed that the 5,101 veterans who reported sexual assault to SAPRO during the review period were more likely to be female, younger, and of a lower pay grade at the time of discharge when compared with those who did not report to SAPRO. The younger age at discharge may explain, in part, the lower pay grades.

The OIG observed that veterans who reported sexual assault to SAPRO were more likely than veterans who did not report to SAPRO to

- apply (and apply sooner) for VA health care;
- use VA health care more frequently, especially mental health care;
- be diagnosed with mental health disorders (rates of PTSD and major depressive disorder were approximately twice as high);
- use vet center counseling services;
- apply (and apply sooner) for education benefits; and
- receive service-connected disability compensation, have a higher service-connected disability rating, and have a mental health disorder component contributing to their service-connected disability rating.

Still, approximately half of the veterans who reported sexual assault to SAPRO did not use VA health care and a third had not received a service-connected disability rating. Future studies may help to examine potential differences between the veterans who reported to SAPRO and accessed or applied for VA health care and benefits and those who did not. The results may help target outreach efforts to those who reported to SAPRO and did not engage with VA. Targeted VA outreach may help these veterans by raising awareness and an understanding of available VA healthcare and benefits resources to address their medical and psychological needs and support their transition into civilian life.

The OIG presented interim results of this review to VBA and DoD. During the presentation, the OIG raised concerns regarding the low rate of veterans who reported sexual assault to SAPRO receiving service-connected disability ratings. Subsequently, a memorandum of agreement was signed by SAPRO and VBA, effective on November 22, 2022. The agreement established a mechanism by which SAPRO provides data from closed unrestricted sexual assault reports to VBA as corroborating evidence to assist with MST-related claims.[31]

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[31] DoD/VBA, "Memorandum of Agreement Between the Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) and the Department of Veterans Benefits Administration (VBA) for Providing Data to Support Military Sexual Trauma Claims," VBA-2022-03, November 2022.

The OIG is confident that its review provides valuable information to assist in VA's ongoing efforts to meet the healthcare needs of veterans who experienced sexual assault and MST and support their successful transition from military service to civilian life.

Improvements Are Still Needed in Processing MST Claims

In addition to ensuring that the transition to civilian life is successful and VA conducts outreach about health care services, VA has an obligation to provide veterans who are claiming benefits for MST every opportunity to support their claims. This is especially important given how many incidents are not reported, and how difficult it can be to subsequently produce or validate evidence of the trauma.

In response to this challenge, VBA has established special procedures to help veterans support their claims of PTSD related to MST when they do not have the evidence or documentation usually required to receive benefits. In an August 2018 report, the OIG found that about 49 percent of the MST claims denied between April 1 and September 30, 2017, were not properly processed under VBA procedures.[32] The claims processors had not completed all required actions to obtain and review evidence before making a decision. These premature denials could have resulted in veterans not receiving the benefits they deserved. The OIG made six recommendations intended to help VBA review and correct all prematurely denied MST claims since October 1, 2016, and to better process these claims in the future.

In 2021, an OIG team conducted a follow-up review to determine whether VBA effectively implemented these recommendations and improved how it processed MST claims.[33] The review team found that VBA claims processors did not always follow the policies and procedures for processing MST claims that were updated in response to the OIG's previous report recommendations. This noncompliance occurred because VBA leaders did not effectively implement the recommendations and did not ensure adequate governance over MST claims processing. Overall, the review team estimated that denied MST claims were still not being processed correctly from October 1 to December 31, 2019, and did not find an improvement from the 49 percent error rate noted in the August 2018 report. The OIG concluded that VBA was not properly carrying out recommended changes to assist veterans, and as a result, survivors of MST remain at risk of not receiving the VA benefits to which they are entitled and experiencing additional distress when claims are improperly handled or denied.

Three of the four report recommendations have been closed; however, the OIG team continues to review claims now handled by the MST operations center that VBA set up in response to recommendation 2, which remains open, and will continue to monitor progress until sufficient improvement has been documented to warrant its closure.

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[32] VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, August 21, 2018.
[33] VA OIG, *Improvements Still Needed in Processing Military Sexual Trauma Claims*, August 5, 2021.

MST and IVP Coordinators Face Barriers in Complying with Program Requirements

To gather and share pertinent information about VHA's MST and IPV programs, the OIG conducted two separate but similar reviews of medical facilities' compliance with select activities for MST coordinators and requirements for the Intimate Partner Violence Assistance Program (IPVAP), as well as perceived challenges and barriers to compliance.[34]

A review team conducted a national survey to evaluate the duties and perceived challenges of MST and IPV coordinators. An analysis of the survey results and interview information found that failures to more fully protect administrative time, competing role demands, insufficient support staff, and inadequate funding and outreach materials challenged MST coordinators' ability to fulfill their responsibilities. Additionally, over half the facilities did not have the required local IPVAP protocol, which may contribute to leaders' and staff's confusion and lack of knowledge about IPVAP roles, responsibilities, processes, and procedures.

The OIG found that MST and IPVAP coordinators who reported more dedicated time than other coordinators did not necessarily serve at facilities with higher numbers of patients in MST- or IPV-related care. Accordingly, the recommendations called on VHA leaders to determine meaningful guidance for dedicated time assignment calibrated to patient needs as well as MST and IPV coordinators' overall demands.

Most MST and IPVAP coordinators' open text survey and interview responses reflected a sincere commitment to their work, thoughtful consideration of the challenges to successfully and completely fulfilling their roles, and enthusiasm for serving in their capacity. Given the needs of this growing veteran community, the MST and IPVAP coordinator roles are especially critical in establishing and monitoring staff training and promoting a culture of safety to enhance patients' comfort in engaging in screening and treatment.

The OIG recommendation regarding the MST report is now closed. It called on VHA to evaluate for MST coordinators the sufficiency of current guidance and operational status of protecting administrative time; the adequacy of administrative staff support; and funding for outreach, education, and special project resources, with consideration of MST coordinators' responsibilities.

For the IPVAP report, the team made seven recommendations to the under secretary for health related to developing protocols and guidance at medical centers regarding IPVAP coordinators' dedicated time and access to administrative staff support, establishing standardized IPV staff training, developing IPV screening requirements, and evaluating guidance related to the roles and oversight functions of the VISN IPVAP champions and lead coordinators. All recommendations are currently open.

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[34] VA OIG, *Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations*, August 5, 2021; *Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance*, September 28, 2022.

VHA Must Ensure Better Training, Guidance, and Resources Are Available to Manage Emergent Care for Patients Presenting with Acute Sexual Assault

In December 2023, the OIG evaluated VHA management of the emergent care needs of acute sexual assault survivors.[35] Sexual assault can have medical, psychological, and legal consequences, requiring a coordinated and compassionate response from medical providers and law enforcement officers when survivors seek care. Veterans seeking related care may need two types of healthcare services: (1) an evaluation and treatment of medical and mental health needs and (2) a sexual assault forensic examination. While emergent care for acute sexual assault is a low-frequency event in comparison with other emergency care responses in VA facilities, it is crucial for VHA to handle the survivors' needs properly and sensitively.

The OIG found that because staff did not frequently see patients needing acute sexual assault care, their lack of experience contributed to challenges for VHA facilities such as the following:

- Maintaining staff's procedural knowledge and training
- Garnering adequate facility resources and staying knowledgeable of available community supports
- Providing detailed, facility-specific policy or other guidance

These challenges, along with variability in resource capacity and jurisdictional requirements, highlight the importance of clear, accessible facility-specific policy or other guidance. VHA national program office leaders noted the importance of having enterprise-wide policy to ensure staff are aware of practice guidelines to support both recommended medical treatment and forensic examination protocols that is supplemented by facility procedures tailored to distinct local needs.

The OIG made eight recommendations to the under secretary for health to help improve facility compliance with and local implementation of VHA policy by providing frontline staff with relevant, accessible procedures; local community resources; and jurisdictional requirements to support clinical care and the VA police response to patients with acute sexual assault needs. All recommendations are currently open, and VA's progress will be monitored through the OIG's routine tracking process.

CONCLUSION

The OIG appreciates the opportunity to participate in this hearing, increasing the visibility of its work to women veterans and other stakeholders. We will continue to examine the provision of women's health care and benefits to help ensure that as the population and percentage of women veterans grows, so too does the quality and accessibility of VA's services. The OIG's Women's Health Program is currently conducting a national review to assess maternity care coordinators' workload and fulfillment of duties,

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[35] VA OIG, *Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault*, December 12, 2023.

with a follow-on review that plans to include the experience of veterans who have received maternity care coordinated by VHA. Staff at VHA have shown a commitment and enthusiasm for providing all the required needs of gender-specific care. However, the reports cited in this statement highlight that there is more work to be done before women veterans are fully supported by the health care and benefits available at VA. Similarly, the OIG audit staff continue to monitor the processing of MST claims for VA benefits that have disproportionately affected women veterans. The OIG is committed to being a voice for survivors and providing the information to VA needed to improve its efforts to better serve women veterans. Chairman Tester, Ranking Member Moran, and members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.

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Prior to joining the VA OIG, Dr. Baptiste served the Washington DC VA Medical Center for 14 years as a women's health primary care physician. She was the primary care team lead at the Fort Belvoir community-based outpatient clinic (CBOC) for five years, supervising a multidisciplinary team providing healthcare services to veterans. Dr. Baptiste also has experience providing primary care at Kaiser Permanente.

Dr. Baptiste is board certified in internal medicine. She earned her medical degree from Georgetown University School of Medicine. After completing her internal medicine residency at Georgetown University Hospital, Dr. Baptiste served as primary care chief resident supervising trainees at Georgetown and the Washington DC VA Medical Center. Her clinical interests continue to be in the areas of women's health and medical education.

STATEMENT OF ALISSA ENGEL PhD, LCPC, LMFT

MENTAL HEALTH THERAPIST

FOR LINCOLN'S HOPE COUNSELING AND CONSULTING

BEFORE THE

US SENATE COMMITTEE ON VETERANS' AFFAIRS

HEARING ON

CARING FOR ALL WHO HAVE BORNE THE BATTLE: ENSURING EQUITY FOR

WOMEN VETERANS AT VA

April 10, 2024

Chairman Tester, Ranking Member Moran, and Committee Members, thank you for your on-going efforts to provide quality care to all veterans and your current efforts to provide quality and equal care for women veterans specifically. I am honored for the opportunity to present my perspective on how we can ensure equitable access to care for women veterans. My testimony is based on my personal experiences using the VA health care system for over 20 years, and on my experiences serving women veterans in multiple professional roles. I'll present three problematic areas, discuss sources of the problems, and suggest solutions.

I am a mental health therapist in private practice where I am contracted with Montana Veterans Association Care in the Community network. I specialize in treating trauma in the Veteran, military, and first responder populations. I am the Mentor Coordinator of the 8th Judicial District of Montana Veterans Treatment Court (VTC). I am also a combat veteran and 23-year member of the Montana Air National Guard where I volunteer as the Women's Initiative Team lead, and as the alternate Sexual Assault Response Coordinator.

The first topic I'd like to discuss is that of the Military Sexual Trauma (MST) reporting and claims process. While MST affects both women and men, I will focus on women in my testimony. The current process does not follow trauma-informed care guidelines. The nature of MST differs from other forms of trauma in that it often includes an aspect of moral injury and institutional betrayal. As military members, we enlist knowing that we will likely experience trauma, but we assume it will be war/conflict trauma. Often an MST perpetrator is also a military member, and therefore, someone that the victim assumed to be on the same team and trustworthy. The idea that our trauma might be caused by one of our own is never considered on enlistment day. Even if the perpetrator is held accountable and the system works as advertised, the victim will never truly feel safe in the military environment again. This creates complex trauma in veterans, which means the reporting and claims processes cannot be the same as the process for a back injury or tinnitus. Although there's been substantial improvement to the reporting procedures for active military personnel, the process remains arduous, retraumatizing, and flawed. Therefore, many victims never report an MST until they are out of the service, and

some will never report. We must create a separate and distinct system for MST disability claims that adheres to trauma informed processes.

For example, I currently have a Marine client who, years after her violent sexual assault, is working on her trauma using Eye Movement Desensitization and Reprocessing (EMDR) therapy. Initially, she presented to therapy with symptoms of severe Post Traumatic Stress Disorder (PTSD). She'd been out of the military for six years, had a disability rating for her physical injuries, and a small rating for depression. After six months of counseling, she finally revealed that she'd been violently sexually assaulted by her supervisor while on active duty. It took another year of counseling and EMDR to treat some smaller mental health issues before she was willing to address the MST specifically. After six months of work on the MST, she agreed to reattempt her MST disability rating. She'd previously attempted to report her trauma symptoms, but froze during the examination with an unknown male examiner and was unable to talk. Her MST claim was denied. She agreed to try again because she is an exhausted mother, working full time, and she rarely sleeps because she spends her nights repeatedly checking that her doors and windows are locked and her children are safe. Obtaining a higher disability rating would allow her to cut back at work, get some rest, and focus on her mental health treatment. She also agreed, because I was willing to help her with the process. We went to the VSO together, and when the VSO asked her how she was doing, she responded, "Fine" and froze. This is exactly the response she'd described regarding her first rating attempt. However, I was present to help her through it. After filing her supplemental claim, we prepared for the examination. To help with this process, the client told her story over the course of multiple sessions, it was recorded, and I transcribed her account after session. She doesn't have her exam date yet, but she will take the transcription with her to the exam, which we hope will keep the examiner from asking triggering questions. Overall, she is absolutely terrified of the exam, but is doing it for her mental health and the well-being of her children. In preparation for this hearing, I asked her if she had any ideas on how the VA could improve the process and she said, *"The whole process basically retraumatizes people. It would have helped if I didn't have to talk to so many people about it. I had to talk to some guy who made me feel like crap, didn't seem remotely interested in what I was saying, and just kept asking me if I was thinking of dying. If I would have said yes, he would have committed me, but because I said 'no' he wrote that I was 'sometimes sad and depressed'. Even this time, I've seen you for years, but I'm still going to have to go see some stranger who's going to meet me once, and somehow make a determination on me. If they could streamline the process, so people who are already in care didn't have to re-tell and basically beg some stranger to believe them; that would be great. I'm just really tired of constantly living in fear that I have to relive these moments, and hope I'm believed."*

The client's suggestion is reasonable and valid. If a veteran is already seeing a mental health professional, that professional with an existing therapeutic relationship, should be able to make a MST determination and mental health diagnosis for the VA. I understand that most mental health therapists are not doctors (MD, PhD), but they know the client and can produce a more reliable determination than an examiner who sees a veteran once and simply completes a checklist based on DSM criteria. This would also free-up the back-logged examiners to focus on other claims. Additionally, the utmost priority should be placed on the correct processing of MST disability

claims. The mental health consequences resulting from an incorrect denial are catastrophic for victims. Finally, veterans with MST claims should be assigned an advocate with specialized training to guide them through the process.

Another women Veteran recently started her claims process for several assaults that happened while she was at the Air Force Academy. These occurred many years ago, but she is finally recognizing her PTSD and is ready to make her MST disability claim. She attempted to get a referral for a Care in the Community provider, but was told that she needed to see the VA counselor first. She attended her first appointment, could barely speak through her tears, and was met with skepticism. She approached me as a mentor and described her session, while very distraught. She stated, *"This was the first time that I'd ever tried to tell anyone."* Her description didn't sound like she had a trauma informed therapist, so I asked her to request the provider's clinical documentation of the session. After reading the note, she stated, *"I was absolutely upset, angry, hurt, and felt totally invalidated. It just reinforced what I had been feeling (during the counseling session) - that he truly wasn't listening to me at all, and why should I even try opening up to a counselor when they are just going to blame me anyway."* The VA therapist wrote several sentences that victim-blamed the veteran, and didn't display a thorough understanding of common MST reactions in victims. I informed her that she is entitled to a therapist of her choosing, but it is difficult to find one. So, we worked the system backwards. I begged a counseling colleague who is trauma informed and accepts VA insurance to take her on as a client. The therapist had a full case load and was doing me a favor, but agreed. Then we notified Care in the Community of the therapist and the first appointment date. This client is still in the claims process and hasn't received a determination, but her case demonstrates how painful and difficult it is to come forward with a MST claim.

The second topic I'd like to discuss is access to women's health care through the VA. A recent Veteran experience will provide the best illustration. *"I started experiencing pain in my armpit beginning in spring of 2022. I requested a mammogram from my PCP, but he declined my request because I had a mammogram in the fall of 2021. By June of 2022, my pain was severe. I called my PCP again, but he was busy so I talked to his nurse who said she'd pass the message to the doctor, and recommended going to the ER. By August, the pain was bad enough that I did go to the ER, but they would not do an emergency mammogram and sent me home. The next day, I was finally able to convince my PCP to order a mammogram. I waited two more weeks with no call, so I called Care in the Community and asked for the referral status, and I told them I was afraid I had cancer. The person on the other line said that he had a whole stack of requests on his desk and that I'd need to wait like everyone else. I waited until 1 November, and finally had a mammogram. I wasn't contacted for two more weeks. At that point, I was contacted and scheduled for an ultrasound at the end of November. After that, I was scheduled for a biopsy on 8 December. At this point, I met with my PCP again, who showed zero empathy and said, 'Worst case scenario is that you have cancer.' Also, during this appointment, I requested an annual gynecological exam. He argued that it wasn't necessary due to my age, but he finally conceded and gave the referral. The next day, the nurse called and told me that the doctor had rescinded the order because he didn't think it was necessary. I ended up scheduling my annual gynecological exam using my Tricare on the civilian side. At that appointment, the civilian provider examined my breasts and showed great concern. On 21 December my PCP*

finally called and told me that I had cancer; after I told him that I was on the highway driving my grandchildren from Texas to Montana for Christmas. I later got a call from a female provider who helped me set-up oncology treatment in Texas instead of Montana, because I was taking my grandkids back after Christmas. I think if I'd had a female provider; they would have taken my complaints seriously. It took from April to August to get a referral for a mammogram. Then it took another 3-4 months to receive a diagnosis. I will see a GYN on my own now since it was not offered to me by the VA. I also did not think it was wise to give me my diagnosis when I was driving long distance with my grandchildren in the back seat. We never did that in the Air Force; we'd wait until there was support and never on a Friday, without being prepared to provide that support. I saw an oncologist on 10 January in Texas and she told me that I should have had the biopsy immediately following the abnormal mammogram, and that I shouldn't have waited a month for an ultrasound."

This example is one story, but multiple aspects sound like so many others. In this veteran's case, she has Tricare as an additional insurance option. This veteran also had an in-depth understanding of the VA health system, because she worked as a VA employee for years. Many veterans only have the VA as a health care option and have no additional knowledge of how to navigate the maze. One of those veterans said, *"I have a gynecologist who is based somewhere else in Montana. That's a whole other story – I don't feel listened to which makes me avoid going, but apparently, she's the only person in town for that sort of stuff with the VA. They tell me she's my only option and I have to drive to Helena to see her if I need anything in-person. In a nutshell, it just feels like they don't really care. But it's all I've got; so I feel like I can't really complain."*

Mammograms, annual gynecological care, reproductive care, and gender-specific preventative screenings should be more accessible and offer access to multiple providers. They should not be dependent on a PCP's gatekeeping. One solution is that women veterans should be able to obtain care from the women's health provider of their choosing without a referral or authorization. They would schedule the appointment with the radiology or gynecological department, and state that they have VA insurance. The process should look similar to the process veterans use to go to the civilian ER or a same day walk-in clinic.

The third issue I'd like to address is the disability claims process. This issue affects all veterans, but it disproportionately affects women veterans. As women veterans, we are still fighting the stigma that women don't go to combat, or that the only way to be injured (mentally or physically) is by going to combat; making a PTSD disability rating more difficult for women to validate during the claims process. Women's PTSD is more likely to be misdiagnosed as depression or a personality disorder than men's PTSD. I'll use a personal example to illustrate the continued stigma. Each time I have an appointment at my local VA facility, the door greeter asks me if I am there to pick up my husband or if I am looking for my husband. Despite three combat deployments as a Weapons Loader on fighter aircraft and as a C-130 Navigator, it is still assumed that I am a spouse. He is a volunteer with good intentions, and I applaud him for staying active in the veteran community, but it emphasizes the bias that still exists, and inevitably seeps into the claims review process. Women veterans are also less likely to serve a 20-year career due to retention issues and in-service disparities that should be the subject of a separate hearing. Therefore, they are more likely to separate after their first or second

enlistment, which leaves them without Tricare benefits and with VA/TriWest as their only insurance option. A current client's situation illustrates this well.

This client served an honorable six years. Her decision to separate was difficult and largely due to the ostracism, discrimination, and harassment she experienced while serving in a male dominated career field. She'd been engaged in counseling for several years with PTSD and Major Depression diagnoses and several in-patient mental health stays. She was separated in July 2023 as an E-4 without much savings, and was basing her expectation of the separation process on what she learned in TAPS. There was an assumption that her VA insurance would kick-in immediately, and within 6 months, she would have her disability rating. The reality is much different. We had a three-month gap in mental health services after she lost her Tricare coverage and was waiting for the VA referral/authorization process to work. Despite not having an authorization, I told her to contact me if she had a crisis, knowing that the VA authorization would not be back-dated to financially cover those services. In November of 2023, her disability claim was blanket-denied, and she was instructed to initiate a supplemental claim, which she did in December 2023. The VA contracted company told her the claim was denied due to the veteran cancelling her exams. However, the veteran was not aware of the exams and did not cancel them. She still does not have the required exams, and recently stated, *"I am so fucking scared, because I can't get a straight answer about my compensation date. Is it July of 2023 or December of 2023? The VSO told me that my compensation date should stay July, but the lady at the VA told me that it is now December. I don't understand how I can do everything I was supposed to do and they can just keep dangling this over my head. I am basically in a panic attack because I don't know who to believe or trust or what to do."*

Based on my experiences in my counseling practice and with Veterans Treatment Court, the compensation process is so complicated that those who need the help most can't figure out the system and give up. Often MST, other sensitive injuries, and discrimination keep women veterans from speaking up and asking for help. Many of my most severe cases don't have adequate disability ratings; because the process is complicated, frustrating, retraumatizing, and demoralizing. It takes a lot of time, effort, and resiliency to make it through the claims process successfully. VSOs are helpful, but it is difficult to get an appointment, and they are so swamped that they don't have the time it takes to walk a veteran through the nuanced process.

Currently, Tricare provides 30 days of coverage after a member separates. One solution that would help ease the pain of the separation and disability claims process is to extend this coverage for 90 days. This would help bridge the insurance gap, allow the veteran time to get established with a PCP, and allow time for the referral/authorizations to work. If the system is going to be delayed, with no way for the veteran to expedite it, we need to ensure the veteran has adequate coverage while waiting.

There are several procedural issues that contribute to the three topics I presented above. The VA authorization process is broken. First, a veteran must make an appointment with their PCP at the VA to receive a referral. This is approximately a 2 week wait. The primary care provider writes the referral. 30-45 days after the PCP requests the referral, the community care mental health social worker will attempt to find a contracted provider with availability. Once the VA social worker finds an available provider, they fax the referral to the civilian provider. The

civilian provider will contact the veteran for an appointment, complete the scheduled appointment letter, and fax the letter back to the VA. Roughly, a week later, the provider receives the final authorization letter from the VA and can see the Veteran for an intake appointment. This process is entirely too long and cumbersome; especially for a veteran in crisis and for overwhelmed providers. Once again, TriWest and Tricare (military member only, not dependents) are the only insurance companies that require any type of referral/authorization for mental health care.

In addition to the lengthy process, TriWest refuses to back-date authorizations. This is a very dangerous policy. I routinely have veteran clients who haven't been actively engaged in counseling for a period of time; but they have a crisis, a trauma anniversary, or become triggered somehow and contact me for an appointment. These veterans are in crisis and time is of the essence. It is essential that a provider be able to schedule a veteran immediately, but usually these situations mean that a provider will not be compensated for 1-3 sessions while the authorization process is working. My most recent example is a veteran who was in long-term inpatient care for substance abuse and was unexpectedly discharged. When he called for an appointment, his authorization had expired. It was important to see the veteran the same day given his circumstances and a high risk of suicide. I immediately contacted the Care in the Community mental health social worker and asked for a rushed authorization back-dated to the client's inpatient discharge date. The reauthorization still took 30 days, and TriWest refused to back-date it despite the unique circumstance. If you ask the VA, they will tell you that any provider can get an emergency authorization at any time, "just call us and we will get it done," which may be true; but it is not realistic. At a minimum, this would take an hour on the phone, and there is no direct number for providers to call. Mental health providers are typically small offices without administrative staff. If a day goes smoothly, we will have 10 minutes of free time between clients. We absolutely do not have the time to call the VA 1-800 number when a client contacts us in crisis. At most, I can use my 10 minutes to call the client in crisis to schedule them. The only direct contact providers have are to the Care in the Community social workers, and they can't influence the authorization process.

The VA needs a provider-only extension where we can get assistance in a timely manner, and coordinate with the veteran's care team efficiently. Currently, a provider has to navigate the same phone tree that the veteran navigates. The VA also should add a secure messaging option on their app for providers. Again, I will remind the committee that VA/TriWest is the only insurance where a provider needs to do any of this administrative/case management work.

Another problematic aspect of the referral/authorization process is finding a trauma-informed/military informed therapist that accepts TriWest and has availability. First, providers finish graduate school with a basic understanding of trauma. Becoming a trauma-informed therapist requires additional expensive and time-consuming training. Most therapists with this level of training and experience do not need to accept insurance; let alone one of the lowest paying insurances with the most paperwork and case management requirements. These providers can fill their practice with cash-paying clients. In Montana, TriWest's reimbursement rate is slightly higher than Medicaid/Medicare, $40-$60/hour less than private insurances, and

requires the most uncompensated work outside of session. It is not a competitive source of income, and many providers are refusing to accept it anymore. This puts veterans in a very difficult position. When a veteran is ready to engage in mental health treatment or unpleasant women's health screenings, it is demoralizing to realize that either you have no agency in choosing your provider, there are no local contracted providers, or that the local providers are full and cannot accept new referrals. The lack of quality providers stops many veterans from getting the care they need.

The following items should be required of future VA insurance contracts, which will help attract more qualified providers and give more choice to veterans.

1. Must back-date authorizations (up to 45 days).
2. Must reimburse providers at a competitive rate.
3. Eliminate the referral/authorization process. Allow veterans to work directly with Care in the Community to find a therapist with openings. Then allow the veteran to schedule and work directly with their therapist.
4. Authorize a CPT code for administrative and case management work. This will allow providers to be more involved in helping veterans file disability claims for MST, mental health, women's health, and other sensitive injuries.

One final issue contributing to the above problems is high provider turn around. Veterans have a joke that we don't even bother learning our PCM's name, because we will never see them again. This is difficult for all veterans, but I believe it disproportionately affects women veterans. MST, suicidality, and gynecological health concerns are very personal topics. If a provider wants to know the truth, they must have a trusting relationship with the veteran. At every PCP appointment we are screened for a history of MST and suicidal ideation, intent, and plan. The screening is conducted with good intention, but very few veterans feel comfortable answering these questions honestly when they don't know or trust the person asking them. The process is not trauma-informed and is ineffective.

In summary, I've offered solutions to the immediate concerns, but the core solution begins with recruiting and retention. The root cause of many issues specific to women veterans is their continued minority status. The long-term goal of the committee should be to increase retention rates among women currently serving. The research doesn't dictate an exact number, but in general, 30% is the accepted percentage of a population needed to reach critical mass. Once critical mass is achieved, the minority group ceases to feel like a minority and is less likely to experience inequity. How do we do that? We must continue to support women's initiatives such as ending the sexual assault epidemic; establishing parental leave policies; mandating lactation rooms; increasing access to after-hours childcare; updating anthropometric standards, and mandating access to gender-specific body armor, maternity uniforms, and flight suits. Many of these topics have been addressed and changes achieved, but without allocated funding, it is difficult to implement the changes at ground-level. I encourage the committee to continue fighting for woman military members and veterans while insisting that the required funding be attached to any enacted change. If we can do a better job of retaining women in the military, we

will eventually reach that 30% number in the veteran population, and ultimately hold hearings that address all veterans equally.

Mr. Chairman, I appreciate the continued focus on the very important women veteran population. My dissertation, "I just want to do my job: the experience of female fighter pilots in the United States Air Force" offers a more in-depth description of the women military and veteran experience. This concludes my testimony, and I am happy to answer any questions you may have. I am also happy to obtain further information or additional statements from any of the anonymous veterans who bravely provided their stories.

All contents of this testimony are based on my personal opinion and does not reflect the official position or stance of the DOD or the Unites States services.

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STATEMENT OF JULIE HOWELL

ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATECOMMITTEE ON VETERANS' AFFAIRS

ON

CARING FOR ALL WHO HAVE BORNE THE BATTLE:
ENSURING EQUITY FOR WOMEN VETERANS AT VA

APRIL 10, 2024

Chairman Tester, Ranking Member Moran, and members of the committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on ensuring equitable access to care for women veterans. Few veterans understand the full scope of benefits offered by the Department of Veteran Affairs (VA) better than PVA members – veterans who have incurred a spinal cord injury or disorder (SCI/D), including multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS).

While the number of women PVA members is small compared to the rest of the women veteran population, they are an impressive group of individuals who do not allow their disabilities to hinder their efforts to improve access to equitable care for all veterans. Ensuring that women PVA members have timely access to quality care will only help VA to be better positioned to deliver care for all veterans, particularly those with complex injuries and illnesses. Women veterans are the fastest growing veteran cohort using VA benefits and services, accounting for nearly 30 percent of all new VA enrollees. It is our obligation to ensure that women veterans encounter barrier-free access to health care and benefits equal to their male counterparts.

In recent years, women veterans have achieved several legislative wins that are worth celebrating. Bills like the Making Advances in Mammography and Medical Options (MAMMO) Act (P.L. 117-135); the Dr. Kate Hendricks Thomas Supporting Expanded Review for Veterans in Combat Environments Act or the SERVICE Act (P.L. 117-133); the MST Claims Coordination Act, which passed in the Cleland-Dole Act of 2022 (P.L. 117-328); and the Deborah Sampson Act passed in the Isakson-Roe Health Care and Benefits Improvement Act of 2020 (P.L. 116-315), which represented big investments in women veterans' health care. PVA remains grateful to Congress for passing these important bills, but our work is far from over.

We appreciate the opportunity to share our views on the current state of care for women veterans because we believe increased attention is necessary to ensure we are meeting their needs. However, women veterans are veterans, so almost every piece of veterans-related legislation that Congress passes will impact them. Women veterans are served by the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the National Cemetery Administration (NCA) just like their male counterparts. We do women veterans a disservice whenever we fail to consider how all legislation related to these administrations impacts them.

PVA Priorities for Women Veterans with SCI/D

There are several areas of concern for PVA regarding VA's support for our women members. Due to the types of injuries and illnesses that our members live with, their needs are often unique compared to other veterans with disabilities. In our testimony, PVA would like to highlight a few provisions within the Deborah Sampson Act that could be improved, discuss accessibility for gender-specific health care, including mental health supports, as well as limitations for women accessing long-term care, and the need for increased gender-specific research focused on aging women veterans with SCI/D.

Improvements to the Deborah Sampson Act

The Deborah Sampson Act (DSA) was a major achievement because it raised awareness of the deficiencies that women veterans encountered across the VA and forced the department to prioritize women veterans' health care. Three years following its passage, however, our women members report seeing little impact or improvement in their engagements with the VA. Below are a few areas from the law that merit further attention.

Section 5102 of the DSA appropriated $20 million for the VA to retrofit their facilities to better accommodate women veteran care. This section prioritized "fixtures, materials, and other outfitting measures to support the provisions of care to women veterans." Progress has been made in the delivery of care for women veterans, that cannot be denied. However, we hear from our women members regularly that even updated women's health clinics or specialty areas within VHA facilities still lack basic accessibility measures.

Section 5104 of the DSA outlines provisions for reintegration and readjustment services to veterans in group retreat settings provided by VA Vet Centers. Many women veterans have benefited from these retreats, receiving care and camaraderie in safe spaces to discuss their concerns and struggles among their fellow veterans. Unbeknownst to most people, however, is that if a woman veteran uses a wheelchair and/or has additional nursing needs, they are unable to access these transformative retreats. In fact, there is no facility within VHA that allows for residential treatment of any kind for women or male veterans with additional nursing needs. In various briefings offered by VA, PVA has inquired about the locations that offer residential care for catastrophically disabled veterans, which the VA claims exist, but the department has yet to provide them to us.

Section 5108 highlights the need for gender-specific prosthetics for women veterans. Prosthetic devices include more tools and supports than most people think, and VA offers a range of gender-specific prosthetics such as intrauterine devices (IUDs), mobility aids, maternal support equipment, communication and assistive devices, and many other items intended to improve the quality of life for

a veteran. However, PVA has seen disparities when it comes to the availability of critical prosthetic devices, such as gender-specific catheters. For veterans that require catheterization, these are necessary, life-saving devices that when ill-fitting, have the potential to cause lasting harm.

Section 5110 requires a study on infertility services furnished by the VA. PVA has long championed the expansion of assisted reproductive technology (ART) offered by the VA, particularly increased access to in vitro fertilization (IVF). While IVF has gained national attention in recent weeks and months, and as the VA is set to expand access to IVF services for some veterans, we still lack data on the number of veterans applying for IVF, how many veterans are being denied access to these services, and for what reason are they being denied. The report required by section 5110 is critical to understanding the needs of veterans who struggle with infertility.

Section 5502 allows a veteran filing a compensation and pension (C&P) exam related to military sexual trauma (MST) to choose the gender of their provider, affording the veteran the highest level of comfort during this difficult process. MST is a pervasive issue within the military and veteran community and for veterans that are brave enough to come forward the VA needs to be prepared to support them. While the DSA mandated that a veteran could choose the gender of their provider, our national service officers (NSOs) report that this option is not being offered to the women veterans they assist. Several women filing claims have reported that the male providers they were assigned for their C&P exams came across as cold, rude, and short. If we continue to say that the VBA is the doorway to the VA, how can we expect women veterans to feel welcome when at their initial examination they feel disrespected and disparaged?

Additionally, when it comes to C&P exams ordered by the VA, our NSOs have run into complications in accessing obstetrician gynecologists (OBGYN) for reproductive exams. VA should classify reproductive exams as a specialty appointment to ensure women veterans are meeting with the appropriate health care providers when engaging with C&P examiners, which would help ensure another level of gender-specific care and a quality exam.

Veterans service organizations (VSO) are eagerly awaiting the release of all reports mandated in the DSA because the data they will contain is critical in understanding the effectiveness of the Act. Without this information, we are incapable of assessing what is working and what is not. It was recently brought to our attention that a provision within the fiscal year (FY) 2022 National Defense Authorization Act (P.L. 117-263) required all congressionally mandated reports (CMR) to be published to a website managed by the Government Printing Office. The Office of Management and Budget published its guidance for this new rule in June of 2023,[1] but none of the CMRs from the DSA or any other piece of legislation have been published to this central website. We urge Congress to ensure that all CMRs are posted in a timely manner so that external stakeholders can conduct their necessary oversight.

Accessibility for Gender-Specific Care

Most of our members receive much of their care within the VA's SCI/D system of care, which provides a coordinated life-long continuum of services for veterans and is the only such system in the world.

[1] Executive Office of the President, Office of Management and Budget, June 2023.

This unique care system provides services and supports from the time of injury and acute care needs, through the life of the veteran. While the VA's SCI/D system is truly remarkable, there are still concerns for PVA when it comes to accessing care for our women veterans.

Our women members often report that it is difficult to access gender-specific care within the SCI/D system because it requires a high level of cooperation and coordination with the women's health clinics. With limited staff inside women's clinics, there is often difficulty in coordinating this care. It is left up to each facility to proactively establish integrated care for patients within the SCI/D system, and unfortunately, this has not been a priority for many locations.

One PVA leader shared that OBGYN services have only been available at her VA for four years. The only way to access them is through a consult from her primary care provider at the SCI/D center and the women's health clinic, which is sometimes difficult to arrange. Many women veterans receive their primary care through a women's health clinic which eliminates this extra step in accessing their care. She goes on to share there are no other accessible clinics to receive GYN services. Often when providers are made available to the SCI/D clinic, they are general practitioners and unable to answer patient questions. She said the process is, "very embarrassing and it makes you feel second-class."

Many PVA members also share that their women's clinic is not physically accessible to them. As the VA works to fulfill their requirements for the retrofit initiative for women's health, accessibility should be a priority, but it is not. Accessibility goes beyond parking spaces and automatic doors.

In a recent survey, PVA's women leaders were asked about physical accessibility when it comes to receiving gender-specific care. One respondent provided that her experience at the VA includes small exam rooms; inadequate exam tables; a lack of family bathrooms, which are often preferred by our members because of the additional space, and if needed, to accommodate a caregiver of a different gender; an inability to get into some clinic doors; and a lack of general accessibility, starting in the parking lot and continuing to the exam rooms. We also hear from our members that many women's health clinics lack ceiling lifts, which are necessary for the safety of veterans in transferring to and from their wheelchairs. Accessibility concerns were the main driver for PVA to engage in the drafting and passage of the MAMMO Act. PVA is eagerly awaiting the release of VA's study on the accessibility of breast imaging services since we still see many of our women members being sent into the community for this service.

PVA would like to highlight one bill in particular that could help address several accessibility concerns within the VA. S. 2516, the Veteran Accessibility Act, would establish an Advisory Committee that would focus on improving accessibility to VA facilities and electronic information sources. It would also review barriers to health care at VA facilities and its community care providers. Lastly, the bill requires the Committee to ensure the acquisition process will result in the VA receiving products, services, and equipment that meet accessibility requirements. Accessibility needed due to veterans' disabilities should be a priority for the VA; however, we see time and time again that SCI/D veterans often run into architectural barriers, inaccessible medical diagnostic equipment, and technology barriers. Federal laws exist to protect disabled veterans; however, issues persist. We urge Congress to pass S. 2516 to ensure the VA prioritizes accessibility for our disabled veterans.

Access to Long-Term Services and Supports

In his testimony to the Veterans' Affairs Committees on March 6, PVA National President Robert Thomas stressed the need for increased access to long-term services and supports. The lack of adequate long-term care options is a nationwide problem, and if the VA is planning on relying on community care to help with the lack of facility-based beds, many veterans are going to be left behind, particularly veterans with catastrophic disabilities.

The VA operates six facilities that have long-term care beds to serve veterans with SCI/D, but only one of those facilities is west of the Mississippi. All totaled, the VA is required to maintain 198 authorized long-term care beds at SCI/D centers to include 181 operating beds. As of February, only 169 beds were available. This is a variable number, dependent on staffing, isolation precautions, and if there are women veterans admitted for long-term care. When averaged across the country, that equates to about 3.4 available beds per state.

In 2021, construction began to replace an acute SCI/D center in San Diego which will update the 30 acute care beds, many shifting into single occupancy rooms, and add 20 new long-term care beds to the system, but this project isn't projected for completion until 2025. Additionally, there is a new long-term care SCI/D center at the VA North Texas health Care System in Dallas which broke ground in January of 2024. This location will include 26 SCI/D, single occupancy rooms, along with two double occupancy rooms. The project is expected to be completed in 2027. Phase two of the Dallas project would add an additional 28 long-term care rooms (26 single occupancy, two double occupancy), however, phase two of the Dallas project has not been funded. Also, existing VA rules require that space to remain incomplete for a year before construction can begin.

Although applicable to all PVA members, it's crucial to mention these infrastructure projects when it comes to discussions around women veterans. We currently have a woman member in need of a long-term care bed in New York. The SCI/D center she is in reached out to several nearby VA community living centers, but none of them have available beds for female veterans. Thus, she is forced to remain in an SCI/D acute center until a bed becomes available that can provide the level of care she needs.

Long-term care services are expensive, with institutional care costs exceeding costs for home and community-based services (HCBS). Studies have shown that expanding HCBS entails a short-term increase in spending followed by a slower rate of institutional spending and overall long-term care cost containment.[2] Because of the preference of PVA members to live at home and the financial benefits shown by studies like these, PVA supports swift passage of the Elizabeth Dole Home Care Act (H.R. 542/S. 141), which would make critically needed improvements to VA HCBS. We cannot stress enough how disappointed our members are that this legislation still has not passed into law.

Even once HCBS programs are available to veterans, the challenges of receiving proper home care assistance continue. Anne Robinson, PVA National Vice President and Army veteran, was injured in a military vehicle accident in October 1999 that left her as a quadriplegic. Her husband, Harry, has been her primary caregiver but Anne's physical needs are significant, and they must rely on direct care

[2] Do noninstitutional long-term care services reduce Medicaid spending?

workers to provide the level of care Anne requires.[3] Finding a candidate who understands the unique needs of this work has been difficult for Anne and Harry. They have interviewed more than 100 applicants to help provide this critical care, but few have lasted more than a handful of months due to the limited pay authorized through the Veteran Directed Care program and the complexity of her care needs. Anne not only lives with complex SCI/D but now she has been burdened with the realities of the direct care worker shortage.

The shortage of caregivers or direct care workers is not unique to the VA. Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. I share these stories to emphasize how precarious the HCBS/long-term care system is and how the lack of home care providers is adversely impacting the care and quality of-life of veterans with SCI/D. Veterans with disabilities have the right to quality care in their homes.

Research Focused on Women Veterans with SCI/D

The increased focus on women's health research at the VA is essential in understanding the needs of our women veterans. However, research for veterans with SCI/D in general is lacking, and this is particularly true when it comes to women veterans with SCI/D. The VA's century-long history of improving the lives of veterans and other Americans through medical and prosthetics research positions them well to conduct studies focusing on these vulnerable populations.

The passage of the Honoring our PACT Act (P.L. 117-168) has been center stage for much of the marketing and focus coming from the VA and Congress in recent years. However, we need additional research into toxic exposures and how they may have uniquely impacted women veterans. Initial data published in the American Journal of Obstetrics and Gynecology, shows an association between environmental, chemical, and hazardous materials and infertility, which was supported by work done by VA Health Services Research and Development Service (HSR&D) researchers.[4] PVA encourages the VA to increase its efforts in women's health research so that the VA is prepared and educated about the unique experiences of women veterans that affect fertility.

Thanks to medical advancements, increased regulation, and improved safety measures, veterans with SCI/D are living longer than ever. This means that as the timeline of care increases, veterans are sure to experience increased care needs, and comprehensive understanding about aging will be critical in supporting these veterans. Only recently have research efforts been focused on what it means to age as a woman and that body of knowledge is limited, particularly for women veterans with catastrophic disabilities. This becomes a critical data point when one realizes the average age for a woman veteran enrolled in VA health care is 55-62.

SCI/D veterans are no different from their ambulatory counterparts when it comes to aging. Their injury does not change the reality that they'll age into the same biological aging disabilities as their peers such as decreased muscle mass, cognitive decline, and osteoporosis. However, for a veteran with SCI/D, these conditions may be exacerbated due to the limited function of their aging body.

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[3] PVA.com, Caregiver Support

[4] Lifetime infertility and environmental, chemical, and hazardous exposers among female & male US veterans, November 2022.

Existing literature focused on people aging with SCI/Ds discusses the complications that can arise from SCI/D and the treatments that exist to combat them. Anyone aging with an SCI/D is likely to see complications in the musculoskeletal system, as well as the endocrine (glands) and cardiovascular systems. They are also more likely than those without SCI/Ds to have bone density loss, chronic pain, pressure injuries, and kidney and bladder stones. Preliminary research also shows an increased risk of developing dementia when someone lives with an SCI/D, meaning that the aging challenges likely to be encountered by our women members are going to be dynamic[5].

We know that women with MS run into challenges with aging that are unique to their medical needs. Women are twice as likely as men to be diagnosed with MS. Research highlights that disability associated with MS tends to worsen around the fifth decade, meaning that our women veterans with the disease face unique challenges that the VA needs to be prepared to react to and ready to treat. Many advances have been made in treating MS including improved disease-modifying therapies, however, research shows that women with it are prone to adverse effects of these treatments, as they age. Research also shows that for aging women with MS, the "age-related decline in physical health is accelerated by 15-30 years compared to their unaffected peers"[6].

PVA members are already living with catastrophic disabilities. As time goes on, those disabilities will be exacerbated, and eventually, they will experience the inevitable biological disabilities that come with aging. The comorbidities they are likely to encounter as aging veterans with SCI/D are under researched, leaving many veterans unsure of what to expect in the coming years, and this is particularly true of our women veterans. PVA commends the efforts the VA has made around gender-specific research, particularly within the HSR&D and the VA Women's Health Research Network. The SCI/D system should work in coordination with HSR&D to advance the impressive body of research already possessed by the VA, particularly around women veterans.

Cultural Competency on Women with SCI/D and MST

The national dialogue around sexual trauma and standards of behavior has changed drastically over the past twenty years. As more and more individuals come forward to share their experiences, veterans and servicemembers are also speaking out. Per the Department of Defense's (DOD) Annual Report on Sexual Assault for FY 2022,[7] 8.4 percent of active-duty women, and 1.5 percent of active-duty men experienced unwanted sexual contact. This accounts for nearly 36,000 servicemembers, many of whom might seek benefits and services from the VA.

In January of this year, research was published that analyzed MST claims ratings from October 2017-May 2022. From that five-year period, an estimated 27.5 percent of claims were denied, especially when compared to combat-related PTSD claims which were only denied at the rate of 18.2 percent.[8]

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[5] Characteristics of Women Veterans with Dementia: Care Report and Review of the Study of Health of Vietnam-Era Women's Study, April 2024.

[6] Impact of aging on treatment considerations for multiple sclerosis patients, July 2023.

[7] Department of Defense Annual Report on Sexual Assault in the Military, FY2022.

[8] Military sexual trauma-related posttraumatic stress disorder service connection: Characteristics of claimants and award denial across gender, race, and combat trauma, January 2024

The denial rate becomes even greater for women of color and male veterans. The number of veterans living with a history of MST is significant and yet they are still encountering challenges when filing claims with VBA.

Long-range symptoms of MST that a veteran can use to justify their claims include things like "sexual difficulties; chronic pain, weight or eating problems, gastrointestinal problems," as well as physical pain in affected areas of the body.[9] Often veterans are unable to grapple with their MST until years, sometimes decades, later. In a 2021 survey of PVA's women members, nearly 40 percent of the respondents had experienced MST in service and many PVA members are finally filing MST claims 20 or 30 years after the incident. However, for several of our SCI/D veterans, due to their injuries, some of the physical long-range symptoms of MST are incapable of manifesting. This doesn't make their experience and trauma any less real.

The VA has made strides toward increasing the accuracy of MST claims in the past several years. Multiple VA Office of Inspector General (OIG) reports have underscored VBA's incremental improvements around the processing of these claims. However, a few percentage points in an OIG report still represents thousands of veterans. Due to the continued challenges with MST claims decisions, PVA recommends Congress pass S. 1028, the Servicemembers and Veterans Empowerment and Support Act of 2023, which aims to expand the evidentiary standard for survivors applying for disability benefits from the VA to ensure MST survivors are provided equal access to benefits and care.

IVF Efforts and Infertility

PVA has long championed increasing access to ART, particularly access to IVF. Recently, the VA and the DOD, announced expanding access to IVF services for some servicemembers and covered veterans. We commend the agencies in removing the marriage requirement along with the previous prohibition on donated genetic material. VA's proposed changes went into effect on March 28, and while it is an important victory, they will only impact a small number of veterans.

PVA strongly supports S. 2801, the Veteran Families Health Services Act of 2023, which seeks to alleviate issues servicemembers and veterans face when trying to receive fertility treatment. The bill would expand VA and DOD fertility treatments and ensure they offer comprehensive family-building assistance for veterans and servicemembers. Also, it creates proactive fertility cryopreservation procedures which will help if a veteran or servicemember faces an illness or injury. If passed, the bill would also increase adoption assistance for a veteran that has a proven infertility diagnosis.

Collaboration with Other Stakeholders

The committee expressed interest in learning more about the work of the VSO Women Veteran Working Group. PVA is fortunate to work with several coalitions focused on increasing awareness, equity, and resources for veterans and all people with disabilities. The working group creates an environment to facilitate discussion about the various needs of our memberships, review legislation, and identify areas of concern and possible solutions. We also work with Congress and the VA to review

[9] Military Sexual Trauma Fact Sheet; Department of Veterans Affairs

data to gauge the effectiveness of policy and we invite subject matter experts to share with us, particularly in the areas of women veteran research.

Now that several iterations of the House's Women Veteran Task Force have completed their work, and subsequent united call for additional support from Congress, we are pleased that there is now a bipartisan, bicameral discussion with organizations on women veterans open to all VSOs. We are hopeful that these conversations will provide space for further discussions around women veterans and that policy solutions will arise from this collaboration.

PVA would like to thank the committee for allowing us the opportunity to share the unique needs of our women members. Our members are almost exclusively reliant on the VA for their health care, benefits, and ultimately, their independence. Ensuring that the VA works for the most vulnerable veterans does not take away from other veterans, rather it guarantees that the VA can serve all the veterans they are obligated to provide care for. PVA is happy to answer any questions the committee may have.

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WOUNDED WARRIOR PROJECT
STATEMENT FOR THE RECORD

COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA"

April 10, 2024

Chairman Tester, Ranking Member Moran, and distinguished Senate Committee on Veterans' Affairs members – thank you for inviting Wounded Warrior Project (WWP) to submit the following written statement about how the Department of Veterans Affairs (VA) can support women veterans. We share your commitment to ensuring that VA is providing high quality care, benefits, and services that meet the needs of female veterans, and we are pleased to share our perspectives on the agency's current performance and future possibilities.

For 20 years WWP has been dedicated to our mission to honor and empower wounded warriors. In addition to our advocacy before Congress, we offer more than a dozen direct service programs focused on connection, independence, and wellness in every spectrum of a warrior's life. These programs span mental, physical, and financial domains to create a 360-degree model of care and support. This holistic approach empowers warriors to create a life worth living and helps them build resilience, coping skills, and connection to peers. Our organization has grown alongside the warriors we serve, and we strive to tailor our programming to the evolving needs of post-9/11 generation warriors. Today we serve more than 200,000 warriors, including more than 35,000 female veterans.

Our service to women warriors is part of a larger trend. In greater numbers than ever, women are stepping up to serve — representing the fastest-growing population in both military service and the veteran community. As women have become an increasingly significant portion of the WWP warrior population, WWP launched the Women Warriors Initiative in 2020. The initiative has been rooted in our desire to better understand, empower, and advocate for these women warriors who have served our nation. The Women Warriors Initiative is comprised of three core elements: (1) tailoring our programs for women warriors, (2) direct engagement with women warriors to discuss their experiences as Service members and veterans, and (3) the WWP Women Warriors Report; all informing our ongoing efforts to best support and advocate of women warriors.

WWP's Women Warriors Initiative

Programs for Women Warriors

Wounded Warrior Project offers direct service programs that span mental wellness, connection, physical wellness, financial wellness, independence, and advocacy. We have worked to adapt and structure these programs to ensure that all warriors have a quality experience and beneficial engagements with staff, other veterans, and the greater public. Although these programs are generally co-ed and designed to foster connection across the veteran community, dedicated tracks for certain populations can enhance impact and create unique opportunities for engagement. Gender-specific programming has provided an opportunity for women warriors to participate in female-focused events and activities, including in women warrior peer support groups, women warrior mental health retreats, and advocacy programs focused on the challenges and opportunities facing women warriors. In just the last year alone (October 1, 2022, to September 30, 2023), WWP has:

- Helped **721** women warriors receive treatment for PTSD, traumatic brain injury, substance use disorder, and military sexual trauma through **Warrior Care Network**, a partnership between WWP and four premier academic medical centers;
- Placed **6,091** emotional support calls with women warriors through **WWP Talk**, a nonclinical, telephonic, goal-setting program designed to help warriors and family service members plan individualized paths toward personal growth;
- Brought **416** women warriors through **Project Odyssey**, a 12-week mental health program that uses adventure-based learning to help warriors manage and overcome their invisible wounds and empower them to live productive and fulfilling lives;
- Supported **158** women warriors in their roles as Peer Support Leaders or Warrior Leaders, WWP-sponsored volunteer positions that create pivotal leadership roles in their communities; and
- Hosted virtual and in-person events for **5,256** women warriors to keep them and their families connected and out of isolation.

Women Warrior Engagement

In addition to efforts to tailor our programs for women, the Women Warriors Initiative has been a forum to provide opportunities for feedback and data to better inform WWP services, perform research on the female veteran population, and deliver recommendations related to the future of women veterans. Through this initiative, in 2023, WWP staff held five virtual focus groups and traveled to five cities to bring women warriors and key stakeholders together to facilitate discussions around experiences, challenges, and accessing care and services. These engagements empowered women warriors to engage directly with congressional and federal government professionals and culminated in the Women Warriors Summit. The Summit brought over 50 women warriors from across the country to Washington, DC to meet with VA, White House, and Congressional leaders to engage in conversation, learn about public policy efforts, and advocate for changes to support women veterans.

2023 Women Warriors Report

Published in September 2023, the 2023 Women Warriors Report[1] is a mixed-methods research study that presents quantitative data from surveys completed by women veterans registered with WWP and qualitative data from focus group interviews with women warriors that took place both in person and virtually. The report is a comprehensive examination of the experiences and challenges faced by female veterans in the United States. The 2023 report was the second iteration of data being produced focused on women veterans through WWP. The 2021 report began with an initial survey to identify key themes of interest, and then focus groups were held to discuss those themes in more elaborative detail. The 2023 Women Warriors Report utilized quantitative data collected through the 2022 Annual Warrior Survey and through virtual and in-person focus groups.

The 2023 Women Warriors Report focused on 5 key areas: mental health, access to care, financial wellness, social health, and the military transition as well as a special topics section which included physical health, military sexual trauma (MST), and toxic exposure. Among the most notable findings:

- **76.9%** of WWP women warriors have sought professional mental health care
- **53.2%** of WWP women warriors had difficulty or delayed getting care for physical injuries or problems
- **10%** of WWP women warriors are unemployed, compared to 6.3% of male warriors, despite higher educational attainment

Through extensive research and data analysis, the report sheds light on the unique struggles encountered by women who have served in the military, ranging from difficulties accessing health care to navigating reintegration into civilian life. The report serves as the primary reference point for the discussion that follows.

Mental Health

Military service can impact a woman's mental health while they are in uniform, but also after their transition to civilian life. Some mental health impacts related to military service can interfere with a woman veteran's life, including her employment.[2] The 2023 Women Warriors Report builds upon existing research which generally shows that, overall, women veterans indicate higher rates for certain mental health conditions compared to male veterans, and unique health risk factors and outcomes.[3] The most striking findings are below:

PTSD, Depression, and Anxiety

WWP women warriors are more likely to present with moderate to severe mental health symptoms than WWP male warriors. Whether PTSD (50.7% vs. 48.2%), depression (58.7% vs.

[1] The 2023 Women Warrior Report can be viewed online and downloaded by visiting https://newsroom.woundedwarriorproject.org/women-warriors-initiative.
[2] Kelli Godfrey et al., *Negative Impact of Military Service on Women Veterans' Mental Health Can Lead to Long-term Poor Mental Health and Higher Unemployment Rates*, 10(3) MILITARY BEHAV. HEALTH 243, 243-48 (2022).
[3] Jennifer Runnals et al., *Systematic Review of Women Veterans' Mental Health*, 24(5) WOMEN'S HEALTH ISSUES 485, 485-502 (2014).

54.1%), or anxiety (49.3% vs. 46.2%), women warriors were more likely to score higher on objective severity measures.[4] Interestingly, women generally experienced specific symptoms more commonly than men. Symptoms including trouble relaxing, worrying, and feeling anxious were reported at higher rates by women than men, who more commonly cited becoming easily annoyed or irritated. Sleep challenges, feeling tired or having little energy, and having poor appetite or overeating were more common among women, while men were more likely to cite having little interest or pleasure in doing things. These insights complement prior research that shows women warriors report using mental health tools or services such as mental health care or prescription medication at rates higher than their male counterparts.[5]

Suicidal Ideation and Alcohol Use

More than half (56.1%) of women warriors reported at least one instance of suicidal ideation in their lifetime, which was higher compared to male warriors (50.8%). Approximately one-third (33.2%) of WWP women warriors have attempted suicide at least once in their lifetime compared to 23.5% of male warriors. About two in five (47.2%) of WWP women warriors screened positive for potential hazardous drinking or active alcohol use disorders. A military background has been shown to be increase experiencing disparities for women veterans when seeking support care or services, including substance use treatment services.[6]

Mental Health Seeking Behavior

Across several measures, WWP women warriors report seeking care more often than men. When asked about tools and resources used for stress, emotional challenges, or mental health concerns, women were more likely to report talking to friends and family (71.1% to 64.2%), seeking services at VA (60.7% vs. 54.0%), engaging in physical activity (58.0% vs. 54.0%), and using prescription medication (66.6% vs. 57.4%). Men were only more likely to talk with another veteran (61.1% vs. 58.0%). In focus groups, women warriors spoke about having interests in exploring holistic and alternative forms of therapeutic care and treatment for mental health, including meditation, treatment-focused applications, and other modalities of support.

Quality of Life

Compared to the general U.S. women population, WWP women respondents scored lower on the mental component (34.5 v. 50.8) but slightly higher on the physical component (38.6 v. 37.0). These scores are based on the Veterans RAND 12-Item Health Survey (VR-12) where higher scores indicate better health.

[4] The PTSD Checklist for DSM-5 (PCL-5) was used for PTSD, the Patient Health Questionnaire-9 (PHQ-9) was used for depression, and the General Anxiety Disorder 7-Item (GAD-7) was used for anxiety.
[5] David L. Albright et al., *Mental and Physical Health in Service Member and Veteran Students Who Identify as American Indians and Alaskan Natives*, 69(7) J. AMERICAN C. HEALTH 783, 783-90 (2021).
[6] David Albright et al., *Pregnancy and Binge Drinking: An Intersectionality Theory Perspective Using Veteran Status and Racial/Ethnic Identity*, 25(8) MATERNAL AND CHILD HEALTH J. 1345, 1345-51 (2021).

How WWP Helps:

WWP is committed to helping warriors and their families face the future with confidence. We understand that there is always another goal to achieve and another mission to discover – that's why we provide a variety of programs and services, all available at no cost to veterans and their families.

Telephonic emotional support: WWP Talk is a nonclinical telephonic emotional support and goal-setting program that connects warriors and/or family members, via a weekly call, with a dedicated team member who can help with developing an individualized plan to promote a path towards personal growth. In FY 23, WWP provided Talk services to 680 women warriors.

Adventure-based healing: Project Odyssey is a 12-week program that includes outdoor, adventure-based learning to help warriors develop better coping and communication skills. Project Odyssey is also available as a couples program. In FY 23, WWP hosted over 30 unique sessions specifically for women warriors (20.5% of the Project Odyssey sessions).

WWP Recommendations

Since publishing the 2023 Women Warriors Report, WWP has engaged with veterans, media, policy makers, and other stakeholders to help raise awareness and identify solutions to the challenges outlined above. Regarding mental health care, the legislative solutions we seek are generally agnostic to gender and reflect that better access to mental health care – which benefits all veterans – is the goal. WWP supports:

- The ***Making Community Care Work for Veterans Act*** (S. 2649) and the ***Veterans' Health Empowerment, Access, Leadership, and Transparency for Our Heroes (HEALTH) Act*** (S. 1315). As veterans continue to report being offered mental health care appointments that are months away, or different modalities that may provide care sooner (like group therapy), we believe that more success will be found by ensuring that current access standards are clearly communicated and adhered to. Both bills would codify existing mental health care access standards in an effort to increase VA accountability. In addition, both bills would address glaring deficiencies in how VA provides access to its Residential Rehabilitation Treatment Programs.

- The ***Mental Health Professionals Workforce Shortage Loan Repayment Act*** (S. 462, H.R. 4933). This bill would provide up to $250,000 in eligible student loan repayment for mental health professionals in substance use disorder treatment who pursue employment in Mental Health Professional Shortage Areas. With increasing numbers of veterans specifically seeking treatment for substance use disorder, passing this legislation will incentivize the training of more providers in this space, resulting in better access to care for veterans and shorter wait times for treatment.

- WWP also supports oversight of past legislation like the ***VA Peer Support Enhancement for MST Survivors Act*** (P.L. 117-121), which requires the Veterans Benefits Administration (VBA) to ensure every veteran who files a claim relating to MST is assigned a peer support specialist during the claims process, (unless they elect not to), and the ***STRONG Veterans Act*** (P.L. 117-328, Div. V), which includes a section (§ 503) partially intended to better understand the challenges women veterans face in accessing critical services at residential substance abuse rehabilitation programs that include a safe and welcoming environment during treatment.

- Additional research to help understand these issues should include exploration of the root causes of trauma women veterans face and the coping skills they employ; the factors that impact women veterans' mental health issues, as well as the factors and treatments that can improve these issues; risk factors for suicide attempts and how they differ between women veterans and male veterans, as well as the factors that contribute to the higher rates of attempted suicide among WWP women warriors compared to WWP male warriors.

Access to Care

The 2023 Women Warriors Report illuminates challenges encountered by female veterans in accessing health care services. The report reveals disparities in health care access, with many women facing barriers such as long wait times, inadequate provider knowledge about women's health issues, and difficulties accessing specialized care. Additionally, geographical constraints often exacerbate these challenges, particularly for women residing in rural areas. These findings align with existing women veteran research which suggests that women veterans consider factors related to safety, quality, and the value of health care in their accessing care options.[7] Among the most notable findings in the 2023 Women Warriors Report:

Women's Health Care Services

The most common form of health care for WWP women warriors is VA health care (90.3%), with Tricare (53.2%) as the second most common. Nearly three in four (71.0%) women warriors reported using VA medical services for primary care; however, only 61.9% use VA for women's health care specific services.

Barriers to VA Care

WWP women warriors are more likely to report challenges accessing VA care than WWP male warriors. Among the most significant areas of concern were the prevalence of WWP women warriors who reported insufficient access to VA health care services and benefits (19.9% vs. 15.8% of men), VA providers being insensitive to patient needs (19.7% vs. 13.7%), and no access to childcare (9.4% vs. 4.3%). As a reflection of overall experience, more than half of WWP women warriors (53.2%) indicated they had difficulty or put off getting needed care for physical injuries or problems, which is a higher proportion than male warriors (42.0%).

[7] Elizabeth A. Evans et al., *Why Women Veterans Do Not Use VA-provided Health and Social Services: Implications for Health Care Design and Delivery*, 64(2) J. HUMANISTIC PSYCHOL. 251, 251-80 (2024).

Military Sexual Trauma

Although WWP women warriors reported military sexual trauma at a rate more than three times higher than male warriors, they reported receiving MST care through VA less often (4.6% vs. 6.8%). Findings in the report showed that over two-thirds (64.9%) of WWP women warriors indicated they had experienced sexual harassment, which was higher than male warriors (5.1%).

How WWP Helps:

Fitness and nutrition: WWP's Physical Health & Wellness program empowers warriors and family members to make long-term changes toward a healthier lifestyle through movement, nutritional education, coaching, goalsetting, and skill-building. In FY 23, WWP assisted 1,647 women through this program and provided several female-focused tracks including a Hormones Wellness Series, a woman-warrior only coaching program, and non-coached programming to teach women warriors about pelvic floor health, self-defense, weightlifting, yoga, and other wellness workshops.

WWP Recommendations

When looking beyond mental health, the 2023 Women Warriors Report strongly suggests that VA can improve gender-specific care. Gender-specific care for women refers to medical, psychological, and social services tailored to address the unique health needs and challenges faced by women. Ensuring that female-specific care is easy to access – whether it be reproductive health care, breast and cervical cancer screening, or menopause management among others – is an intuitive priority. However, our 2023 Women Warriors Report concluded that many WWP women warriors notice discrepancies in accessing care related to nutrition, support for weight-related concerns, and pain. Congress can support women veterans' health needs by supporting legislation below:

- The ***Maternal Health Care for Veterans Act*** (H.R. 3303). Congress recently codified VA's Maternity Care Coordination program with the *Protecting Moms Who Served Act* (P.L. 117-69) and provided $15 million in initial funding. This program manages the maternity care coordination position at VA, a multifaceted role that supports pregnant women veterans as a liaison between the patient, the non-VA provider, and the VA facility through monitoring the delivery and coordination of care and tracking outcomes of services related to maternity care. The bill would reauthorize funding for the Maternity Care Coordination program at the same authorized funding level of $15 million per year for the next five fiscal years. It would also require VA to provide an annual report to Congress through FY 2028 on its activities and use of funds relating to the coordination of maternity health care.

- The ***Service Women and Veteran Menopause Research Act*** (H.R. 7596). Research has shown that women veterans entering or experiencing menopause with a higher

menopause symptom burden may be most vulnerable for chronic pain.[8] Additionally, there are unique issues related to menopause care that can be better understood with more research, such as hormone therapy.[9] This bill would require VA and the Department of Defense to collaborate on an evaluation of certain research related to menopause, perimenopause, or mid-life women's health, and to conduct or fund associated research.

- WWP continues to support oversight of legislation that impacts women veteran health care, including key provisions of the ***Deborah Sampson Act*** (P.L. 116-315 §§ 5101 (Office of Women's Health), 5107 (Programs on Assistance for Child Care for Certain Veterans), 5108 (Availability of Prosthetics for Women Veterans), 5111 (Sense of Congress on Access to Facilities by Reservists for Counseling and Treatment related to Military Sexual Trauma), 5201 (Staffing of Women's Health Primary Care Providers at Medical Facilities)).

- WWP also encourages expanding the hours and days of operation of VA clinics. While some facilities already have policies that extend hours and days of operation, this is not consistent enterprise wide. WWP appreciates a recent Veterans Health Administration (VHA) initiative ("Access Sprint") to increase appointment availability for three specialized services – cardiology, mental health, and gastroenterology – by offering night and weekend clinics.[10] Moving forward, an access sprint for mammograms and gender-specific services (gynecological and cervical exams) as well as endocrinology services (related to hormone wellness for aging women veterans) would be welcomed.

- Women warriors would also benefit from more tailored tools for navigating VA's healthcare system. Allowing them to weigh in on what community care providers they are referred to for services, especially for infertility and gender-specific care, would be another potential avenue of building trust and empowering women veterans to play active roles in their health care journeys. Publishing an online directory of VA-approved community care providers specializing in women's health care is an additional supportive way we can help women veterans make more informed decisions about their care.

- WWP also encourages VA to take steps that are focused on long term care planning for women veterans. Increased communication, investment, and research about women veterans as they age, as well as to ongoing efforts to raise awareness for existing programs, services, and opportunities can help. One such opportunity that could be highlighted is for women veterans over the age of 55 to participate in the VA Golden Age Games, where women have been historically underrepresented.

- WWP recommends VA conduct a system assessment of innovative technologies such as 3D mammography technology. Currently, VHA has active mammography programs only at 78 facilities in 17 out of the 18 regional VISNs. This suggests that some veterans would have to utilize multiple facilities for comprehensive care and facilities would

[8] Carolyn Gibson et al., *Menopause Symptoms and Chronic Pain in a National Sample of Midlife Women Veterans*, 26(7) MENOPAUSE 708, 708-713 (2019).
[9] Noella Dietz et al., *Women Veterans and Menopause: Knowledge and Preferences*, 58(8) WOMEN HEALTH 898, 898-914 (2018).
[10] Jory Heckman, *VHA Launches 'Access Sprints' to Offer More Medical Appointments to Veterans*, FED. NEWS NETWORK, Jan. 22, 2024, *available at* https://federalnewsnetwork.com/workforce/2024/01/vha-launches-access-sprints-to-offer-more-medical-appointments-to-veterans/.

potentially have to transfer records. A full understanding of innovative technologies would benefit veterans and their health care providers.

Financial Wellness

The 2023 Women Warriors Report includes financial wellness findings that shed light on the economic struggles and challenges faced by women warriors. The report reveals disparities in financial stability, with many women experiencing challenges such as inadequate employment opportunities, lower wages compared to their male counterparts, and difficulties in transitioning to civilian careers. Moreover, the report underscores the impact of these financial stressors on overall well-being, including mental health and family stability. Key areas of research include:

Unemployment

Despite being more educated, WWP women warriors face higher rates of unemployment than male warriors and women in the U.S. general population (based on August 2022 data). Women warriors reported a 10.0% unemployment rate (vs. 6.3% for male warriors), which was notably higher than U.S. women with a disability (7.8%), U.S. women overall (2.4%), and all U.S. women post-9/11 veterans (2.0%). Family and/or childcare responsibilities are one of the top barriers to employment for unemployed WWP women warriors (27.6%) – and only 17.4% of unemployed male warriors report this barrier.

Income, Debt, and Food Security

Across several measures of these contributors to financial strain, women and male warriors were generally similar. Women and men both show a median household income between $50,000 and $74,999, although there were variances in weekly compensation for work ($1,407 full-time and $555 part-time for men vs. $1,371 and $867 for women). More than 9 in 10 (92.3%) of WWP women warriors have debt other than mortgage, of which 55.9% have at least $20,000 in total debt (excluding mortgages). This is similar to the level of indebtedness reported by WWP male warriors (92.9% and 57.1%, respectively). Both women and men were relatively close in meeting the threshold for being food insecure (40.0% vs. 38.4%); however, these figures are nearly four times higher than what is seen in the U.S. general population (10.2%). Despite these findings, WWP women warriors were more likely to show moderate to high financial distress (72.1%) than WWP male warriors (68.6%).

How WWP Helps:

Career coaching: Warriors to Work helps warriors and family members succeed in the civilian workforce by finding meaningful employment that matches their skillsets. In FY 23, WWP served 1,398 women warriors and delivered 14,845 total services such as resume and cover letter review, networking and interview preparation, and post-placement counseling.

Financial education and counseling: WWP's Financial Education team facilitates education and support to support warriors and families succeed in improving their financial well-being. Over 800 women warriors were served in FY 23, receiving services including budget and

credit counseling, financial advising, and financial education. Similarly, WWP provided 1,160 emergency financial assistance grants to women warriors to help with urgent needs like food, rent, and utilities.

WWP Recommendations

Similar to our recommendations around mental health, WWP supports measures around financial wellness that are gender agnostic. However, the proposals outlined below can potentially have a bigger impact on women warriors based on the employment findings discussed above. WWP encourages Congress to pass the following:

- The ***Edith Nourse Rogers STEM Scholarship Opportunity Act*** (H.R. 5785). Within STEM professions, higher education leads to higher pay.[11] In 2023, the STEM workforce included 12.3 million women (35% of the workforce) and is projected to increase.[12] This bill would expand eligibility for veterans seeking education in STEM related fields, which we believe would encourage more women veterans to pursue efforts in STEM. WWP supports provisions in this bill that would extend the scholarship to graduate-level programs and mandate research about denied applicants, including demographic information. As women veterans and Black veterans were found to be disproportionately denied for the scholarship, WWP supports a House Committee on Veterans' Affairs amendment to would require VA reporting on the objective processes for scholarship acceptance and administration.[13]

- The ***VET–TEC Authorization Act*** (S. 1678). This bill would reauthorize VA's Veteran Employment Through Technology Education Courses (VET-TEC) program. The program accepted 6,700 veterans during the initial years of the program (through March 2022), with a majority (66%) successfully completing the program.[14] With the program scheduled to end this month (April 2024), VA reported that the program supported over 14,000 beneficiaries who completed the program, with nearly half reporting having found sustainable employment with starting salaries averaging $65,000.[15] With the success of having impacted veteran lives and developing opportunities for veterans to pursue meaningful employment, WWP supports this and other efforts to reauthorize the program.

- Beyond these bills, policymakers and organizations can work towards improving the overall quality of life for women who have served in the military. One area where WWP women warriors have expressed a need for is in professional development and connection with mentors. WWP encourages policies and programs that invest in mentorship and transition support services for women veterans through the development of a program

[11] Liam Knox, *Measuring Outcomes in Income*, INSIDE HIGHER EDUC., May 4, 2023, *available at* https://www.insidehighered.com/news/students/careers/2023/05/04/measuring-outcomes-income.
[12] NAT'L CTR. FOR SCI. ENG'G STATS., NAT'L SCI. FOUND., DIVERSITY AND STEM: WOMEN, MINORITIES, AND PERSONS WITH DISABILITIES 2023 (2023), *available at* https://ncses.nsf.gov/wmpd.
[13] U.S. GOV'T ACCOUNTABILITY OFF., HIGHER EDUCATION: VA COULD IMPROVE SUPPORT FOR VETERANS PURSUING STEM DEGREES (2022).
[14] U.S. GOV'T ACCOUNTABILITY OFF., VETERANS EMPLOYMENT: PROMISING VA TECHNOLOGY EDUCATION PILOT WOULD BENEFIT FROM BETTER OUTCOME MEASURES AND PLANS FOR IMPROVEMENT (2022).
[15] Press Release, U.S. Dep't of Vet. Affairs, VET-TEC Update: The Pilot Program Concludes this April (Apr. 1, 2024), *available at* https://news.va.gov/129949/vet-tec-update-the-pilot-program-concludes-this-april/.

that connects women veterans with professional mentors. Recommendations for future research including developing an understanding in why differences exist in unemployment rates among women and men in both veteran and civilian populations. Additional research should study the impact of supporting obligations on women veterans' financial wellness.

Social Health & Military Transition

The 2023 Women Warriors Report includes social health findings that offer important new perspectives on the social welfare of women warriors. WWP defines social health as "health, resilience, and camaraderie marked by meaningful relationships and experiences with both individuals and a community." The findings emphasize how difficult it is for women to establish and preserve social ties after leaving the military.

For many women, social health is tied in to the overall experience of military transition and veteran identity. The transition from active-duty military service is recognized to be a stressful time in a Service member's life and journey. Existing research has focused on developing an understanding around personal well-being outcomes (sense of purpose) for women veterans during their military research, finding that many women veterans are not satisfied with current available transition support services.[16] Building from these findings, the 2023 Women Warriors Report underscores important facets of the post-service adjustment process for women warriors.

The report sheds light on the range of complex obstacles that women face when they leave the military and enter the civilian workforce. These obstacles include finding jobs that match their background and skill set, navigating the healthcare system, and gaining access to resources for housing and education. Key findings include:

Community and Loneliness

Loneliness and being alone are two different things. Individuals can feel lonely even if they are surrounded by people. The average loneliness score of 6.6 among WWP women warriors falls within the threshold indicating loneliness, which is similar to the average score among male warriors (6.1); however, more WWP women warriors fall into the loneliness range. When categorized into groups, the majority (73.0%) of WWP women warriors are considered lonely, compared to 64.9% of male warriors. More specifically, WWP women warriors were more likely than WWP male warriors to feel isolated (82.0% vs. 76.7%), feel left out (79.4% vs. 71.6%), and lack companionship (77.8% vs. 69.0%).

Veteran Identity

For WWP women warriors, the challenges of veteran identity are magnified. When asked to agree or disagree with a series of statements about life after service, key differences emerged for WWP women warriors. Only 66.0% of women warriors viewed their military

[16] Kari Fletcher et al., *Transition Services Utilization Among US Women Veterans: A Secondary Analysis of a National Survey*, 8(1) J. VETERANS STUDIES 161, 161-74 (2021).

experience positively (vs. 82.3% of WWP male warriors). WWP women warriors were also less likely to agree that people in their community respect that they are veterans (78.3% vs. 83.7% of WWP male warriors). That difference was even more pronounced when asked if co-workers respect that the individual is a veteran (78.8% of WWP women warriors vs. 86.0% of male warriors).

In addition to these statistics, focus groups revealed several common factors in social health for women veterans. Veteran identity often shapes social interactions for WWP women warriors. The lack of outreach or community for women veterans was noted by many, with some women sharing that they had been the only woman or the youngest person in attendance at local veteran events. Social anxiety and rural living both create barriers to social health.

How WWP Helps:

Warrior and family events: The Alumni Connection Program creates meaningful engagement opportunities through face-to-face and virtual programming for warriors and family members to meet and connect with other veterans and families within and outside their communities. Over 5,200 women warriors participated in these activities in FY 23 (20% of all participants) for a total of 26,619 unique engagements (30% of all engagements).

Group meetings: WWP Peer Support Groups offer a safe, judgment-free environment to regularly meet, share experiences, and build relationships with other veterans through meetings held nationwide. There are currently 14 Women Peer Support Groups.

WWP Recommendations

The 2023 Women Warriors Report encourages VA to conduct in-person and virtual quarterly town halls at each regional office, led by the Women Veterans Coordinators, to allow engagement and connectivity with women veterans and VA staff. This was a requirement included in the *Deborah Sampson Act* that has been implemented, but there are opportunities for further growth. Most VA Medical Centers (88.5%) were in compliance of holding two public forums for a total of over 68,000 attendees in Fiscal Year 2023. Between 80.5-83.5% of facilities held a focus group each quarter for a total of 1,765 women veteran participants across all facilities, averaging about 4 women veterans per group. WWP encourages closer inspection of accountability protocols for facilities not in compliance, or to develop a greater outreach campaign to increase participation.

Research recommendations include future studies that look at the types of peer support women veterans seek as they transition out of the military, root causes of isolation and barriers to social engagement among women veterans, and the impact of military experiences on resilience among women veterans. Additionally, there are measures not unique to women that we believe would help improve military transitions. Those bills include:

- The ***Servicemembers and Veterans Empowerment and Support Act*** (S. 1028, H.R. 2441). Focused on the challenges veterans are having when seeking to establish service

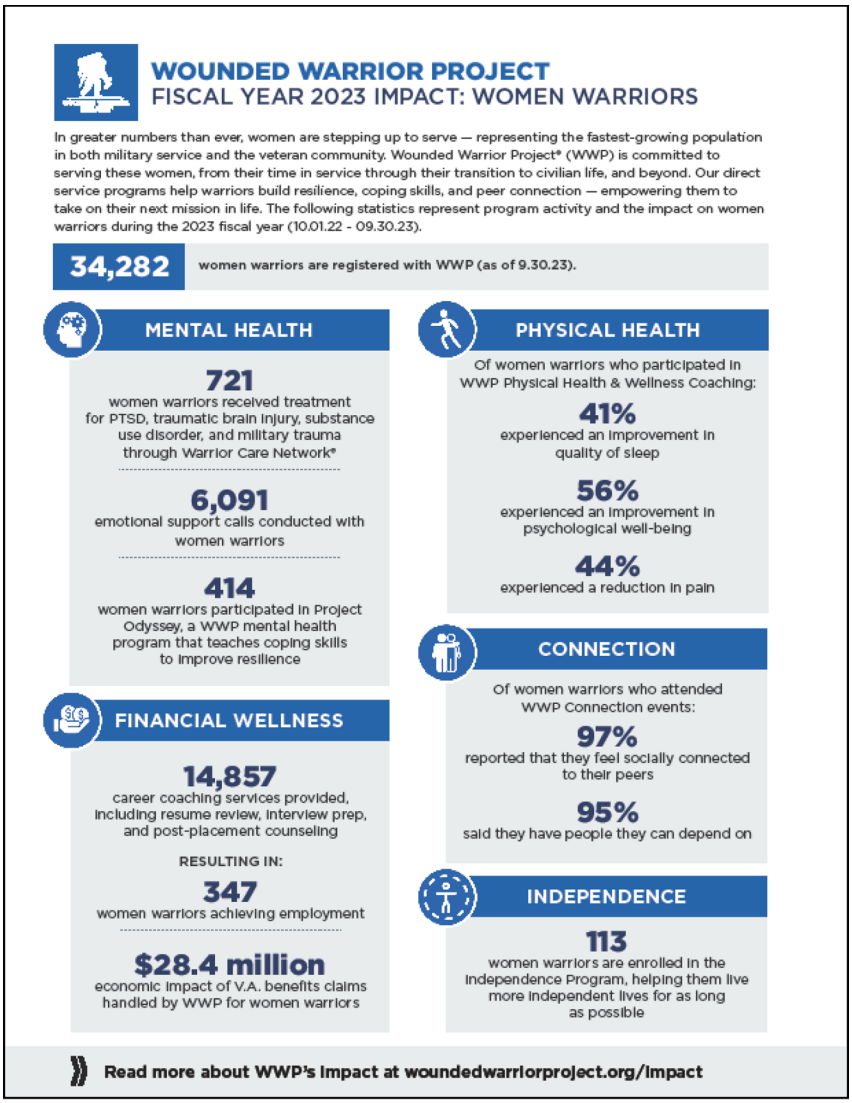
connection for mental health conditions caused by military sexual trauma, this bill would provide for several improvements to disability compensation and claims processing, and health care access. Most notably, the bill outlines several changes related to evidence and development of claims.

- The ***Combat Veterans Pre-Enrollment Act*** (S. 3560). This bill would allow Service members who have served in combat theaters to enroll in VHA prior to separating from the military. The goal is to improve the transition and the continuum of care and increase the likelihood of enrollment upon discharge.

- In addition to these bills, WWP encourages VA and the Department of Defense to find ways to avoid re-traumatizing MST survivors and reducing the stigma around reporting procedures; adapt the current VA program, VA MOVE!, to be more inclusive and specific to women veterans; and extend more outreach and communication for women-specific innovative programs or services, such as VA's THRIVE and VA's RENEW programs. Research should focus on the differences in MST related symptoms among men and women regarding societal and cultural exposures and their impact on quality of life as well as differences in chronic pain among women and men- including the veteran population, as the research on this specific population and topic is limited in the civilian population in general.

CONCLUDING REMARKS

Wounded Warrior Project once again extends our thanks to the Committee for its continued dedication to our nation's veterans. Specifically, we appreciate the opportunity to speak about WWP research and other efforts intended to develop a greater understanding of women veterans. It is paramount to recognize the invaluable contributions of women veterans to the American population today. Their dedication, sacrifice, and resilience have not only fortified our nation's defense but also enriched our society in countless ways. As leaders, caregivers, innovators, and advocates, women veterans play integral roles in shaping our communities and advancing our collective prosperity. By honoring their service and amplifying the voices of women warriors, we not only honor the principles of equality and justice upon which our nation was founded but also ensure a brighter, more inclusive future for all Americans.



WOUNDED WARRIOR PROJECT
FISCAL YEAR 2023 IMPACT: WOMEN WARRIORS

In greater numbers than ever, women are stepping up to serve — representing the fastest-growing population in both military service and the veteran community. Wounded Warrior Project® (WWP) is committed to serving these women, from their time in service through their transition to civilian life, and beyond. Our direct service programs help warriors build resilience, coping skills, and peer connection — empowering them to take on their next mission in life. The following statistics represent program activity and the impact on women warriors during the 2023 fiscal year (10.01.22 - 09.30.23).

34,282 women warriors are registered with WWP (as of 9.30.23).

MENTAL HEALTH

721
women warriors received treatment for PTSD, traumatic brain injury, substance use disorder, and military trauma through Warrior Care Network®

6,091
emotional support calls conducted with women warriors

414
women warriors participated in Project Odyssey, a WWP mental health program that teaches coping skills to improve resilience

FINANCIAL WELLNESS

14,857
career coaching services provided, including resume review, interview prep, and post-placement counseling

RESULTING IN:

347
women warriors achieving employment

$28.4 million
economic impact of V.A. benefits claims handled by WWP for women warriors

PHYSICAL HEALTH

Of women warriors who participated in WWP Physical Health & Wellness Coaching:

41%
experienced an improvement in quality of sleep

56%
experienced an improvement in psychological well-being

44%
experienced a reduction in pain

CONNECTION

Of women warriors who attended WWP Connection events:

97%
reported that they feel socially connected to their peers

95%
said they have people they can depend on

INDEPENDENCE

113
women warriors are enrolled in the Independence Program, helping them live more independent lives for as long as possible

Read more about WWP's impact at woundedwarriorproject.org/impact

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STATEMENT OF
NAOMI MATHIS
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE DISABLED AMERICAN VETERANS
FOR THE SENATE COMMITTEE ON VETERANS' AFFAIRS
APRIL 10, 2024

Chairman Tester, Ranking Member Moran, and Members of the Committee:

On behalf of DAV's (Disabled American Veterans) more than 1 million members, thank you for inviting us to provide testimony for the Senate Veterans' Affairs Committee hearing titled, *"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA."*

DAV members, all of whom are war-time disabled veterans who were wounded, injured, or made ill during their service, utilize the Department of Veterans Affairs (VA) benefits and the Veterans Health Administration (VHA) services at extremely high rates—in fact many depend on VA as their sole source of health care.

Throughout its 100-plus year history, DAV has been an unwavering champion of women veterans and made a concerted effort to highlight and recognize their contributions to the defense of our country. The integration of women into every career path in the armed services has resulted in a rise in the number of women who serve and subsequently increasing numbers of women have applied for disability benefits and enrolled in VA health care following military service. Women are in fact the fastest-growing demographic of veterans—with over 650,000 now using VA health care services. Women veterans using VA care have high rates of service-connected disabilities, many have medically complex health histories and use specialty care—such as mental health and substance use disorder services at higher rates. Unfortunately, for too many women veterans untreated mental health issues have led to a rising suicide rate among this population in recent years.

About two years ago, DAV began work to review all available medical research literature concerning mental health among the women veterans' population, particularly focused on gaps in care and solutions to prevent suicide. In February of this year, DAV released our new report *Women Veterans: The Journey to Mental Wellness* with our findings and recommendations for change. This report is the third in a series of reports on women veterans DAV has released over the past decade, but the first one that is dedicated to mental health. Our report is a comprehensive look at the unique risk factors contributing to the staggering rate of suicide among women veterans and how the VA can and must do better. In addition to identifying gaps in gender-tailored mental

health care and suicide prevention initiatives, DAV offers more than fifty legislative and policy recommendations that have the potential to save the lives of women veterans.

Our report comes on the heels of VA's most recent Annual Veterans Suicide Prevention Report published in November 2023, which is based on the most recent data and analysis from 2021. Despite a public health approach and concerted efforts to reduce suicide among veterans, VA's report showed increased rates of suicide for veterans. However, the most alarming finding was that the suicide rate among women veterans jumped 24.1% in 2021; nearly four times higher than the 6.3% increase among male veterans and vastly higher than the 2.6% increase among non-veteran women. While there has been significantly more attention and resources provided in recent years to reduce veteran suicide, these statistics demonstrate there is a need to focus more on the unique challenges and obstacles women veterans face on their journeys to mental wellness.

VA Women's Health Research

As we conducted an exhaustive review of the most recent and available VA research on women veteran's mental health care, the most consistent finding, regardless of the issue, was that there simply is not sufficient research or data specifically focused on women veterans. We found, and the VA recognizes, the need to invest in more research on issues impacting women veterans, and to ensure that data on this group of veterans is included in all VA research and data collection efforts.

Researchers within the VA have long recognized the need to address challenges to fully integrate women into a health care system that has historically focused on the majority male population it serves. For those reasons, the Women's Health Research Network (WHRN) was established within the VA in 2010 to connect researchers interested in issues affecting women veterans. This initiative has resulted in the most extensive volume of women veterans-specific research anywhere and has made the VA a knowledge leader in women veterans health. While this effort has resulted in real progress, it is clear there is still more work to be done to ensure this growing population has access to effective health care services and programs tailored to meet their needs.

DAV recommends that Congress ensure the Women's Health Research Network has sufficient resources to continue its efforts to map gaps in the women veterans' research agenda, especially in the area of suicide prevention, and to recruit investigators with subject matter expertise to address them. The VA must ensure all research efforts include over-sampling of all underserved veteran subpopulations, including women who have been too often left out of research until the last few decades. In particular, DAV recommends that VA expand its research on mental health issues that are associated with elevated risk of suicide, specifically those discussed in the testimony below.

Lethal Means Safety

The issue of lethal means safety is particularly important when it comes to suicide prevention for our nation's veterans and a growing concern among women

veterans who are at significantly higher risk compared to their civilian counterparts. According to VA's 2023 Annual Veterans Suicide Prevention Report, firearms were used in 51.7% of women veterans' suicides, more often than all other methods combined. The rate of women veterans dying by firearm suicide was nearly three times higher than for non-veteran women dying from firearm suicide.

Developing an effective lethal means safety initiative begins by understanding the many reasons why women veterans choose to own firearms. Perhaps the most common reason cited is to protect themselves—which requires that the firearm is easily accessible. This coincides with the fact that many women veterans have experienced military sexual trauma (MST) or interpersonal violence (IPV). However, we know that suicidal ideation is episodic and when individuals are in crisis they often vacillate in their intent to die, which is why interventions that can create a barrier of time and space between the thought of suicide and the action are considered most effective. VA needs to promote lethal means solutions that are designed specifically for women veterans, and that are communicated in an effective manner to women veterans.

In an effort to raise awareness about suicide prevention, VA included women veterans in its lethal means safety campaigns. Unfortunately, these efforts have not been as successful as hoped. Women veterans who were part of a focus group looking at VA's public awareness campaign expressed that the ads fell short and it was not clear why it is so important to keep their firearms at a safe distance in a time of crisis. Women indicated they understood the message about the need for safe storage of firearms in general, but that there was lack of clarity about suicide prevention and crisis intervention messaging. As such, VA will need to refocus its efforts and develop clear, concise messaging for women veterans.

DAV recommends the Women's Health Research Network's Suicide Prevention Work Group, in collaboration with the VA Offices of Women's Health and Mental Health and Suicide Prevention, investigate how suicide prevention materials and lethal-means counseling interventions are perceived and accepted by women veterans in order to help determine which suicide prevention approaches are most effective. The VA should continue to conduct focus groups with women veterans to determine the most effective secure firearm storage messages and messengers for this population.

Another way to improve lethal means safety awareness is by requiring training for VA's community care network (CCN) providers. Women veterans are high users of community care, particularly since the many gaps in gender-tailored care and specialized care regularly require women veterans to be referred out to the community. Suicide prevention is the Veterans Health Administrations (VHA) number one clinical priority and it is required that all VA clinical providers take a specially designed course on suicide risk identification and intervention. VA providers are also trained in how to counsel at-risk veterans to temporarily reduce access to firearms and other lethal means. However, the CCN third-party administrators do not require their providers to take suicide prevention or lethal means safety counseling. It has been reported that only 2,300 of VA's community care providers have completed a lethal-means safety course,

representing less than 1% of the pool of the nearly 1.6 million community care providers.

DAV recommends that the VA amend its contracts with community care providers, or Congress must legislatively mandate, that all community care providers who treat veterans must be trained in suicide prevention and lethal-means safety counseling on at least an annual basis, the same as VA providers. To ensure this training is being completed, the VA should regularly publish the number of community care providers who have taken VA suicide prevention and lethal-means safety counseling training.

Rural Women Veterans

For many women veterans who live in rural areas, mental health issues and suicidality are magnified. The number of transitioning service members that choose to live in rural areas has risen, and according to the VA, 1 in 4 women veterans who use VA health care services live in rural areas. Research shows that there is a 20% increased risk for suicide among rural veterans, and rural women veterans have higher rates of suicide by firearm than their urban women veteran peers.

Rural veterans already face unique challenges, including access to basic healthcare, lack of transportation, long distances to health care facilities, and a lack of digital communication services. Veterans living in highly rural and remote communities, such as Guam, American Samoa, Puerto Rico, U.S. Virgin Islands and the Northern Mariana Islands, face even greater challenges due to limited or poor infrastructure.

Accessing mental health services can be especially difficult in rural communities, where even the most basic medical care can be a challenge to access. In addition, the isolation that comes from living in these areas has been identified as a high-risk factor for suicide and intimate partner violence, yet another layer of obstacles facing rural women veterans.

Researchers also found that rural women veterans, like their urban peers, have a high prevalence of MST and mental health conditions, including depression and PTSD. Unfortunately, rural women veterans are less likely to receive mental health and gender-specific health care services compared with urban women peers, and those with longer drive times to access care are more likely to drop out of care.

DAV recommends the VA develop targeted solutions to bridge gaps for the provision of mental health care services in rural communities—especially for women veterans who require specialized, evidence-based treatments for MST-related PTSD, depression, and other mental health issues linked with higher suicide rates.

Military Sexual Trauma and Intimate Partner Violence

All too frequently military sexual trauma (MST) and/or intimate partner violence (IPV) goes unreported or unrecognized. Jennifer Alvarado, who was profiled in our report, is a Navy veteran who suffered in silence for 15 years reeling from the effects of repeated MST and IPV that she experienced during her time in service. When Alvarado

reported the abuse she was experiencing at home to her leadership, rather than help, she was met with sexual harassment. Subsequently, she battled with homelessness, depression, as well as PTSD and turned to drugs and alcohol to cope until one day, she considered suicide. Fortunately, Alvarado is one of the lucky ones, because eventually she was able to receive the help she needed. She found a VA therapist that listened and helped her get through this crisis. She also credits DAV benefits assistance with helping her get beyond survival mode and working with her to get her claim for MST-related PTSD approved.

It is important to note, that women veterans are not the only ones who may experience sexual trauma. Among veterans enrolled in the VA, 1 in 3 women and 1 in 50 men report experiencing MST. Also, despite the increased focus by the Department of Defense on eliminating MST in recent years, we found that the number of service members who report having experienced sexual harassment and sexual assault has steadily increased. Research continues to show that MST is a major risk factor for suicide among veterans regardless of gender.

DAV strongly recommends that MST be a central pillar of suicide prevention efforts in VHA, given the exceedingly high prevalence of MST-related trauma among VHA patients.

Women veterans are also at higher risk for intimate partner violence than those who did not serve. In fact, according to one study 1 in 5 women veterans using VHA primary care reported experiencing IPV or domestic assault. There is also a strong association between a positive IPV screen and suicidal ideation and self-harm behaviors among women veterans. Women veterans who seek help for intimate partner violence not only need mental health support, but also benefits claims assistance and the kind of wrap-around social services offered by VA.

DAV recommends that VHA educate community care partners that women veterans have higher rates of IPV and require that patients who screen positive be referred back to the VA for information, treatment, resources, and safety planning if needed.

Having a safety plan can play a critical role in helping to save the life of a woman who might be experiencing intimate partner violence. While there are options to get help such as the National Domestic Violence Hotline, we believe it could be made easier for a veteran in crisis to reach this life saving line.

DAV recommends the Department of Health and Human Services to create a three-digit number, similar to the "988" Suicide Crisis Line (with a veteran option) for the National Domestic Violence Hotline (800-799-7233) to ensure veterans can get the support and services they need to address IPV.

REACH VET—Suicide Predictive Modeling

One of the main tools in VA's suicide prevention strategy is a predictive model of suicidality in the veteran population called REACH VET (Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment), that identifies veterans at higher risk for suicide and who may benefit clinically from outreach, additional risk assessment and enhanced care. The REACH VET model flags veterans who, because of certain risk factors, are more likely to be at heightened risk for suicide. Veterans identified through the model are included in a monthly dashboard by the VA Office of Mental Health and Suicide Prevention and passed on to local suicide prevention coordinators and VA mental health providers for assessment and care.

Initial evaluation of REACH VET has proven it to be successful for the veterans who were identified. In the first year of implementation, patients receiving the intervention completed more mental health appointments and health care appointments overall, missed fewer appointments, completed more suicide prevention safety plans, and experienced less all-cause mortality. We appreciate VA's effort to leverage technology to reduce the number of veteran suicides, however we found that the original REACH VET predictive model did not include MST or IPV as a risk factor in its algorithm. We are pleased to learn that revisions to the model are now being made and that REACH VET 2.0 is underway.

DAV strongly recommends that VHA revise its REACH VET model to incorporate all risk factors that significantly impact women, such as MST and intimate partner violence.

Substance Use Disorder and Eating Disorders

Within the veteran population, there is a high risk of substance use disorders (SUD), too often originating as an attempt to control pain or to cope with trauma and post deployment mental health issues. The risk of suicide death among women veterans with active substance use disorder is more than 2 times the rate of male veterans. Research shows there is a direct link between trauma and substance use disorder as well as eating disorders. According to one study, 16% of women veterans have substance use disorder associated with traumatic experiences, including combat and MST. Furthermore, most women veterans with at-risk alcohol use are not in treatment—citing stigma and discomfort with mix-gender programs as reasons for not engaging in treatment.

One important way VA treats substance use disorder and mental health issues, such as PTSD is through inpatient treatment. VA's Mental Health Residential Rehabilitation Treatment Program (MHRRTP) provides residential treatment for substance abuse, as well as domiciliary care for veterans experiencing homelessness, and residential treatment for veterans with PTSD. This program provides veterans a 24/7 transitional living environment in a safe and therapeutic community setting to address clinical and rehabilitation issues that can help optimize successful recovery.

DAV recommends the VA should assess the need to add additional domiciliary beds and gender-specific programming in residential rehabilitation programs to improve access and better serve women veterans.

Women veterans are often the sole provider and caregiver of their families which can limit the amount of time they are able to be away from their family to receive treatment or care. For women in these roles, residential treatment is often not a viable option. In order to address this gap, VA has integrated mental health care with primary care in their Patient Aligned Care Team (PACT) system to better support women veterans who have comorbid mental and physical health issues. PACTs that specialize in caring for women veterans who have substance use disorder and chronic pain issues could be a very effective treatment option that would not require them to sacrifice time away from their families or jobs.

DAV recommends that Congress provide additional funding to expand women-centered PACT programming to meet the needs of veterans with comorbid substance use disorder and chronic pain.

Another area of concern among the women veteran's population which can have an impact on suicide rates is eating disorders. The VA's National Center for PTSD notes that individuals with eating disorders have high rates of comorbid PTSD and that military-specific traumas—such as MST and combat—as well as the military's strict weight and fitness requirements, may make veterans particularly vulnerable to eating disorders. DAV found that eating disorders are not as well researched within the veteran community as other types of mental health issues, despite the fact that VHA estimates as many as 14% of female and 4% of male veteran patients have eating disorders. One study found that women veterans reporting MST were twice as likely to develop an eating disorder and suggested that it may be useful to focus on women reporting MST when implementing eating disorder screening and treatment programs.

DAV recommends that VA continue to conduct women veteran-focused research on the association between multiple forms of trauma and eating disorders in order to develop more effective interventions, treatments, and therapies.

Trauma Informed Care and Social Support

Trauma-Informed Care (TIC) is an approach that can be used by health care providers and assumes that an individual is more likely than not to have a history of trauma. TIC principles help providers recognize the presence of trauma symptoms in patients and to better understand the role trauma may play in an individual's life. We know that women veterans are more likely to have been exposed to trauma such as combat, MST and IPV compared to civilian counterparts. VHA has been a leader in this type of care approach, and has trained its providers to ensure a patient is not retraumatized when they are being treated. We are concerned that when women veterans go to VA community care providers they will not receive the same quality of trauma informed care. It is essential that Congress, the VA, veterans advocates and

other interested stakeholders work together to ensure our nation's women veterans have access to the timely, high-quality, trauma-informed and gender-specific care they need.

DAV recommends that VA develop an awareness campaign to educate and engage VA community care network providers in employing principles of universal precautions in trauma informed care.

Social support is well-established as a major protective factor following traumatic events that can lower suicide risk. One exceptional non-governmental program DAV has strongly invested in is the Save A Warrior program, a nonprofit organization committed to ending the staggering suicide rate plaguing veterans, active-duty military and first responders. We are proud to have provided a major grant to support the construction and development of Save A Warrior's National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio, which provides a healing outlet for ill and injured veterans combating suicide and mental health issues. We have also provided significant support to the Boulder Crest Foundation which hosts retreats with gender-tailored programming for women veterans, with DAV leaders and spouses serving as mentors for the latest generation of seriously injured veterans and their caregivers. Boulder Crest programs use the science of post-traumatic growth to help participants and their families transform struggle and trauma into lifelong growth and strength.

The VA also sponsors women-only retreats through its Vet Center Program. The VA has the authority to provide counseling in retreat settings to veterans through 2025, in accordance with Public Law 116–315, which are sometimes women-only, and may provide financial, vocational, and stress-reduction counseling. Women veterans attending these retreats report they are highly beneficial in helping them make peer connections and build a network of peer support.

DAV recommends VHA assess whether its current Vet Center retreat programming meets demand and whether it would be beneficial to increase the number of retreats for women veterans. We also recommend that the current statutory authority for these retreats that expires at the end of FY 2025 be made permanent.

Another form of social support comes through VA's peer specialists who provide support services to help other veterans by sharing common experiences and working towards their recovery and wellness goals. The VA has stated it plans to use more peer support in mental health settings, including substance use disorder programming, to improve veterans' retention and engagement in more intensive evidence-based treatments.

DAV recommends that Congress expand the VA's authority and resources to establish an appropriate training and oversight infrastructure to increase hiring and employment of women veteran peer support specialists in all service lines where they would be most beneficial.

Reproductive Mental Health Care

Perhaps the most underappreciated aspect of women veterans mental health care is the relationship to reproductive care. During the life cycle of women—pregnancy, birth and menopause can bring about significant hormonal shifts and increase the possibility for mental health challenges.

Research indicates that pregnant veterans who come to VA are likely to have elevated rates of trauma exposure and mental health conditions that can increase risks during pregnancy. For example, PTSD during pregnancy is associated with a 35% increased risk of pre-term birth, a 40% increased risk of gestational diabetes, and a 30% increased risk of preeclampsia. It is also associated with increased risk for postpartum depression and poor mother-infant bonding.

I know first-hand how dramatically pregnancy can impact a person's mental health. During my service in Iraq, I experienced a number of traumatic combat experiences that eventually led to a diagnosis of PTSD, and a course of treatment that included a number of medications. Later, while on active duty as an instructor at Keesler Air Force Base, I became pregnant and medical complications forced me to have an emergency C-section, giving birth to my son two months early. Subsequently, I began experiencing postpartum depression. One day, while my baby boy was sleeping on the bed, I started having terrible, intrusive thoughts that threatened to harm both of us. This served as a wake-up call for me, and I quickly got the mental health care I required to get through this crisis.

While I was fortunate to get the right help to get through my crisis, many women veterans are not even aware of the powerful impact hormonal changes can have on their mental health. Although most maternity care is provided through community partners, the VA has worked hard to create a supportive maternity experience for women veterans, which includes making maternity care coordinators available to veterans and establishing national requirements for the management of pregnant veterans.

DAV recommends that VHA assign responsibility for tracking and reporting suicide screening, referral and follow-up care within VHA to maternity care program coordinators, and that the data they collect be reported in the VA's annual report to Congress on suicide prevention.

Another issue that affects many women veterans' mental health, but often does not get as much attention is menopause. Usually, menopause comes with fluctuations in hormone production, beginning between ages 45 and 55, and is frequently accompanied by a variety of symptoms, including hot flashes, sleep disruption, body aches, weight gain, incontinence and memory problems. Menopause has also been shown to double the risk for depression. However, the impact of menopause on mental health and suicide risk among women veterans is understudied and not yet well-defined. Given the rising suicide rate for women veterans, including older women, and a

preliminary indication of concern with depression, chronic pain and polypharmacy increasing the risk of suicide, further research into menopause and mental health is clearly warranted.

DAV recommends that VA's Offices of Mental Health and Suicide Prevention, Women's Health, and Research & Development coordinate with the Women's Health Research Network – in addition to VA and non-VA experts in perimenopausal women's health – to explore a research agenda on the related threads of menopause, depression, polypharmacy and suicide. They should also work together to target and promote greater suicide prevention efforts both in the VA and among community care network providers who care for older women veterans.

VA's Community Care Network (CCN) and Care Coordination

Women veterans are referred to the community for all maternity care, and at times for many other gender-specific services; in fact, some VA health care facilities don't provide any specialty gender-specific care, instead using its CCN providers. It is critical that the VA's CCN providers transmit all of their medical records back to VHA so that they can incorporate them into the veteran's electronic health record to ensure safe and high-quality care for veterans receiving care at both VA and in the community. Unfortunately, the transfer of medical records back to VA continues to be a problem. VA has community care coordinators to help ensure veterans' records are complete and that referrals to its CCN providers result in veterans receiving the care they need. VHA uses one-on-one maternity care coordinators as a resource for pregnant veterans because of pregnancy-related risks and the potential for developing post-traumatic stress, suicidal thoughts, or associated postpartum depression.

DAV recommends that VHA ensure maternity care coordinators have adequate allocated time to track and manage veterans with complex health histories, especially those utilizing community care services.

Mr. Chairman, first and foremost we appreciate the continued focus by this Committee on addressing the needs of our nation's women veterans. DAV's report, *Women Veterans: The Journey to Mental Wellness* includes dozens of recommendations to improve the mental health and lives of women who have served. A finding highlighted throughout the report and this testimony is that many women veterans who utilize the VA have significant comorbid physical and mental health conditions and trauma histories. And for too long, women veterans have been made to fit inside of a health care system designed for men. Given the significantly increased rates of suicide among this population we can and must do better.

While VA has made progress and important changes to improve care and services for women veterans, gaps still exist—especially in mental health programs and services. VA must continue and expand its women's health research efforts, improve community care provider training and address the limited access to gender-specific mental health programming. Based on the findings we have highlighted, it is essential

that Congress, the VA, and veterans advocates work together to ensure our nation's women veterans have access to the timely, high-quality, trauma-informed and gender-specific care they need. When we work together, we can not only improve the lives of our nation's women veterans, we can save them.

This concludes my testimony on behalf of DAV. Again, we appreciate the opportunity to testify and I am happy to address any questions members of the Committee may have.

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KEEPING OUR PROMISE TO AMERICA'S VETERANS

Biographical INFO

NAOMI MATHIS
Assistant National Legislative Director
DAV (Disabled American Veterans)

Naomi Mathis, a combat-disabled Air Force veteran, was appointed assistant national legislative director in August 2023 for the more than 1 million-member DAV.

A member of DAV's legislative team employed at DAV National Service and Legislative Headquarters in Washington, D.C., Mathis works to advance legislation and policies critical to disabled veterans and their families. Throughout her DAV career, Mathis has spread the word about DAV's services including appearing in public service campaigns and interviews.

Mathis served in the Air Force from 2000 to 2007 as a command battle management operations specialist with the 728th Air Control Squadron. She deployed in 2003 to Baghdad, Iraq and attained the rank of staff sergeant before being medically retired.

Mathis began her DAV career in 2007 as a transition service officer at Keesler Air Force Base in Biloxi, Mississippi. In 2018, she became a national service officer apprentice in Bay Pines, Florida. She was promoted to national service officer in 2020 and continued her career assisting individual veterans with their Department of Veterans Affairs claims and benefit applications until her present appointment.

A native of Queens, New York, Mathis has three children. A life member of DAV Chapter 10 in Arlington-Fairfax, Virginia, she resides in Springfield, Virginia.

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record for the Hearing
"Caring for All Who Have Borne the Battle:
Ensuring Equity for Women Veterans at VA"
Committee on Veterans' Affairs
United States Senate

April 10, 2024

Questions for the Record from Senator Kirsten Sinema

Questions for Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services, Veterans Health Administration, Department of Veterans Affairs

QUESTION 1: Women veterans who have experienced MST have expressed being triggered by providers and medical facilities that are not sensitive to gender-specific services. What is the VA doing to address these concerns?

VA Response: VA is committed to ensuring that Veterans who experienced military sexual trauma (MST) or who have a history of other types of trauma receive care that is sensitive to and adapted, as needed, to address those experiences, a well as sensitive to gender-specific concerns.

VA policy (VHA Directive 1115(1), "Military Sexual Trauma (MST) Program," amended December 1, 2021) specifies that MST-related services must be provided in a gender-sensitive manner. Specifically, Veterans with a history of MST can express preferences regarding the gender of their providers and/or whether they receive treatment in single or mixed gender environments or therapy groups. Facilities must offer, when clinically indicated, options for single-gender MST-related mental health care, including but not limited to: single-gender group therapy; individual therapy; clinical video teleconferencing (telemental health); community care; or referral to a Vet Center.

Further, the Veterans Health Administration (VHA) has established national policy that all primary care and mental health providers must complete mandatory training on MST. The trainings for both groups of providers review how MST can affect a Veteran's experience of health care, how to adapt care to address the needs of MST survivors, and other information pertinent to the provision of care (e.g., health conditions associated with MST, how to screen for MST, gender-specific concerns, etc.). VHA also offers a range of voluntary training opportunities, such as bimonthly training calls and an annual virtual conference, to assist providers in expanding their expertise in providing care to Veterans who experienced MST. In addition, VHA's national MST Support Team has established an MST Consultation Program that is available to any VA staff member with a question related to assisting individuals who experienced MST. The program provides information, help in problem-solving, and support regarding clinical and non-clinical issues that may arise in assisting individuals in their recovery from MST, including questions related to gender-sensitive care. These individualized consultations

are a key opportunity to assist staff in providing high quality care and services to MST survivors.

VHA is participating in ongoing work to transform the culture of VA to one of full inclusion. This involves training of providers and staff as well as Veteran facing campaigns on topics of anti-harassment and respect related to gender, race, ethnicity, and sexual orientation. The Office of Women's Health has conducted bystander intervention training to cultivate an environment of intolerance to harassment and discrimination.

Clinical staff are trained on Trauma Informed Care (TIC) strategies applicable to all aspects of Veteran care. TIC is an approach to care that recognizes that trauma exposure is common and adapts care to avoid re-traumatization and promote safety and healing for survivors.

Regarding to services through the Veterans Benefits Administration (VBA), Veterans can request a male or female medical disability examination (MDE) provider for any exam that involves gynecological health, breast, rectal/anal, genital, or mental health, and for any exams for mental or physical health conditions resulting from Military Sexual Trauma (MST). Reproductive health disability benefit questionnaires do not require specialist examiners; however, exams are subject to gender preference requirements and chaperone attendance when requested by the Veteran or examiner.

To support Veterans' choice of examiner gender, MDE vendors are alerted to gender preference via the Examination Scheduling Request, if known, prior to a claims processor scheduling the request with the contract vendor. When scheduling the exam, the MDE vendor will also ask the Veteran if they have an examiner gender preference. If the MDE vendor is not able to honor the request of a gender specific examiner, they are required to send a cancellation request to VBA so that VBA can submit a new request to another vendor to ensure gender preference is honored.

In November 2022, VA deployed system enhancements which allow gender selections to be applied to electronic medical disability examination requests which can facilitate scheduling examinations with the claimant's preference.

QUESTION 2: I have also been hearing about a lack of women-centered care options for women veterans in my state. Can you speak to what the VHA is doing to address this?

VA Response: VA delivers care to women and gender diverse veterans through designated women's health primary care providers who are specially trained and experienced in women's health. This includes not only general primary care, but also care unique to women which includes cervical and breast cancer screening, preconception care, birth control counseling, and management of menopause. When needed, VA women's health primary care providers refer Veterans to VA gynecologists and other specialists. VA offers high-quality comprehensive gynecologic services, including complex gynecology care such as minimally invasive gynecologic surgery and treatment of gynecologic cancers.

Through the Women's Health Innovation and Staffing Enhancement (WHISE) Initiative, VA has funded over 25 women's health positions across the state of Arizona since fiscal year (FY) 2021 including gynecologists, pelvic floor physical therapists, and women's health pharmacists.

VA uses women's health education and training programs to equip VA clinicians with the knowledge and skills to treat unique health issues faced by women Veterans. Since FY 2021, VA's three AZ facilities (medical centers and affiliated community-based outpatient clinics) have over 130 of Women's Health primary care providers serving over 24,000 Veterans in partnership with VHA's flagship training initiative, the women's health mini-residency, which is an interactive, intensive hands-on program. VA also offers many opportunities for all clinicians to engage in continuing women's health education including monthly webinars, annual update seminars, and over 150 online courses.

The above resources and training have allowed the development of programs for reproductive mental health. Facilities in Arizona are offering groups and 1:1 sessions for Veterans who are pregnant/post-partum addressing depression and anxiety.

Each facility offers quarterly focus groups and biannual Town Halls specifically for women Veterans to provide direct feedback on services and programs.

All Arizona Facilities now have a Women's Health Pharmacist dedicated to women Veteran medication management and to provide support to prescribers who care for women Veterans. All the facilities in Arizona offer programs to assist Veterans who may be experiencing violence in their relationship. This includes groups, on line support and 1:1 services.

QUESTION 3: For the services that are offered, many women veterans are not aware they exist. Beyond the TAPS program and call centers, what is the VA doing to improve outreach procedures to ensure that women veterans are aware of women-specific services?

VA Response: VA strives to provide valuable information to Service members transitioning from active duty to veteran status during VA's portion of the Transition Assistance Program (TAP). The mandatory 1-day VA Benefits and Services (BAS) course provides a standardized curriculum on available MST-related care and services, as well as support that ensures all Service members receive the same level of information regardless of their character of discharge or health care eligibility status. Specifically, the course defines MST, explains eligibility for VA treatment for MST, and discusses how to apply for disability compensation related to MST. The information in the course is provided by VA MST subject matter experts who are trained in trauma informed care. This comprehensive approach ensures that Service members are well-informed about the available resources and benefits and can make informed decisions about their care and recovery. To supplement the BAS course, VA recently updated the

VA BAS participant guide to enhance MST resources. These updates were released in Version 6.0 on January 2, 2024.

Additionally, in order to supplement VA TAP, VA offers Women's Health Transition Training (WHTT). WHTT is a five-module web-based course that can be taken anytime, anywhere and is open to all Service women and women Veterans. Topics include transitioning to civilian life, health benefits (emphasizing women-specific needs), mental well-being, managing health care, eligibility, and transition assistance resources. The course content informs participants about women-specific health care services available after their separation from the military and empowers them with information to enroll and utilize VA health care services. VA consistently promotes WHTT via social media platforms, the Center for Women Veterans webpage and during the VA Benefits and Services course. To encourage Service women to take advantage of the course, VA coordinates with TAP interagency partners via the Strategic Communications Working Group whereby members assist VA in promoting WHTT. Further, VBA's Public Contact Team front line employees, and VA Solid Start and National Contact Center call agents, have received the necessary training and information to properly connect to Women Veterans Coordinators (WVC) and homeless Veterans coordinators in the local regional offices (RO) and VA medical centers (VAMC).

Further, to support Veterans, transitioning service members and their families in successfully navigating the adjustment from military to civilian life, VA hosts Veterans Benefits and Hiring Fairs as a part of our Economic Initiatives. These typically two-day, no-cost events connect participants with resources that promote financial stability, career opportunities, mental health and wellness initiatives, and helps them plan for the future. Veterans can obtain information on earned benefits from VA and other organizations, get help filing disability compensation claims, receive private, on-site disability medical examinations, and find resources for mental health support. Guest speakers discuss current issues and share presentations on a variety of topics relevant to Veterans. Information is provided to Veterans and their spouses, family members, caregivers and survivors on available benefits related to continuing education, managing finances, pensions, survivor benefits, burial at Veterans' cemeteries and VA health care. Attendees at the Hiring Fair portion of the event can learn about industries in high demand, find new career options, fill out job applications, network with hiring authorities and, in some cases, have on-site interviews. Experts are on hand to help participants update their resumes, gain new interview skills and prepare for introductions.

Also, all RO Outreach Coordinators are educated about Veterans Health Administration (VHA) MST resources and services. Outreach Coordinators at ROs provide claims assistance and coordinate with VHA MST Coordinators to assist Veterans at VAMCs and Vet Centers for treatment and health care for MST related conditions. There are 112 WVCs across VBA – every RO is required to have at least one. The WVC is the primary contact for women Veterans at the RO. WVCs must:

- maintain detailed knowledge about VA benefits, services and an awareness of women Veteran issues and concerns;

- work with other special issue coordinators to provide necessary assistance, such as coordinators for MST, Homeless and Justice Involved;
- maintain an effective network and referral system with the local VHA Women Veterans Program Manager;
- liaise with local women Veterans' organizations;
- maintain information on local outreach activities such as community events, workshops, etc.; and
- communicate information to others via email about VA events.

Additionally, VBA collaborates with VHA and its Vet Centers to conduct an annual symposium targeting Women Veterans and an MST Outreach Training. Each RO has two dedicated VBA MST Outreach Coordinators (one male and one female). In line with trauma-sensitive practices, Veterans and Service members have the choice to correspond with either MST Outreach Coordinator based on personal preference.

VBA MST Outreach Coordinators establish and maintain a network of community service providers and regularly share information about MST-related claims processing with Women Veterans Program Managers, MST Coordinators at VAMCs, Vet Center staff, and community organizations.

QUESTION 4: I have heard concerns from constituents regarding 1) MST and PTSD treatment providers not having enough time and resources to dedicate to additional sessions, 2) a shortage of MST and PTSD providers to provide care, and 3) a lack of treatment options at an appropriate level of care. What is the VA doing to action these issues?

VA Response: VHA's Office of Mental Health (OMH) annually conducts an analysis of capacity to provide MST-related mental health care, and conclusions from the most recent report (November 2023) were that nationally, staffing remains adequate to meet the MST-related mental health care needs of Veterans. The analysis looks at recent trends in level of demand for MST-related mental health care services and whether data indicates current VA staffing is sufficient to meet that demand. VA annually submits a Congressionally Mandated Report to Congress describing the results of this analysis. The latest report was submitted to Congress in December 2023.

VA policy (VHA Directive 1115(1), "Military Sexual Trauma (MST) Program", amended December 1, 2021) requires facilities to have appropriate physical and mental health care services available to treat conditions related to MST, including PTSD. Outpatient and inpatient mental health programming must be available to treat MST-related conditions such as PTSD, substance use, depression, and other issues in a way that is sensitive to the unique ways MST influences the development and presentation of those conditions. Care must also be provided in a timely fashion, consistent with the requirements of VHA Directive 1160.01 ("Uniform Mental Health Services in VHA Medical Points of Service", dated April 27, 2023). Moreover, VHA's Office of Mental Health (OMH) is strongly committed to ensuring that Veterans have access to VA/DoD-recommended PTSD psychotherapies across the continuum of care, which is supported

by policy (VHA Directive 1160.03, "Treatment for Veterans with Posttraumatic Stress Disorder", dated October 16, 2023). OMH works closely and collaboratively with VHA Operations to address potential facility compliance and implementation issues in relation to these and other policy requirements.

VA offers a full continuum of heath care services for Veterans of all genders who experienced MST. Every VA health care system has a designated MST Coordinator who serves as the local point person for MST-related issues and can help individuals access MST-related services and programs. Outpatient MST-related services are available at every VA health care system. MST-related outpatient counseling services are also available through VA's community-based Vet Centers. For individuals who need more intensive treatment and support, VA has mental health residential programs that target rehabilitation, recovery, health maintenance, improved quality of life, and community reintegration. VA also has mental health inpatient programs available for acute care needs, such as psychiatric emergencies and stabilization or medication adjustment. Those who meet the eligibility requirements for community care for any service in VA's medical benefits package according to standard MISSION Act criteria for travel distance, access time, or best medical interest, are eligible for MST-related care in the community to treat an MST-related condition. For those interested in self-help resources that can be used alone or in conjunction with formal treatment, VA has also developed an MST-specific mobile app, *Beyond MST*, for individuals who experienced MST. It was created with input from those who experienced MST specifically to help individuals cope with challenges, manage symptoms, improve their quality of life and find hope.

QUESTION 5: The DAV's and the Wounded Warrior Project's recent reports included numerous recommendations on improving care for women veterans. What are the top three priorities for the VA that we can help action?

VA Response: VA appreciates the opportunity to consider ways that Congress can support VA's implementation of recommendations included in recent Disabled American Veterans' (DAV's) *Women Veterans: The Journey to Mental Wellness* and the Wounded Warrior Project's (WWP) *Women Warriors Report*. Here are three key areas of focus that overlap with recommendations included in these reports and align with VA strategic priorities, as well Congressional interests:

1. Advancing Women Veterans' Reproductive Mental Health

One top priority for VA is to advance reproductive mental health throughout the lifespan for women Veterans. VA appreciates the DAV report's policy recommendations regarding reproductive mental health, which dovetail with VA's priorities. As noted in the DAV report, VA's National Reproductive Mental Health Consultation Program provides expert consultation to VA clinicians on topics such as such premenstrual, perinatal and perimenopausal mental health conditions, and mental health challenges associated with gynecologic conditions. This means that regardless of where a woman Veteran receives VA

services, her providers have access to subject matter experts who can inform treatment planning and decision-making on a range of women-specific, mental health concerns. The program is a novel VA resource that can improve access to specialized, gender-specific care for rural Veterans who, as noted in the DAV report, experience unique access issues. Data collected by this program helps VA identify key reproductive mental health concerns and unmet needs throughout VA. This positions the team's subject matter experts and other key stakeholders to address emergent concerns, congruent with DAV recommendations.

Advancing reproductive mental health for women Veterans can also be accomplished by offering reproductive mental health training to VA clinicians. VA offers a 12-session course in women's reproductive mental health throughout the lifespan. This course is updated and offered live, virtually, every three years. The live sessions are recorded; the recordings remain available on demand until the next update. In addition, VA offers intensive clinical training in interpersonal psychotherapy (IPT). This is the psychotherapy with the strongest evidence for efficacy for preventing and treating depression during pregnancy and postpartum. Maintaining and expanding these trainings, congruent with DAV recommendations, should substantially support women Veterans' reproductive mental health.

VA is taking active steps to accomplish these goals and appreciates Congress's interest in and awareness of this important work.

2. Increasing awareness of, and confidence in, VHA services for women Veterans

As noted in DAV's report, the vast majority of women Veterans who use VA health care (including mental health) are highly satisfied with their care and continue to choose VA as their health care provider. Unfortunately, misconceptions about the availability and quality of VA health services for women persist. Research shows that many women Veterans do not know that they are eligible for VA health services, do not think VA offers health services for women, or are not aware of the breadth and sophistication of gender-tailored and gender-specific services that VA provides. Congruent with WWP recommendations, continued efforts to dispel misconceptions and ensure that all women Veterans — including those who do not currently use VA care — receive accurate information about VA care options and preferences and needs is essential.

Recent advancements in VA services for women Veterans, including numerous gender-tailored treatments and programs, are also described in the DAV report. For example, all VA providers have access to specialized training in women's mental health and that every VA medical center has at least one Women's Mental Health Champion. Women's Mental Health Champions are mental health clinicians who have received advanced training in women's mental health and work to advance women's mental health services at the facility-level.

VA advertising campaigns and recurring outreach initiatives directly engage women Veterans and their loved ones. These initiatives convey the quality, innovation and continued growth of VA services for women Veterans. For example, VA's Office of Mental Health regularly develops and publishes an expansive amount of digital content to reach women Veterans where they are, including but not limited to social media posts, monthly email newsletters, website content, paid media advertisements, women Veterans' testimonial/interviews through VA's Make the Connection campaign, and materials in support of observances such as Sexual Assault Awareness and Prevention Month. Each May, VA recognizes "National Mental Health Month" with awareness-raising campaigns that include testimonials from women Veterans (examples available at www.MakeTheConnection.net/mhm) sharing their mental health journeys and examples of the support and treatments that helped them to connect, heal, and find balance in their lives.

Moreover, VA's Make the Connection campaign features hundreds of women Veterans' stories of mental health treatment and recovery and continues to capture women Veterans' stories each year. Furthermore, in May 2023, VA distributed a series of audio news releases focused on women Veterans' mental health, which continue to promote awareness about available mental health resources for women Veterans.

VA is actively engaging women Veterans. Importantly, high-profile Veteran stakeholder reports and recommendations, as well as enduring Congressional interest, also help to raise awareness.

3. Strengthening social and community support for women Veterans

Both DAV's and WWP's reports reference unique challenges and stressors that many women Veterans experience in their civilian lives, such as loneliness, lack of recognition of their service within their communities, and limited opportunities to connect with other women Veterans. Ongoing efforts, described above, to outreach to women Veterans and increase public awareness of their contributions help to mitigate these concerns. Likewise, actions that continue to increase the visibility of women Veterans within VA health care systems are also essential. As noted, Women's Mental Health Champions facilitate awareness of women Veterans and the visibility of VA services designed to meet their health and mental health care needs. Additionally, more than half of VA mental health providers are female.

Another significant VA initiative, in line with specific recommendations from DAV and WWP, is the expansion of peer support services for women Veterans. VA peer specialists, who are Veteran employees with personal experience in mental health recovery, serve as relatable role models and offer hope to others. They work in a variety of clinical settings to help Veterans apply self-management skills and healthy coping strategies, access resources, connect with others and find a sense of belonging in their communities. Peer support services are available within all VA health care systems, with 1 in 5 VA peer

specialists being female. Current and ongoing endeavors to enhance VA peer support services for women Veterans involve creating and distributing educational materials to equip all VA peer specialists with the essential knowledge required to deliver gender-sensitive support. Additionally, ongoing efforts include the dissemination of advanced, gender-specific training and programming for peer support. For instance, in direct accordance with DAV's recommendations, VA has adapted community-based WoVeN support groups, led by volunteers, and introduced "WoVeN in VA" implementation. Early evaluation results showed that the majority of women Veterans who participated in WoVeN indicated high satisfaction and reported feeling less isolated, more empowered, and having increased self-esteem as a result. In qualitative interviews, some also noted that the experience had a positive impact on their view of and engagement in VA mental health services. Additional peer support initiatives are in progress and in development for implementation in fiscal year 2025.

QUESTION 6: Not only are women veterans experiencing difficulty accessing healthcare, but I have also heard concerns from veterans in my state that those who are also single mothers are increasingly impacted by financial hardship due to increasing costs of living, which aligns with the Wounded Warrior Project's recently released report that women veterans' unemployment rate is four times higher than the U.S. veteran population. What is the VA doing to help women veterans with families?

VA Response: In fiscal year (FY) 2023, single mothers made up 4.9% of the total Veteran Readiness and Employment (VR&E) participation. VR&E saw a 3.6% increase in single mother participation in the Chapter 31 program from FY 2022 to FY 2023. As of July 31, 2024, the FY 2024 current participation is 6,076 and on track to meet or exceed FY 2023 participation. In FY 2023, 956 single mothers completed the Chapter 31 program and found employment, representing 3% of all rehabilitations in the Chapter 31 program.

In addition to participation, the number of single mothers who received one or more subsistence payments increased by 3.2% from FY 2022 (5849) to FY 2023 (6042). These payments ensure single mothers are able to offset living expenses while receiving employment training.

Number of single mothers who received at least one VR&E Subsistence Allowance payment:

FY	# of single mothers who received at least one VR&E Subsistence Allowance Payment
2022	5,849
2023	6,042
2024 (as of July 31, 2024)	5,907

VA offers Women's Health Transition Training (WHTT). WHTT is a five-module web-based course that can be taken anytime, anywhere and is open to all Service women and women Veterans. Topics include transitioning to civilian life, health benefits (emphasizing women-specific needs), mental well-being, managing health care, eligibility, and transition assistance resources. The course content informs participants about women-specific health care services available after their separation from the military and empowers them with information to enroll and utilize VA health care services. Further, front line employees in the Veterans Benefits Administration (VBA) Public Contact Teams, VASS call agents, and National Call Centers have received the necessary training and information to properly connect to Women Veterans Coordinators (WVC) and homeless Veterans coordinators in the local regional office and/or medical center.

Further, VA ensures all Regional Office (RO) Outreach Coordinators are educated about VHA MST resources and services. Outreach Coordinators at ROs provide claims assistance and coordinate with VHA MST Coordinators to assist Veterans at VAMCs and at Vet Centers for treatment, health care, and counseling for MST-related conditions. The VA also provides support for women Veterans through Women Veteran Coordinators (WVC) at each RO, who assist women Veterans in navigating all VA services and accessing available resources.

Additionally, VBA collaborates with VHA and VHA Vet Centers to host an annual symposium with a focus on targeting women Veterans and MST Outreach Training. Each RO has two dedicated VBA MST Outreach Coordinators (one male and one female) and at least one WVC. In line with trauma-sensitive practices, Veterans and Servicemembers can choose to correspond with either MST Outreach Coordinator based on their personal preference.

VBA MST Outreach Coordinators establish and maintain a network of community service providers. They share information about MST-related claims processing with Women Veteran Program Managers (WVPC), MST Coordinators at VAMCs, Vet Center staff, and community organizations.

QUESTION 7: How can we help ensure that single mothers are not excluded from support due to lack of access or childcare?

VA Response: VA recognizes that childcare is a barrier for many Veterans and one that disproportionately affects women Veterans. VA is currently preparing for implementation of 38 U.S.C. § 1709C, as added by section 5107(a) of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315), which requires all sites to provide a form of childcare assistance by January 2026. VA is using a two-pronged approach. First, designated health care systems will be opening no-cost, drop-in childcare centers for eligible Veterans to use

during their qualified VA appointments. The second prong is Direct Veteran Reimbursement, which will enable Veterans to obtain and be reimbursed for licensed, drop-in childcare services rendered in the community. The reimbursement option will be available to all qualified Veterans whether the facility has a drop-in childcare center or not. Once operational, VA will leverage the media, community organizations, Veterans Service Organizations, and our VA Women's Health programs to educate Veterans about these services.

VA's VR&E is able to assist with a Veteran's childcare needs. A VR&E case manager may authorize assistance for a Veteran's childcare if the case manager determines that childcare is necessary for the implementation or continuation of the Veteran's rehabilitation program as outlined in Title 38 Code of Federal Regulation (CFR) 21.156, Other incidental goods and services. Generally, reoccurring childcare expenses are not authorized and limited childcare assistance is authorized until a case manager can assist the Veteran is securing long-term childcare assistance.

Questions for the Record from Senator Thomas Tuberville

Questions for Dr. Scavella

QUESTION 1: Disabled American Veterans recently issued a report on women veteran care that mentions the increased rate of substance abuse among women veterans as compared to their male counterparts. According to the report, one of the reasons women veterans are reluctant to enter treatment programs is their discomfort with mixed-gender programs. In Alabama, both the VA and outside organizations are working to improve the availability of gender-specific residential treatment programs. How is the VA working with community partners to increase the capacity for gender-specific treatment programs?

VA Response: VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program* (dated July 15, 2019) defines specific requirements to ensure women Veterans have access to mental health residential rehabilitation treatment program (MH RRTP) services, and that options exist for women Veterans to access residential treatment in a setting that best meets their needs. Options include mixed gender programs and units, gender-specific units that provide both gender-specific and mixed-gender programming, and programs for women only. During FY 2023, 90% of MH RRTPs reported that they admit women Veterans. Among the programs serving women, 60% have beds in a separate, secure wing, offering a separate gender-specific unit. Across all programs, approximately 40% report providing gender-specific services for women Veterans in addition to mixed gender programming. Currently, 13 programs across 9 facilities report they provide a specific residential program for women only. Five of those 13 programs provide residential treatment for substance use disorder (SUD) as a primary area of focus. VHA is working to implement two additional SUD residential programs specifically for women in Bay Pines, FL and American Lake, WA.

In addition to planned growth in SUD-specific services for women, residential treatment programs continue efforts to increase awareness of currently available resources. VHA prioritizes developing relationships with community entities that provide services for women Veterans. We ensure those facilities provide safe and secure lodging and meet all standards of care. Community residential programs are required to provide individualized services tailored to women Veterans' continuing care needs following residential treatment through linkage to VA or community SUD services and other mental health and medical services.

QUESTION 2: Women around menopausal age, some as early as late 30s, can gain about 15 pounds or more due to hormonal imbalances, leading to increased risk in heart health. 26% of Americans die from cardiovascular-related events. What is VA doing to reduce the cardiovascular risk for women veterans? Does VA provide education and counseling to women veterans on dietary health and lifestyle management? Additionally, a report recently released by Disabled American Veterans showed an alarming connection between women veterans experiencing menopause and suicide. How is VA working with the Office of Mental Health to address this issue? Does VA currently offer all FDA-approved treatments for menopause?

VA Response: VA recognizes that women Veterans have higher rates of cardiovascular disease as well as higher rates of cardiovascular risk factors than their civilian counterparts. Accordingly, VA's Office of Women's Health, in partnership with the VA National Cardiology Office, started a Women Veterans Cardiovascular workgroup comprised of researchers, clinicians, and subject matter experts to address these issues. The workgroup is focusing on optimizing secondary prevention medical therapy for women Veterans with established cardiovascular disease and optimizing cardiovascular health during transition from the military and beyond. Additionally, provider education has been developed to improve and maintain women Veterans' cardiovascular health.

VA provides women Veterans with the opportunity to receive in person or virtual visits from a registered dietician, and they can receive referral to these services through their primary care provider. Some programs are targeted at reducing obesity and offered in group or individual settings. Additionally, our healthy teaching kitchens program provides registered dietician guidance on making nutritious meals at home, therefore, providing sustainable skills for women Veterans to improve their nutrition independently.

VA provides a full spectrum of care for perimenopause and menopausal symptoms. Women Veterans experiencing symptoms receive first line of care from their women's health primary care providers (WH-PCP).

WH-PCPs manage routine menopause management and address vasomotor symptoms and genitourinary symptoms of menopause. WH-PCPs receive regular evidence-based

training on all aspects of care for women Veterans, including management of menopause. All VA health care systems have at least three designated WH-PCPs.

Gynecologists are specialists trained in management of reproductive health conditions in women. VA gynecologists offer consultative support to primary care providers for complex menopause management, pelvic floor disorders associated with menopause, abnormal uterine bleeding associated with perimenopause/menopause, and sexual function concerns. VA gynecologists receive regular training tailored to the gynecologic needs of Veterans, and topics include management of menopause in the Veteran population. More than 80% of health care systems have gynecologists on site.

Interdisciplinary care is used to treat the effects of perimenopause, menopause, and genitourinary syndrome of menopause, and this care is tailored to the patient's needs. WH-PCPs, gynecologists and other providers utilize both non-pharmacologic treatment (such as life-style modifications and complementary and integrative therapies) and also prescribe non-hormonal and hormonal medications when needed. The full range of Food and Drug Administration-approved hormonal and non-hormonal therapies are available from VA. Experts, such as pelvic floor physical therapists, mental health providers, behavioral health specialists, clinical pharmacists, whole health coaches, and others, are involved in care when clinically appropriate or requested by the patient.

QUESTION 3: Home ownership is a cornerstone to the American Dream and a critical way people can build wealth. Of the number of veterans leveraging the VA Home Loan Program, what percentage are women veterans? What is the VA doing to promote financial literacy among veterans, specifically younger veterans who may have no experience in the home buying process?

VA Response: In FY 2023, approximately 15.7% of VA-guaranteed loans were for female Veterans (for reference, women make up approximately 11% of the Veteran population). This represents a nearly 2% increase from FY 2022 (13.8% of loans guaranteed were to female Veterans). In FY 2024 (as of April 30, 2024), approximately 15.6% of VA-guaranteed loans were for female Veterans. VA anticipates further increasing this percentage through continued outreach efforts. VA promotes financial literacy through the Veterans Benefits Banking Program, which offers one free consultation with a credit or financial counselor. Women Veterans can get help managing their debt with a credit counselor certified by the National Foundation for Credit Counseling. They can also speak with an Accredited Financial Counselor® at the Association for Financial Counseling and Planning Education® to help them improve their budgeting and saving. For more information, please visit https://veteransbenefitsbanking.org/financial-counseling/.

Further, in partnership with Prudential Financial, VA offers Veterans, transitioning Service members, spouses, their family members, and caregivers, the Wellness Wednesday Financial Educational series. The series addresses financial literacy gaps

across the military and Veteran community and is comprised of two free programs, 1) an online website portal that contains a roster of financial literacy information and resources available at www.prudential.com/Veteran, and, 2) the Wellness Wednesday Financial education series, offered live the 3*rd* Wednesday of every month that focuses on a variety of topics such as: 1) purchasing a home; 2) paying for college; 3) planning for retirement; and 4) learning the building blocks of how to save, budget, and make a return on investments.

Additionally, VA has other financial literacy resources such as a fraud prevention toolkit and a money management tool set that can be found at https://benefits.va.gov/benefits/financial-literacy.asp.

Question 4: The SERVICE Act requires the VA to conduct mammograms for women who served in certain areas of the world regardless of age, symptoms, or family history. Since March 2023, VA has contacted over 10,000 veterans for advanced screenings under this authority. Of those veterans contacted for screenings, how many women veterans have been screened? Of those screened, what has the VA been able to determine regarding toxic exposure among women veterans?

VA Response: In accordance with the Dr. Kate Hendricks Supporting Expanded Review for Veterans In Combat Environments (SERVICE) Act (P.L. 117-133; the SERVICE Act), since March 2023, VA has contacted over 24,000 Veterans to offer breast cancer risk assessment and mammography if clinically appropriate. Of those contacted, 1,600 have declined a risk assessment; 7,500 have completed a risk assessment; and 17,000 were found to be ineligible (mostly due to not serving in an eligible area). While it is not currently known if or which military environmental exposures are a risk for breast cancer, VA is aware there have been tragic individual cases, and further research needs to be done. VA is reviewing data to determine potential links between military service and breast cancer incidence.

QUESTION 5: There is a known association between moderate amount of alcohol intake and increased risk of breast cancer. What is the VA doing to address long-term negative outcomes of alcohol intake among female veterans?

VA Response: VA is uniquely situated to identify and address the long-term negative outcomes of alcohol intake among female Veterans. VA has taken the following actions to address alcohol use disorder (AUD) among women Veterans**:**

- Every VAMC has a SUD specialty outpatient clinic where women Veterans with SUDs can obtain individual care, group care or both. Additionally, VA SUD programs address co-occurring medical, mental health and psychosocial needs, including support for employment and housing.

- VA has recently adjusted its population-based screening for AUD among Veterans to reflect differences in binge drinking definitions identified by VA researchers in the scientific literature. This gender-tailored screening is anticipated to improve the sensitivity of the screening process to allow more precise identification of women Veterans who are engaged in risky drinking and those with AUD so treatment is offered to this at-risk population of Veterans.

- By reducing barriers, VHA has successfully implemented evidence-based treatments (medications and psychotherapies) for AUD at every VAMC.

- VA SUD care is not limited to specialty care settings. Women Veterans who are engaged in risky drinking or have a diagnosis of AUD can receive treatment outside specialty care (i.e., in primary care settings and general mental health settings). Furthermore, VA is seeking to expand AUD treatment offerings in its Hepatology clinics where both alcohol-related liver disease and AUD can be concurrently treated.

- Launched in May 2018, VA's Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) initiative has brought buprenorphine prescribing to primary care, general mental health and pain clinics to reach Veterans where they receive most of their care.

    - In addition to SCOUTT's traditional focus on expanding access to medication for opioid use disorder, this pilot program is exploring options for embedding AUD treatment services within Women's Health Clinics as initial discussions with local Women's Health Clinic leadership has consistently indicated a larger need for AUD services, relative to OUD treatment services, within their clinics. VA also has greatly expanded telehealth, to include buprenorphine prescribing for all Veterans, including those with pain and opioid use disorder.

- In collaboration with DoD, VA offers annual in-person trainings for VA and DoD clinicians on foundational aspects of mental health for women Veterans and Service members. These include training about SUD in women, including the relationship between alcohol use and breast cancer.

VA's Reproductive Mental Health Consultation Program is a team of subject matter experts that offers prompt consultation to VA clinicians about any aspect of reproductive mental health, including the relationship of alcohol drinking to breast cancer.

Questions for the Record from Senator Angus King

Questions for Dr. Scavella

QUESTION 1: As we discussed during the hearing, sexual assaults are not unique to our military or veterans, but addressing the trauma that accompanies these events are unique for our veterans. The OIG published a national review in December 2023 called, "Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault." Unfortunately, this report found some troubling gaps in the VHA's response to veterans presenting and reporting sexual assaults.

a. **According to that OIG review, there was no documentation of psychological counseling services or mental health referrals for 53% of survivors who came to VHA for emergency sexual assault care. Can you discuss the potential impact on survivors if they don't have access to these mental health services as they're trying to recover from these traumatic events?**
b. **Does VHA policy require that sexual assault survivors be offered referrals to mental health services? Why or why not?**

VA Response: VHA is committed to providing high-quality, trauma-informed care to all Veterans, especially those who have suffered from acute sexual assault. Understanding that there may likely be long-term psychological sequelae to such assaults, VHA policy requires consideration of mental health follow-up for victim-survivors of acute sexual assault when clinically appropriate and when consented to by the Veteran. Although not everyone who experiences a sexual assault will need or want mental health treatment, ensuring Veterans have the option to access mental health care is an important part of their recovery. Such treatment can assist Veterans in navigating the initial aftermath of sexual assault, providing pivotal emotional support during a challenging time. Mental health treatment provided in the acute aftermath of sexual assault can also assist in a Veteran's longer-term recovery by facilitating understanding of common reactions in the acute phase following sexual assault by offering assistance in coping and coping skills development and through timely identification of developing mental health conditions (e.g., PTSD, depression) that require more focused and sustained treatment.

QUESTION 2: In Maine, we are incredibly fortunate to have a unique organization called the Sisters In Arms Center. They provide transitional housing for women veterans and their children. In addition, they connect those women to community support resources, including peer support and support groups. Many who access their services have experienced significant trauma—including MST—and getting them into a continuous care setting can be challenging because it is hard for these veterans to trust the system that might have failed them before.

Organizations like this fill the gap for women veterans who don't feel comfortable accessing VA care and instead, allows for the care they need while meeting them

where they are. Additionally, many of the volunteers and Board Members of Sisters In Arms are women veterans themselves, so they share that deep bond and understanding, perhaps even helping to build up their trust enough to help them access to VA and the broad services they can provide.

a. Do any of you have experiences with a similar organization? What kind of role could this sort of organization play in filling the gaps and ensuring that women veterans get the care they need, without having to face the barriers that sometimes come with gaining access to the VA and benefits?

VA Response: VA's **Grant and Per Diem (GPD)** program awards grants to nonprofit, State or local government agencies, or Federally-recognized Indian Tribal governments to provide transitional housing with wrap-around supportive services to assist vulnerable Veterans as they move into permanent housing. Additionally, the GPD program offers Case Management grants to support housing navigation and permanent housing retention for Veterans who were previously homeless. The grants are designed to meet Veterans at various stages as they move to stable housing. In 2021, Congress expanded VA's authority to provide additional per diem payments for Veterans who have care of minor dependents.

- Currently, the GPD program funds more than 350 grantees providing over 11,000 Veteran beds and approximately 500 minor dependent beds nationwide. Approximately 6% of the Veterans served by GPD grantees are women. In FY 2023, GPD grantees housed more than 1,550 women Veterans (about 6% of all participants).
- In Maine, there are two GPD grantees authorized to provide up to 42 transitional housing beds for Veterans. In FY 2023, approximately 5.5% of Veterans served by these grantees were women.
- Sisters In Arms is not a GPD grantee.
- Periodically, GPD issues Notices of Funding Availability (NOFA) where new eligible organizations may apply for grant funding. Currently, there are no open grant opportunities, but future funding announcements will be posted on these webpages: www.va.gov/homeless/gpd.asp and www.grants.gov.

VA's **Supportive Services for Veteran Families (SSVF)** program provides rapid re-housing and prevention services for Veterans and Veteran families experiencing homelessness or at imminent risk of homelessness. Nationally, approximately 256 grantees provide services across the U.S. and the territories.

- In FY 2022, 13.8% of Veterans served by SSVF identified as women Veterans (Source: SSVF_FY_2022_Annual_Report.pdf (va.gov)). In FY 2023, approximately 14% of Veterans served by SSVF identified as women Veterans.
- This percentage of female Veterans served by SSVF is significantly higher than the 7.7% of women Veterans served nationally in shelter programs (FY 2021 annualized data) and the FY 2022 US Veteran population (11%). It also represents a higher percentage than was found in the 2022 Sheltered Homeless Veterans (Point In-Time) Count (7.7%).

- Specific to the State of Maine, there are two SSVF grantees serving Veterans. Sisters in Arms is not currently a SSVF grantee. In FY 2022, 11.2% of Veterans served by SSVF were women in Maine.
- SSVF Program is unique in that is can directly serve all household members, including dependent children, of homeless and at-risk Veterans. As women are often the primary caretakers for a family's dependent children, this feature of SSVF is critical to meeting the needs of these women Veterans. SSVF can offer families temporary childcare, thereby providing opportunity for women Veterans with children to seek employment and needed medical and mental health care.

Periodically, SSVF issues NOFAs where new eligible organizations may apply for grant funding. Currently, there are no open grant opportunities, but future funding announcements will be posted on these webpages: https://www.va.gov/homeless/ssvf/index.html and www.grants.gov.

QUESTION 3: In another OIG national review on VHA Reproductive Health Services, OIG looked at access to the full suite of reproductive care services for veterans, including contraception, preconception care, sexual dysfunction treatment, infertility evaluation and treatment, maternity care, pregnancy counseling and abortion services, and more. While VA offers some gender-specific care, a lot of the care women veterans may need to access is specialized and isn't provided by the VA, so they need to seek care through community providers.

In a rural state like Maine, accessing specialized care can be a challenge—for veterans and non-veterans alike. If you're living in Fort Kent, you're probably going to have to go to Bangor for most specialized services—that's more than a three-hour drive, one way. If Bangor doesn't offer what you need, hopefully a doctor in Portland does, but that'll take you another 2 hours each way.

a. Can you discuss some of the challenges women veterans in rural areas face when they need to access gender-specific care? How does the VA help them navigate these challenges and what more can the VA do to ensure that these challenges aren't preventing women from getting the care they need?

VA Response: VA recognizes that rural veterans often encounter difficulty in traveling to appointments or coming for follow up care.

To increase women's health care coordinators at rural facilities, VA has funded a care coordination program. Women's Health care coordinators track cervical and breast cancer screening and help Veterans navigate follow up imaging and consultations for abnormal results.

Additionally, VA provides comprehensive women's health and gender specific primary care provider training targeted to rural locations to ensure rural women Veterans have access to skilled and knowledgeable clinicians to care for their gender specific needs.

Having access to convenient care close to the Veteran's home decreases the requirement for lengthy travel to other sites of care and making additional appointments for gender specific care.

To decrease breast cancer screening disparities in rural communities VA has utilized Mobile Mammography Unit and Teleradiology Program. Additionally, leveraging the National TeleOncology program has increased virtual access to state-of-the-art specialty care, tumor board discussions, and collaborations with VA and non-VA research entities for patients who have been identified to need a higher level of expert care related to breast and other gynecological cancers.

Women Veterans who experience travel barriers or other appointment scheduling concerns such as childcare can also utilize telehealth appointments, which have provided opportunities for Veterans to engage in health care services such as primary care, mental health, pharmacy, and specialty care in a virtual environment.

Questions for Dr. Haskell

QUESTION 1: Another issue that is of great importance to me as it relates to healthcare and the veteran's community: falls prevention. Among a number of risk factors like balance issues or having a previous fall, osteoporosis is a critical risk factor – and it affects four times as many women as men. This is one of the most preventable types of major injuries, and spending a small amount of money up front on prevention methodologies like screening or evidence-based falls prevention programs can be meaningful to saving significant dollars, preventing injuries, and saving lives.

a. **Can you discuss the work of VA and VHA to address falls prevention as it relates to women veterans?**

VA Response: To prevent osteoporosis, which is a risk for fall-related fractures, VA has focused on increasing bone density screening and treatment through provider education, electronic medical record tools to identify Veterans eligible for osteoporosis screening, and Veteran-facing education, including a campaign on healthy aging and staying active. VA's expert physical therapists provide Veterans exercise and fall prevention counseling, as evidence supports the use of exercise and physical activity to improve bone health.

Senator King
Questions for the Record
Senate Veterans' Affairs Committee
"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA"
April 10, 2024

Questions for Dr. Engel

1. As we discussed in the hearing, too many women veterans who have experienced MST have associated trauma from that experience. This trauma makes it hard for them to willingly put themselves out there to be retraumatized by being forced to share these experiences in order to gain access to the care they need to begin the recovery process. There won't be a single solution that works for everyone, but we need to be thinking of better ways to engage women veterans—especially those who need our help the most—in safe, welcoming environments.

   In Maine, we are incredibly fortunate to have a unique organization called the Sisters In Arms Center. They provide transitional housing for women veterans and their children, they also connecting those women to community support resources, peer support, and even have a support group. Many who access their services have experienced a lot of trauma—including MST—and getting them into a continuous care setting is challenging because it is hard for them to trust a system that might have failed them before.

   This kind of organization can help fill the gap for women veterans who don't yet feel comfortable accessing VA care and provide them the care they need while meeting them where they are. Additionally, many of the volunteers and Board Members of Sisters In Arms are women veterans themselves, so they share that deep bond and understanding, perhaps even helping to build up their trust enough to help these women veterans access to VA and the broad services they can provide.

   a. Do any of you have experiences with organizations like Sisters In Arms? What kind of role could this sort of organization play in filling the gaps and ensuring that women veterans get the care they need, without having to face the barriers that sometimes come with gaining access to the VA and benefits?

2. Another issue that I have been focusing on broadly but has particular relevance to veterans, and especially women veterans, is falls prevention. This is one of the most preventable types of major injuries, and spending a small amount of money up front on prevention methodologies like screening or evidence-based falls prevention programs can be meaningful to saving significant dollars, preventing injuries, and saving lives. Among a number of risk factors like balance issues or having a previous fall, osteoporosis is a critical risk factor – and it affects four times as many women as men.

    a. In your experiences, has VA or VHA done enough to ensure that veterans, including women's veterans, have access to falls prevention programs? Does VA or VHA do enough to ensure that safe patient handling techniques and transfers are adequate in all settings?

Responses were unavailable at the time of publication.
Contact U.S. Senate Committee on Veterans' Affairs for additional information.

Paralyzed Veterans of America

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501(C)(3) Veterans Non-Profit

May 8, 2024

The Honorable Angus King
Senate Veterans' Affairs Committee
Washington, DC 20510

Dear Senator King,

Paralyzed Veterans of America (PVA) appreciated the opportunity to share our views at last month's Senate Veterans' Affairs Committee hearing examining the level of care provided to women veterans by the Department of Veterans Affairs (VA). In response to your questions for the record, I offer the following comments.

Question: As we discussed in the hearing, too many women veterans who have experienced MST have associated trauma from that experience. This trauma makes it hard for them to willingly put themselves out there to be retraumatized by being forced to share these experiences in order to gain access to the care they need to begin the recovery process. There won't be a single solution that works for everyone, but we need to be thinking of better ways to engage women veterans—especially those who need our help the most—in safe, welcoming environments.

In Maine, we are incredibly fortunate to have a unique organization called the Sisters In Arms Center. They provide transitional housing for women veterans and their children, they also connecting those women to community support resources, peer support, and even have a support group. Many who access their services have experienced a lot of trauma—including MST—and getting them into a continuous care setting is challenging because it is hard for them to trust a system that might have failed them before.

This kind of organization can help fill the gap for women veterans who don't yet feel comfortable accessing VA care and provide them the care they need while meeting them where they are. Additionally, many of the volunteers and Board Members of Sisters In Arms are women veterans themselves, so they share that deep bond and understanding, perhaps even helping to build up their trust enough to help these women veterans access to VA and the broad services they can provide.

Do any of you have experiences with organizations like Sisters in Arms? What kind of role could this sort of organization play in filling the gaps and ensuring that women veterans get the care

they need, without having to face the barriers that sometimes come with gaining access to the VA and benefits?

Response: PVA has 33 chapter across the country and Puerto Rico, each is its own 501 (c)(3). We encourage our chapters to engage with other service organizations and support services that provide assistance in their local communities. Coalitions are critical in ensuring veterans, particularly disabled veterans, are able to find the support and resources they need to thrive.

The VA often says that "word of mouth" is more impactful than their outreach and that proves true when you talk to veterans. The trust that veterans place in their "battle buddies" is critical in getting veterans to engage with VA. Building a grassroots network of local veteran organizations, support organizations, and the larger VA system helps to meet veterans where they are with the resources they may need. VA cannot do it all on their own. This is especially true for veterans who do not have a service-connected disability and therefore do not engage with VA.

It becomes even more true for women veterans who may not trust VA or other veterans if they experienced trauma in service. Many women veterans find community at the local level, outside of the VA system, and engage with local support networks. After time and healing, they may or may not decide to engage with VA. I am personally aware of many women veterans who waited five, ten, and even twenty years before they finally felt comfortable and confident enough to seek services within VA. Local veterans' organizations, like PVA, serve as the gateway to get women veterans to VA and they are critical for successful outreach.

Question: Another issue that I have been focusing on broadly but has particular relevance to veterans, and especially women veterans, is falls prevention. This is one of the most preventable types of major injuries, and spending a small amount of money up front on prevention methodologies like screening or evidence-based falls prevention programs can be meaningful to saving significant dollars, preventing injuries, and saving lives. Among a number of risk factors like balance issues or having a previous fall, osteoporosis is a critical risk factor – and it affects four times as many women as men.

In your experiences, has VA or VHA done enough to ensure that veterans, including women's veterans, have access to falls prevention programs? Does VA or VHA do enough to ensure that safe patient handling techniques and transfers are adequate in all settings?

Response: Working with veterans with complex injuries and illnesses is complicated and VA staff could use additional training to ensure the safety of women veterans with spinal cord injuries or disorders. As I mentioned in my written statement, many VA women's clinics lack basic accommodations that are needed to ensure the safety of women accessing services. This includes ceiling lifts and exam tables that raise and lower to accommodate patient transfers.

When it comes to preventing falls, there are several home adaptation grants that could be used by a veteran in need. Programs like the Home Improvements and Structural Alterations (HISA)

grant program, as well as the Specially Adapted Housing (SAH) grant. The SAH grant has more stringent eligibility criteria than the HISA grant, but both allow veterans to improve their home's overall accessibility by providing for things like handrails and guards that could be used to prevent falls. An eligible veteran may also use the Independent Living track within the Veteran Readiness and Employment (VR&E) program. While VR&E is predominantly an employment and education program, the Independent Living track seeks to improve a veteran's quality of life if they encounter barriers to their daily living due to their injuries or illnesses.

While housing adaptations are important for the quality of life and independence of many disabled veterans, the programs that provide them need additional resources to ensure that veterans can access them. For example, rates for the HISA grant haven't been updated in 14 years; thus, what the benefit provides falls well short of what veterans need to make necessary safety modifications to their homes. Legislation such as S. 3290, the Autonomy for Disabled Veterans Act, has been introduced to make needed changes to the HISA program. PVA strongly supports this bill and seeks its swift passage.

Lastly, VA could improve the department's outreach regarding their falls prevention program. Developed by the Office of National Patient Safety, the toolkit (https://www.patientsafety.va.gov/professionals/onthejob/falls.asp) they developed helps veterans understand the resources available to help them avoid these preventable injuries.

We appreciated the opportunity to participate in this hearing and would be happy to answer any additional questions you may have.

Sincerely,

Julie Howell,
Associate Legislative Director
Paralyzed Veterans of America

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WOUNDED WARRIOR PROJECT

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SUPPLEMENTAL STATEMENT FOR THE RECORD OF
DR. KIRSTEN LAHA-WALSH
GOVERNMENT AFFAIRS SPECIALIST

COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA"

May 20, 2024
(to supplement April 10, 2024 statement)

ATTN: Sen. Angus King (I-ME)

Thank you for inviting Wounded Warrior Project (WWP) to submit this statement for the record in response to your questions about services for women veterans. For your convenience, we have repeated those questions below in italics. Our responses follow in normal font.

Question 1:

As we discussed in the hearing, too many women veterans who have experienced MST have associated trauma from that experience. This trauma makes it hard for them to willingly put themselves out there to be retraumatized by being forced to share these experiences in order to gain access to the care they need to begin the recovery process. There won't be a single solution that works for everyone, but we need to be thinking of better ways to engage women veterans—especially those who need our help the most—in safe, welcoming environments.

In Maine, we are incredibly fortunate to have a unique organization called the Sisters In Arms Center. They provide transitional housing for women veterans and their children, they also connecting those women to community support resources, peer support, and even have a support group. Many who access their services have experienced a lot of trauma—including MST—and getting them into a continuous care setting is challenging because it is hard for them to trust a system that might have failed them before.

This kind of organization can help fill the gap for women veterans who don't yet feel comfortable accessing VA care and provide them the care they need while meeting them where they are. Additionally, many of the volunteers and Board Members of Sisters In Arms are women veterans themselves, so they share that deep bond and understanding, perhaps even helping to

build up their trust enough to help these women veterans access to VA and the broad services they can provide.

Do any of you have experiences with organizations like Sisters In Arms? What kind of role could this sort of organization play in filling the gaps and ensuring that women veterans get the care they need, without having to face the barriers that sometimes come with gaining access to the VA and benefits?

Engaging women in safe, welcoming environments is unequivocally one of the strongest solutions to making care and support more accessible to women veterans. Culturally competent connections benefit the rapport between women veterans and their support systems, including with the Veterans Health Administration (VHA) and other Department of Veterans Affairs (VA) facilities. The White Ribbon VA program is a result of the increase of legislative and policy efforts looking at military sexual trauma (MST) and the impact MST has on a veteran's life, and seeks to eliminate sexual harassment, sexual assault, and domestic violence across VA. The desired culture shift is a positive endeavor to identify individuals (VA staff and stakeholders) who have committed to standing up against sexual harassment, assault, or domestic violence through their display of a white ribbon pin. The White Ribbon VA program is an expansion of the White Ribbon international movement, which has spread to 60 countries, and can also be found on military bases and states worldwide.[1]

Sisters In Arms – and others like – exist in part because not every woman veteran's journey begins or ends at VA. At WWP, we have designed gender-specific programs for women warriors who are more comfortable or more inclined to engage with other women warriors. For example, women-only cohorts are held within Project Odyssey, an adventure based mental health program. Women-only peer support groups are also held across the country, both in person and virtually. Efforts like these can help foster trust in our organization and our ability to facilitate the safe, welcoming environments that some will seek and all should expect.

In addition to offering these programs ourselves, WWP maintains a strong awareness of other community resources and actively pursues partnerships and relationships to make warriors aware of other supportive programming. For example, through our Alumni program, which hosts social and connection events for warriors, there is organizational knowledge of many supportive organizations throughout the country. Many of these groups offer services from social engagement to networking and professional development opportunities for women veterans to connect, but these can be hard to find without access to the appropriate resources.

Wounded Warrior Project hosts, builds, and maintains a database of vetted organizations that operate a national, state, and local levels to veterans and Service members seeking support. That database, which is accessed daily to assist those who call WWP, currently includes more than 1,500 services – including 55 unique nationwide services – that specifically serve women. WWP has more formal community partners such as Veteran Sisters, Cohen Veterans Network, and The Bob Woodruff Foundation who offer specialized care for women veterans. Another partner, Boulder Crest Foundation, offers a posttraumatic growth (PTG) focused program, Warrior PATHH, that features women only opportunities, currently on its seventh women-only

[1] U.S. DEP'T OF VET. AFFAIRS, *White Ribbon VA* (2024), *available at* https://www.va.gov/health/harassment-free/.

cohort. Through WWP's own Warrior Care Network, Academic Medical Center partners hold specialized cohorts for intensive outpatient treatment for MST and other service-connected issues that primarily affect women veterans.

These organizations have an important role to play through their actions related to awareness, engagement, and empowerment. Awareness and outreach efforts are needed to ensure that women veterans are being made aware of and accessing the appropriate services. Through the *Deborah Sampson Act*, VA was required to host biannual public town halls. However, there was no requirement built in to document the topics being discussed within the town halls. Documenting the topics would help VA understand what information is being disseminated throughout the Veteran Integrated Service Networks (VISNs) and could potentially offer oversight and support to ensure to identify gaps in curriculums.

Culturally competent engagement is needed to meet the warriors where they are and to ensure their needs are getting met. One recommendation through this would be to encourage VHA, through the Women Veteran Program Managers and support staff, to perform quarterly engagement outreach calls where they would reach out to women veterans enrolled in VHA to ask, "Are your health care needs being met?"

The final piece, empowerment, is achieved when women veterans are aware, engaged, and can navigate the system with little to no barriers. Women veterans who access VA with little to no barriers still face challenges, especially when attending appointments. Ensuring to recognize and acknowledge all veterans for their service, including women veterans. While efforts have been made to identify everyone as "Veteran _____," not all staff and facilities are compliant, with women veterans still being asked "Where is your husband?" Instead of asking questions like that, questions like "what branch did you serve in?" or "where did you serve?" would be stronger. These questions provide a validation of service while also confirming that the individual is the veteran, regardless of gender. Such a shift would require not only education for VA staff, but a culture change where inclusion is key.

Question 2:

Another issue that I have been focusing on broadly but has particular relevance to veterans, and especially women veterans, is falls prevention. This is one of the most preventable types of major injuries, and spending a small amount of money up front on prevention methodologies like screening or evidence-based falls prevention programs can be meaningful to saving significant dollars, preventing injuries, and saving lives. Among a number of risk factors like balance issues or having a previous fall, osteoporosis is a critical risk factor – and it affects four times as many women as men.

In your experiences, has VA or VHA done enough to ensure that veterans, including women's veterans, have access to falls prevention programs? Does VA or VHA do enough to ensure that safe patient handling techniques and transfers are adequate in all settings?

Wounded Warrior Project's mission is primarily focused on serving post-9/11 wounded, ill, and injured veterans. As the average age of a warrior completing our *2022 Annual Warrior*

Survey was 41 and less than one percent reported an age over 65, the vast majority of those we serve are not yet facing issues that are more common among older veterans, like falling. However, with 36% of warriors reporting a history of traumatic brain injury and 5% reporting blindness or other vision impairment, there is still room for concern.

There is a lack of data in the academic literature space regarding differences in gender and falls prevention in VA facilities, specifically VHA. Research focused on State Veterans Homes has suggested that innovative efforts, such as post fall huddles, intentional rounding, and staff education opportunities would have a positive impact and reduce the number of falls.[2] There is especially a need to have precautions in place to support women veterans in VA facilities, as there has been an increase in the national population of women with osteoporosis (29% increase from 2010 to 2020), and osteoporosis is reported by women at a higher prevalence than males.[3] More research is needed on various aspects of inpatient care as well as fall prevention. It is known that patients who have cognitive issues, including dementia, have a higher risk of falls, but also, antihypertensive medication use has been found to be a potential risk factor to falls.[4]

[2] Lisa Zubkoff et al., *How to Prevent Falls and Fall-Related Injuries: A Virtual Breakthrough Series Collaborative in Long Term Care*, 37(4) PHYS. & OCC. THERAPY IN GERIATRICS 234, 234-246 (2019).
[3] Joanne LaFleur et al., *Fracture Rates and Bone Density Among Postmenopausal Veteran and Non-Veteran Women from the Women's Health Initiative*, 56(Sup.1) GERONTOLOGIST S78, S78-S90 (2016).
[4] Chintan V. Dave et al., *Antihypertensive Medication and Fracture Risk in Older Veterans Health Administration Nursing Home Residents*, JAMA INT'L MED. (2024).

KEEPING OUR PROMISE TO AMERICA'S VETERANS

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Senator King
Questions for the Record
Senate Veterans' Affairs Committee Hearing
"Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA"
April 10, 2024

Questions for Ms. Mathis

1. As we discussed in the hearing, too many women veterans who have experienced MST have associated trauma from that experience. This trauma makes it hard for them to willingly put themselves out there to be retraumatized by being forced to share these experiences in order to gain access to the care they need to begin the recovery process. There won't be a single solution that works for everyone, but we need to be thinking of better ways to engage women veterans—especially those who need our help the most—in safe, welcoming environments.

   In Maine, we are incredibly fortunate to have a unique organization called the Sisters In Arms Center. They provide transitional housing for women veterans and their children, they also connect those women to community support resources, peer support, and even have a support group. Many who access their services have experienced a lot of trauma—including MST—and getting them into a continuous care setting is challenging because it is hard for them to trust a system that might have failed them before.

   This kind of organization can help fill the gap for women veterans who don't yet feel comfortable accessing VA care and provide them the care they need while meeting them where they are. Additionally, many of the volunteers and Board Members of Sisters In Arms are women veterans themselves, so they share that deep bond and understanding, perhaps even helping to build up their trust enough to help these women veterans access to VA and the broad services they can provide.

   a. Do any of you have experiences with organizations like Sisters In Arms? What kind of role could this sort of organization play in filling the gaps and ensuring that women veterans get the care they need, without having to face the barriers that sometimes come with gaining access to the VA and benefits?

Response: Unfortunately, MST continues to be pervasive in the military branches as well as in the Service Academies. We concur there needs to be better ways to engage

women veterans who have experienced sexual trauma and that there won't be a single solution that will work for everyone.

I reviewed the services of the amazing Sisters in Arms program in Maine, and it appears to be a program that will help to fill gaps in services that are not provided by VA. Evidence shows that women veterans who suffered military sexual assault do feel safer sharing their experience and recovery journey with their peers who have had a similar experience. This is an excellent example of the community coming together to assist our veterans when they come home devasted and broken and feeling betrayed. This goes beyond what they experienced in the military setting and for so many the trauma is compounded as they try to seek help to address their mental health challenges and file a claim for earned benefits.

The VA sponsors women-only retreats through its Vet Center Program and has the authority to provide counseling in retreat settings to veterans through 2025, in accordance with P.L. 116–315, Section 5104. DAV fought hard to have this program included in the law and see its continuing value. Women veterans attending these retreats report they are highly beneficial in helping them make peer connections and build a network of support.

DAV has provided significant resources to support Boulder Crest retreats, where DAV leaders and spouses serve as mentors for the latest generation of seriously-injured veterans and their caregivers. Programs like Boulder Crest offers peer to peer counseling and comradery that is often lost when women service members leave the military. Women veterans report they often feel very isolated after experiencing military sexual trauma and desire gender-specific programming to deal with sensitive topics during the recovery process.

We certainly see the value of programs like Sisters in Arms, particularly since the program includes child care options for participants, which as we know without it is often a barrier to seeking needed treatment.

While we do not have a connection to an organization exactly like Sisters in Arms, another exceptional program DAV has supported/invested in is the Save A Warrior program:

> *Save A Warrior® (SAW) is a trailblazer in combating the military and Veteran suicide epidemic, operating out of the National Center of Excellence for Complex Post-Traumatic Stress in Hillsboro, Ohio in partnership with DAV. With an unparalleled efficacy rate of over 99.7%, our Cohort intervention program has established itself as a gold standard in suicide prevention. The intervention employs precision storytelling and deep listening techniques to accelerate the healing of intergenerational traumas and formative wounds,*

supported by evidence-based practices that bolster mental, emotional, and physical resilience.

Upon completion, participants can immediately join the Save A Warrior Community of Practice—a 24/7/365 accessible network that comprises over 70% of legacy graduates. This community offers a research-backed 500-Day Plan, maintained through accountable support from Cohort "Shepherds," to deepen the original healing experience and foster continuous individual recovery. Through these unique features, SAW transcends conventional approaches, ensuring that warriors emerge with a renewed sense of purpose, compassion, and dedication to their communities and loved ones. This transformative experience creates a ripple effect that positively impacts many others who might otherwise face the loss of a warrior to suicide.

In partnership with organizations like the Disabled American Veterans (DAV), and designed to be inclusive and equitable, SAW is committed to serving warrior communities of all races, colors, religions, sexual orientations, and backgrounds. Our approach understands that the roots of suicide are multifaceted and informed by each individual's unique experience and background. By treating the whole person, our program has proven invaluable for over 2,300 Warriors, changing not only their lives but also significantly benefiting society at large.

Recently, after a short battle with cancer, DAV lost Ginger MacCutcheon, whose story about overcoming MST and suicidal ideation is featured in our report, *Women Veterans: The Journey to Mental Wellness* (https://www.dav.org/women-veterans-study/). Ginger attended SAW and was in an all-female cohort. She credited Save a Warrior with helping her stating "[They] dealt with me as a whole person, like my whole 65 years," MacCutcheon said. "I was a changed person when I got out of there." Here is a link to Ginger's story (https://www.dav.org/learn-more/news/2024/decades-after-assault-womens-army-corps-veteran-finds-hope-and-healing/).

It is for women veterans like Ginger that we feel a nationwide pilot program based on Sisters in Arms could be beneficial. This is a topic that warrants further discussion and a possible roundtable with the VSO community. DAV co-hosts a VSO Women Veterans Working Group made up of a variety of organizations interested in improving services for women and other underserved veteran populations. We are happy to work with your staff on how we can work together to make it happen.

2. Another issue that I have been focusing on broadly but has particular relevance to veterans, and especially women veterans, is falls prevention. This is one of the most preventable types of major injuries, and spending a small amount of money up front on prevention methodologies like screening or evidence-based falls prevention programs can be meaningful to saving significant dollars, preventing injuries, and saving lives. Among a number of risk factors like balance issues or having a previous fall, osteoporosis is a critical risk factor – and it affects four times as many women as men.

    a. In your experience, has VA or VHA done enough to ensure that veterans, including women veterans, have access to falls prevention programs? Does VA or VHA do enough to ensure that safe patient handling techniques and transfers are adequate in all settings?

Response: We are aware of your work on falls prevention, including the Preventative Home Visits Act (S. 2941). While this legislation is not specifically veteran focused, we know that a number of our aging population of veterans could benefit from it.

We have included a link to VA's website regarding falls prevention here: https://www.prevention.va.gov/Healthy_Living/Be_Safe_Prevent_Falls.asp. We believe that this is an area where VA can possibly improve and expand its falls prevention measures.

It appears that VA institutes traditional patient protocols for falls prevention within their facilities. However, it would be beneficial to have a case manager or appropriate personnel come and assess the homes of veterans that are deemed homebound to ensure they have falls preventative measures put into place. Having a thoughtful piece of legislation might help in ensuring that such an assessment takes place for our most vulnerable veterans who are homebound.

Senator King, I remember when my mother sent me a picture of my Marine veteran grandfather at age 91, on the floor of his bathroom. He lived at an independent living facility and had fallen the night prior. When my mother asked what happened he stated "Oh it's OK, it was quite comfortable because I landed on the rug." Looking back on it, his bathroom was not adequate to prevent this fall and he could have benefited from having someone come in and assess his surroundings. Falls prevention was just not something we had on our mind at the time. Thankfully, my grandfather was fine and my mother moved him in with her shortly afterwards, and we got to spend another three years with him in our lives.

We appreciate your forward thinking on this issue as it isn't just the geriatric population, but also service-disabled veterans who are more susceptible to falling in their home. Service-disabled veterans usually deal with more than one medical issue, and when combined, could contribute to a fall. For example, many veterans suffer from symptoms

associated with TBI, and inner ear issues, take a variety of medications, and experience orthopedic issues and spinal cord injury or disease causing foot drop and other complications. It is important to find where the gaps are that need to be filled in order for our service-disabled veterans to have preventative measures put in place.

Thank you for the opportunity to offer our feedback and recommendations on the additional questions you sent to DAV. If you need clarification on any points we made do not hesitate to have your staff reach out to me.

Statements for the Record

STATEMENT FOR THE RECORD OF

CHRISTIE BLOOMQUIST, VICE PRESIDENT, GOVERNMENT AFFAIRS AND POLICY, ASTELLAS PHARMA US, INC.

U.S. SENATE COMMITTEE ON VETERANS AFFAIRS HEARING: CARING FOR ALL WHO HAVE BORNE THE BATTLE: ENSURING EQUITY FOR WOMEN VETERANS AT VA

APRIL 10, 2024

Chairman Tester, Ranking Member Moran, and distinguished members of the Committee, thank you for the opportunity to submit a Statement for the Record for this hearing focused on ensuring equity of care for women veterans through the Veterans Health Administration (VHA).

Astellas is a pharmaceutical manufacturer committed to improving the lives of patients across the globe. We pioneer first-in-class health solutions that have transformed disease management and reshaped patients' expectations of care. Astellas is focused on turning innovative science into medical solutions that bring value and hope to patients and their families, especially those impacted by serious diseases with no or limited treatment options.

Astellas is committed to women's health by ensuring they have access to therapies through all stages of life. As a leader in women's health solutions, Astellas is working to help women at mid-life suffering from vasomotor symptoms – or VMS – otherwise known as hot flashes/flushes and night sweats due to menopause. As a normal part of aging, menopause can bring changes that are more significant and distinct from other phases in life that precede it. By 2025, an estimated 1.1 billion women worldwide between the ages 40 and 58 will have experienced menopause or be postmenopausal.[1][2][3] Despite the tremendous number of women impacted, conversations about menopause are often limited, most likely due to stigma surrounding it globally, leaving them vulnerable at a time when they need guidance and support.

According to the VA Office of Women's Health, women are the fastest growing group of veterans using VA services. The number of women veterans using VHA services has tripled since 2001, growing from 159,810 to over 600,000 today. In fact, women make up 30% of all new VHA patient enrollments.[4] Additionally, a recent report published by the Department, *VA State of Reproductive Health Report in Women Veterans*, specifically discusses the need for an increased focus on treating menopause and menopausal disorders among women veterans 45-64 years old, noting that menopausal symptoms may negatively impact a woman's quality of life.[5] The report also notes that among the current cohort of women veterans ages 18-44 years, the demand for these health care services and treatments will

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[1]Shifren, J. L., & Gass M. L. S., NAMS Recommendations for Clinical Care of Midlife Women Working Group. (2014). The North American Menopause Society recommendations for clinical care of midlife women. Menopause, 21(10), 1-25. https://www.menopause.org/docs/default-source/2014/nams-recomm-for-clinical-care.

[2] Jones, R. E., & Lopez, K. H. (2014). Reproductive aging. In: R.E. Jones & K. H. Lopez, Eds, Human reproductive biology (4th ed., p119-131).
Elsevier.

[3] Santoro, N. F. (2019). Menopause. In: C. J. Crandall, G. A. Bachman, S. S. Faubion, W. Klein, J. H. Liu, J. E. Manson, J. Mortimer, J. V. Pinkerton, N. F. Santoro, J. L. Shifren,

[4] U.S. Department of Veterans Affairs, V.H.A. (2022, March 28). VA Office of Women's Health.

[5] Veterans' Health Administration. (2023). *VA State of Reproductive Health Report in Women Veterans.* VA Office of Women's Health. https://www.womenshealth.va.gov/docs/SRH_FINAL.pdf

sharply increase.[6] Astellas would like the opportunity to work closely with VHA to ensure the Department meets the needs of current women veterans requiring treatment for menopause and menopausal disorders, but to also ensure VHA is ready for the forthcoming wave of women veterans who will need treatments as they enter midlife.

While we understand the symptoms of menopause and menopausal disorders can often vary, Astellas is pleased the Committee is receiving testimony from the Disabled American Veterans (DAV) on their recently released report, *Women Veterans: The Journey to Mental Wellness*. This report aptly points out how women veterans are often more negatively impacted by menopausal symptoms as they age, as compared to their female civilian counterparts. Additionally, the report details that menopause is a vulnerable time for women veterans and corresponds to the highest rates of suicide among U.S. women.[7] Further, the report discusses that perimenopause has been shown to raise the risk for depression in women twofold.[8]

As the number of female service members continues to grow, so too will the profound impact that menopausal symptoms may have on the health of service members and veterans, as well as the potential to affect military readiness.

Therefore, Astellas supports the establishment of a new separate line item for a menopause research program at the Department of Defense (DoD) Congressionally Directed Medical Research Program (CDMRP) in the Fiscal Year 2025 Defense Appropriations Bill. This program will examine the impact of menopause on service members and their families and its effects on military readiness, mental and physical well-being, and DoD healthcare costs, as well as develop strategies to improve education, treatment, and support before, during, and after the menopause transition to ameliorate these impacts.

Astellas encourages VA to provide access to all FDA-approved treatments for symptoms of menopause. Further, we encourage the VA to:

- Establish a program for women veterans to increase awareness of menopause symptoms, related chronic conditions, and treatment options;
- Invest in medical education and training programs to train VA healthcare professionals in managing menopause symptoms and related conditions; and
- Enhance and improve how the VA health workforce are educated in menopause through the development, evaluation, and distribution of evidence-based resources.

Thank you again for the opportunity to provide input to this valuable hearing. Our women veterans have served honorably and bravely shoulder-to-shoulder with their male counterparts, and therefore, deserve the best high-quality care available. Astellas stands ready to collaborate with VA and to be a resource on menopause and menopausal disorders for our women veterans.

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[6] Veterans' Health Administration. (2023). *VA State of Reproductive Health Report in Women Veterans.* VA Office of Women's Health. https://www.womenshealth.va.gov/docs/SRH_FINAL.pdf

[7] Disabled American Veterans (DAV). (2024, February 28). *Women Veterans: The Journey to Mental Wellness.* Women Veterans Report. https://www.dav.org/women-veterans-study/

[8] *Ibid.*

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NEVER AGAIN WILL ONE GENERATION OF VETERANS ABANDON ANOTHER.

April 22, 2024

The Honorable Jon Tester
Chairman, Committee on Veterans' Affairs
United States Senate
412 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Tester,

In response to the recent hearing on women veterans' health, our National Women Veterans Committee Chair Kate O'Hare Palmer has asked to add their recent notes from the board of directors meeting held on April 20th. You will note that the complex issues mentioned that our women warriors face at an advancing age, requires their voice on the hill when assessing women's healthcare issues.

It is imperative that we add this information to the recent hearing and ensure that all future hearings, meetings, and efforts regarding women veterans include the voices of the Vietnam Era women veterans.

I will be happy to facilitate and assist in securing members of the VVA to testify and offer testimony when needed, I see a great pathway forward and welcome calls anytime.

Sincerely,

James McCormick
Director Government Affairs

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Statement of Women Veterans Committee
Chair Kate O'Hare Palmer

Senior Women Veterans Health Care

In 2022, the Center for Women Veterans conducted a study on why older women veterans did not use the VA healthcare system as much as their younger women veteran counterparts. Women veterans age 50+ were least likely to use their earned benefits. The top reasons for this cohort of veterans not taking advantage of their earned benefits are that these women (a) did not consider themselves as veterans and (b) were **unaware of their benefits**. This group included women **retired from the military!**

Of the nearly 2 million women veterans, approximately 800,000 (40 percent) are enrolled with the VA healthcare system. However, over 50 percent have not accessed their disability benefits, and only 28 percent have used their mortgage benefits. In this latter group, 51 percent are in the age group of 45-75 years old. The two groups who make up most post-menopausal women veterans are Korean veterans whose median age is 81, and Vietnam veterans with a median age of 68.

The unspoken cause for many women not seeking care is their experience of non-disclosed military sexual trauma, or not wanting to discuss their healthcare needs with a male medical provider. Furthermore, most private sector healthcare facilities do not screen for women veterans, and this keeps them from accessing additional resources through the VA that could lead to increased health and financial security for these women.

There have been a lot of improvements with the understanding and treatment of PTSD and other mental health disorders in the VA. However, the coordination of post-menopausal women's healthcare has many gaps. The access to gerontologists and ob-gyn specialists at every VA hospital is limited, while the average length of time required to schedule appointments has increased these past two years. Referrals to community care are also taking longer or are being denied due to budget constraints.

The President's executive order passed in March 2024, regarding federal research on women's health issues, will hopefully help in the understanding of and treatment for mid-life and senior women's health. However, women veterans' toxic exposures have affected their thyroid, lung, uterine, ovarian, breast, hormones, bones, neurological, and pancreatic systems. Senior women experience a host of service-related health issues, including arthritis, osteoporosis, back pain, neuropathies, hearing loss, incontinence, depression or anxiety, undiagnosed PTSD, sleep disorders, social isolation, as well as limited physical abilities, and Dementia/Alzheimer's. Access to prosthetics for women is also not easy. Frequently, they lack information about geriatric and

long-term care programs, home-based and community services, such as home-aides and housebound help, and veteran homes.

The care that could be accessed through earned benefits would help many senior women veterans on fixed incomes have a higher quality of life, but outreach has been ineffective. More information on mainstream media platforms would help, as would the buddy system where a veteran new to the VA system gets help from another veteran navigating their first appointments. Accessing women veterans by phone, as well as follow-up to the first visit, is key in getting more women to use the VA healthcare system. Just the frustration of navigating the system has made many women not return after a first visit with either the healthcare or benefits side of the VA.

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