Statement for the Record

Of

VIETNAM VETERANS OF AMERICA

Submitted by

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Chair, Women Veterans Committee

Before the
Senate Veterans Affairs Committee

Regarding

Fulfilling the Promise to Women Veterans

April 21, 2015

Good afternoon Mr. Chairman, Ranking Member Blumenthal, and distinguished members of the Senate Veterans Affairs Committee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record Fulfilling the Promise to Women Veterans

Since 1982, Vietnam Veterans of America has been a leader in advocacy and championing appropriate and quality health care for all women veterans. The Department of Veterans Affairs (DVA) has made many innovations, improvements and advancements over the past thirty years. However, some concerns remain respective of its policies, care, treatment, delivery mode, and monitoring of services to women veterans.

MEDICAL TREATMENT OF WOMEN VETERANS BY DEPARTMENT OF VETERANS AFFAIRS (DVA)

Department of Veterans Affairs eligible women veterans are entitled to complete health care including care for gender specific illnesses, injuries and diseases. The DVA has become increasingly more sensitive and responsive to the needs of women veterans and many improvements have been made. Unfortunately, these changes and improvements have not been completely implemented throughout the entire system. In some locations, women veterans experience barriers to adequate health care and oversight with accountability is lacking. Primary care is fragmented for women veterans. What would be routine primary care in the community is referred out to specialty clinics in the VA. Over the last five years the per cent of women veterans using the VA has grown from 11% to 17%, with 56% of OEF/OIF women Veterans having enrolled in the VA. Their average age of women Veterans using the VA is 48.

Vietnam Veterans of America will continue its advocacy to secure appropriate facilities and resources for the diagnosis, care and treatment of women veterans at all DVA hospitals, clinics, and Vet Centers and we ask the Secretary of Veterans Affairs ensure senior leadership at all facilities and Regional Directors be held accountable for ensuring women veterans receive appropriate care in an appropriate environment. Further, we seek that the Secretary ensures:

- The competency of staff who work with women in providing gender-specific health care.
- That VA provides reproductive health care.

- That appropriate training regarding issues pertinent to women veterans is provided.
- That there is the creation of an environment in which staff are sensitive to the needs of women veterans; that this environment meets the women's needs for privacy, safety, and emotional and physical comfort in all venues.
- Those privacy policy standards are met for all patients at all VHA locations and the security of all Veterans is ensured.
- That the anticipated growth of the number of women Veterans should be considered in all strategic plans, facility construction/utilization and human capital needs.
- That patient satisfaction assessments and all clinical performance measures and monitors that are not gender-specific, be examined and reported by gender to detect any differences in the quality of care.
- That the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value report any significant differences and forward the findings to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and chiefs of staff, and the Women's Health Services Office.
- That every woman veteran has access to a VA primary care provider who meets all her primary care needs, including gender-specific and mental health care in the context of an ongoing patient-clinician relationship.
- That general mental health care providers are located within the women's and primary care clinics in order to facilitate the delivery of mental health services.
- That sexual trauma care is readily available to all veterans who need it and that VA ensure those providing this care and treatment have appropriate qualifications obtained through course work, training and/or clinical experience specific to MST or sexual trauma.
- That an evaluation of all gender specific sexual trauma intensive treatment residential programs be made to determine if this level is adequate as related to level of need for each gender, admission wait times, and geographically responsive to the need.
- That Vet Centers are able to adequately provide services to women veterans.
- That a plan is developed for the identification, development and dissemination of evidence-based treatments for PTSD and other co-occurring conditions attributed to combat exposure or sexual trauma.

- That women veterans, upon their request, have access to female mental health professionals, and if necessary, use VA outsource to meet the women veteran‘s needs.
- That all Community Based Outpatient Clinics (CBOC) which do not provide gender-specific care arrange for such care through VA outsource or contract in compliance with established access standards.
- Evidence-based holistic programs for women’s health, mental health, and rehabilitation are available to ensure the full continuum of care.
- That the Women’s Health Service aggressively seek to determine root causes for any differences in quality measures and report these to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and COS, and providers.
- That legislation be enacted to ensure neonatal care is provided for up to 30 days as needed for the newborn children of women veterans receiving maternity/delivery care through DVA.

Senator Dean Heller (NV) (for himself and Ms. Murray) has introduced S.471 the Women Veterans Access to Quality Care Act, when enacted d into law would improve the provision of health care for women veterans by the Department of Veterans Affairs, and for other purposes and based on our recommendations above VVA fully supports the bill.

HOMELESS WOMEN VETERANS

Over the past two decades we have become increasingly more vested in the recognition and address of the situation of homelessness among Veterans. In looking back VVA well remembers the time when the VA acknowledged that as many as 275,000 Veterans filled these roles. With the legislative creation of the VA Homeless Grant and Per Diem HGPD program and its program growth, the VA and community Veteran service providers have been able to chip away at this deplorable situation of life that existed for so many who served this county in its armed forces. Startling is the fact that the percentage of homeless women Veterans has raised from 2% to 6% of the homeless Veteran population and that over the past four years the actual number has doubled.

Currently the VA sites that the number of homeless Veterans has been reduced to 49,933 as reported by the most recent Point in Time count. VVA recognizes this as a useful tool but doubts that this number is necessarily a solid number. It is a snap shot because it is impossible to have on record all the Veterans who are homeless.

Nonetheless it is a true indicator that all the energy surrounding the above mentioned programs has made a difference. It is undeniable that the number of Homeless women veterans has been climbing; however, collection data on homeless women Veterans is not reliable as indicated in the Government Accounting Office's (GAO) 2011 report "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing. The report also cited some significant barriers to access of housing for homeless women Veterans are:

- They are not aware of the opportunities available
- They don't know how or where to obtain housing services.
- They are not easily found/identified in the community. They often "couch surf."
- They have children and avoid shelters because of the safety factor;
- They avoid social service agencies for fear of losing their children to the system.
- 24 percent of VA Medical Center homeless coordinators indicated they have no referral plans or processes in place for temporarily housing homeless women veterans while they await placement in HUD-VASH and GPD programs.
- Nearly 2/3 of VA HGPD programs are not capable of housing women with children.
- The program expense of housing women with children is a disincentive for providers.

VVA believes that it is a very ambiguous plan of the Ending Homeless among Veterans by 2015, but asks the questions? Are women Veterans and their needs truly being met by the programs that exist for them today? "What will be done to reach them, to know them, to meet their needs and provide them a safe environment in which to address them?" VVA believes that a coordinated plan needs to be developed at the local level by the leadership of the respective VA medical center within its homeless Veteran program to address these needs. The influx of women in the military and one of every ten soldiers serving in Iraq a woman, the female homeless population will only grow and or facilities dedicated to women are vital.

WOMEN VETERANS RESEARCH

Because women veterans have historically been a small percentage of the veteran population, many issues specific to women veterans have not been researched. General studies of veterans often had insufficient numbers of women veterans to detect differences between male and female veterans and/or results were not reported by gender. Today, however, women are projected to be more than 11 % of the veteran population by 2020 and 12% by 2025.

Vietnam Veterans of America asks the Secretary to conduct several studies specific to women veterans and that Congress pass legislation to mandate such studies if the Secretary does not act:

- A comprehensive assessment of the barriers to and root causes of disparities in the provision of comprehensive medical and mental health care by DVA for women veterans.
- A comprehensive assessment of the capacity and ability of women veterans' health programs in VA, including Compensation and Pension examinations, to meet the needs of women veterans. (GAO: March 2010: VHA).
- A comprehensive study of the relationship of toxic exposures during military training and service, and the infertility rates of veterans.
- A comprehensive evaluation of suicide among women veterans, including rates of both attempted and completed suicides, and risk factors, including co-morbid diagnoses, history of sexual trauma, unemployment, deployments, and homelessness.
- VA evaluation of the integration of services to support veterans.

CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE

VVA asks that particular reflective consideration be given to the following -- VVA seeks a change in this section of the proposed legislation that would increase the time for the provision of neonatal care to 30 days, as needed for the newborn children of women veterans receiving maternity/delivery care through the VA. Certainly, only newborns with extreme medical conditions would require this time extension. VVA believes that there may be extraordinary circumstances wherein it would be detrimental to the proper care and treatment of the newborn if this provision of service was limited to less than 30 days. The decision for extended would require professional justification. If the infant must have extended

hospitalization, it would allow time for the case manager to make the necessary arrangements to arrange necessary medical and social services assistance for the women veteran and her child. This has important implications for our rural woman veterans in particular. And this is not to mention cases where there needs to be consideration of a woman veteran's service-connected disabilities, including toxic exposures and mental health issues, especially during the pre-natal period, multiple births and pre-mature births. Prenatal and neonatal birthrate demographics (including miscarriage and stillborn data) would seem to be an important element herein.

WOMEN VETERANS AND VETERANS BENEFITS

The Veterans Benefits Administration (VBA), and to a lesser extent, the National Cemetery Administration (NCA), have been less proactive than the Veterans Health Administration in targeting outreach to women veterans and in ensuring competency in managing claims filed by women veterans.

Vietnam Veterans of America will continue its advocacy to secure benefits for all eligible veterans. VVA asks the Secretary to ensure:

- That leadership in all VA Regional Offices (VARO) is cognizant of and kept current on women veterans' issues; that they provide and conduct aggressive and pro-active outreach activities to women veterans and; that VBA leadership ensures oversight of these activities.
- That a national structure be developed within VBA for the Women Veteran Coordinator (WVC) positions, located at each VARO.
- That VBA establish consistent standards for the time allocated to the position of Women Veteran Coordinator (WVC) based on the number of women veterans in the area the VARO serves.
- That VBA develop a clear definition to the job description of the WVC and implement it as a full time position with defined performance measures.
- That VBA identify a subject matter expert on gender specific claims as a resource person in each regional office location.
- That the WVC is utilized to identify training needs and coordinate workshops.
- That the WVC have a presence in the local VHA system**.**

- That VBA ensure that all Regional Offices display information on the services and assistance provided by the Women Veteran Coordinator with clear designation of her contact information and office location.
- That VBA establish a method to identify and track outcomes for all claims involving personal assault trauma, regardless of the resulting disability, such as PTSD, depression, or anxiety disorder.
- That VBA perform an analysis and publish the data on Military Sexual Trauma (MST) claims volume, the disparity in the claim ratings by gender, assess the consistency of how these claims are adjudicated, and determine if increased training and testing is needed in this regard**.**
- That all claim adjudicators who process claims for gender-specific conditions and claims involving personal assault trauma receive mandatory initial and regular on-going training necessary to be competent to evaluate such claims.
- That the VARO create an environment in which staff are sensitive to the needs of women veterans, and the environment meets the women's needs for privacy, safety, and emotional and physical comfort.
- That National Cemetery Administration enhances its targeted outreach efforts in those areas where burial benefits usage by women veterans does not reflect the women veterans' population. This may include collaboration with VBA and VHA in seeking means to proactively provide burial benefits information to women veterans, their spouses and children, and to funeral directors.

WOMEN VETERAN PROGRAM MANAGERS

Women Veteran advocates call for Congressional oversight and accountability during this congress. We are weary of hearing that the position of facility Women Veteran Program Managers would be full time positions, while in reality, after all this time, this isn't necessarily true. As a system wide directive the VA 2010, Handbook 1330.01, Health Care Services for Women Veterans defines the responsibilities of both the VA Veterans Integrated Service Network (Regional) Director and the Medical Center (VAMC) Director and its enforcement demands this attention. Additionally, both WVPM positions are further defined in the VA 2012, Handbook 1330.02 Women Veteran Program Managers.

MILITARY SEXUAL TRAUMA (MST)

Currently, instances of sexual assault in the military must be reported through the chain of command. The creation of a separate and independent office to address such crimes would remove barriers to reporting and provide additional protection and safety for the victims.

According to DoD Sexual Assault Prevention and Response Office (SAPRO), the majority of survivors of MST (71%) are under 24 years old and of lower ranks; whereas the majority of assailants (59.5%) are between 20 and 34 years old and of a higher rank than the survivor. Military groups are extremely small communities and when reports of assault must proceed through the chain of command, it is impossible to guarantee that confidential information will stay with those who have a 'need-to-know'. Additionally, survivors may fear that their own actions may be cause for punishment. The threat of retaliation or fear of being reprimanded is enough to silence many survivors or have them recant their stories. A defined system of checks and balances is needed to level the playing field. This office should also have a legal advisor on the team.

VVA will pursue legislation that reassigns complaints of military sexual trauma by service members and all alleged perpetrators outside of their immediate chain of command.

TRAVEL FOR VHA TREATMENT

The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. This Directive is not aligned with the military sexual trauma (MST) policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

In light of the limited intensive residential treatment programs within the VA that are both MST specific and gender specific, many women veterans, especially those who are homeless and/or have limited income have difficulty seeking and accessing programs that meet their clinical needs.

Vietnam Veterans of America calls on the Under Secretary for Health to review and reexamine existing VHA policy pertaining to the authorization of travel for veterans, who have been referred by their mental health clinician, to a MST-related

specialized inpatient intensive residential treatment programs outside the facilities/Regions where they are enrolled. Additionally, VVA calls for the provision of these travel funds whether the Veteran is an in-patient or an outpatient also that all medical center clinical staff are advised and fully understand the implementation of this policy.

WOMEN VETERANS STRATEGIC PLAN

The strategic plan FY2010-2014 and Addendum FY 2011-2015 stated that the goals and integrated objectives were to be implemented and analyzed with published outcomes of performance measures. However, not all programs that serve women veterans have specific performance measures that track the outcome of programs initiated to respond to the needs of women veterans.

Originally, in the Department of Veterans Affairs (VA) Strategic Plan for FY 2010-2014, the only objective that dealt with the women veterans directly was the Integrated Objective 2: Empower Women Veterans. The purpose of the objective is: Promote recognition of contributions of women, ensure VA programs are responsive to the needs of women veterans, and educate women about VA benefits and services.

The Vietnam Veterans of America will continue its advocacy for women veterans. We recommend the VA should collect, analyze and publish data by gender and minority status for every program that serves veterans to improve understanding, monitoring and oversight of programs that serve women veterans. The data collected must be measured and reported to ensure that the needs of women veterans are met.

IN CLOSING

Vietnam Veterans of America has as its' number one legislative priority the issue of accountability; accountability at every level of any agency, federal, state, or local, that impacts Veterans and their families. It is through this accountability that Vietnam Veterans of America hopes to improve the quality of care and life for all of our nation's Veterans.

VIETNAM VETERANS OF AMERICA

Funding Statement

April 21, 2015

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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KATE O'HARE-PALMER

Commissioned as an RN in the Army Nurse Corp in 1967 from Seal Beach, California. Served as an operating room nurse and emergency room nurse at 2nd Surgical Hospital and 312th Evacuation Hospital in Chu Lai, RVN 1968, and at the 2nd Surgical Hospital, Lai Khe, in 1969.

Worked in Bay area community hospitals in the operating room while attending college. Received Diploma Nursing Program, Los Angeles County Hospital. 1967. UC Berkeley 1974 with BSc. Nutrition. Certified Registered Dietitian 1975. Jin Shin Jyutsu Certification. 1997. Holistic Health modality and BA Music Education. Sonoma State University. 2004.

Worked at the San Francisco VA Medical Center for sixteen years in a variety of positions including: staff nurse, head nurse-medical/surgical, head nurse on Human Studies/Research unit, developed the Nutritional Support Team, Head nurse of out -patient clinics. Also worked as nursing supervisor at Kaiser Permanente Hospitals, VNA and Home Hospice and developed their 5 county Flu Shot Programs

Worked with Vet Connect, education committee, stand downs, grants writing, and coordinate some women veteran activities with California Department of Veteran Affairs. Women Veteran Committee Chair at California State Council for past 5 years. Also a member of the American Legion and AMVETS and joined VVA Chapter 223 in 1994.

Currently retired and live in Petaluma, CA with my daughters