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**STATEMENT OF
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FOR THE RECORD OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 15, 2022**

Chairman Takano, Ranking Member Bost and members of the Committee:

Thank you for holding this oversight hearing to examine women veterans' access to a full spectrum of medical care through the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA). We appreciate the opportunity to submit DAV's (Disabled American Veterans) views on this topic. Women veterans, like their male counterparts, deserve access to a full complement of health care and specialized services to meet their gender-specific needs. More women are serving in the military than ever before and likewise, more women are turning to VA care following military service to address post deployment readjustment challenges, injuries and illnesses. VA continues to make progress in addressing the needs of our nation's women veterans and, while we appreciate the important legislation passed in this Congress, much remains to be done.

As an organization, we have invested significant resources into exploring the unique needs of women veterans and advocating for improved services and programs for this population. While women remain a minority sub-population in terms of numbers when compared to male veterans using VA health services (550,000 women compared to almost 6 million men), they have high rates of service connection, use more care on average and are at high risk for homelessness, post-deployment mental health issues due to military sexual trauma (MST), and substance-use disorders. DAV commissioned a woman veteran-owned consulting group, Sigma Health Consulting, to produce two influential reports on the unique aspects of transition from military service for women veterans—*Women Veterans: The Long Journey Home*, in 2014, and *Women Veterans: The Journey Ahead*, in 2018. Our efforts with Sigma Health continue—and we are planning to publish a series of briefs to further explore VA's targeted services for women veterans in suicide prevention, programming and research into unique risks and protective factors for suicidal behavior as well as gender-specific screening and treatment for women veterans for mental health and substance use disorders.

We applaud Congress for the women veterans legislation enacted in the 117th Congress. Representative Underwood's Protecting MOMS Who Served Act (Public Law 117-69) will place long overdue attention on the maternal outcomes of women veterans, and improve maternity care coordination in VA. Chairwoman Brownley's bill, Making

Advances in Mammography and Medical Options for Veterans (MAMMO) Act (Public Law 117-135) will improve the quality and accessibility of mammograms and breast health options for women veterans using VA. Significant legislative gains were also made for veterans with toxic exposures, including women, with the enactment of the Honoring our PACT Act (Public Law 117-168) and the Dr. Kate Hendricks Thomas SERVICE Act (Public Law 117-133), which allow women who served in locations in which burn pits were used to request mammograms without regard to the usual screening protocols. These are all important gains, but implementation of these new laws will require a continued commitment in terms of resources and oversight to ensure congressional intent is realized and the promises to our nation's veterans fulfilled.

Despite these gains, there is more to be done. Environment of care in VA facilities, staffing and equipment are not always sufficient to address the comprehensive health care needs of women seeking care at VA. Like other health care organizations, VHA is struggling to attract and hire a sufficient number of high-quality women's health providers. In certain locations, VA's designated women's health providers may not treat enough women veterans to gain true expertise in women's health issues or have the expertise to meet more complicated gender-specific needs of women veterans.¹ According to VA's 2023 budget submission, about 84% of women veterans are assigned to Women's Health primary care providers. Assignment to these providers results in improved quality of care and satisfaction among women served. Lack of professional staffing, especially in clinical leadership positions impedes VHA's ability to staff Women's Health Clinics that have also demonstrated high rates of satisfaction in women's health care. To make up for staffing deficiencies, VA has developed special training programs, such as its mini-residencies for providers to gain expertise in women's health issues with focus specifically on training providers in rural health settings, to ensure clinical exposure to the gender-specific needs of women. VA has trained more than 5,500 primary care providers and 900 rural health providers through these programs since 2008.² Each VA medical center also has a Women Veterans Mental Health Champion and a virtual consultant group on reproductive mental health is available to all providers. These training programs and consultative resources must continue as VA addresses deficiencies in staff qualifications to meet women veterans' health care needs.

Women veterans are more likely to have to rely upon community care to address all or part of their gender-specific care needs, including breast health, gynecological care, maternity care, and even hormone replacement therapy for osteoarthritis because in some locations, VA does not have the appropriate equipment, or providers do not have sufficient caseload to maintain clinical expertise to address these needs. To ensure that women veterans' care does not become fragmented, VA has developed care coordinator roles and protocols in such areas as mammography, cervical care, IVF, and maternity care. However, with VA's increased use of community care in recent

¹ Department of Veterans Affairs. Office of Inspector General, Office of Healthcare Inspections (2017). Review of VHA Care and Privacy Standards for Women. Washington, DC. Report No. 15-03303-206.

² Department of Veterans Affairs. Budget Submission for FY 2023: Vol. 2. P. 312.

years, coordinators are increasingly stretched to fulfill their coordinating duties.³ VA reports that all VA medical centers have a part or full-time maternity care coordinator and most have a part or full time breast health and gynecologic care coordinator assigned.⁴ Unfortunately, many coordinators have collateral duties that impede their ability to fulfill their care coordination duties.

As VHA becomes more reliant on its community partners, it is critical to ensure these care coordinators are available to share results from diagnostic, radiologic or laboratory tests done in the private sector, schedule necessary follow up care, answer questions about clinical care and share information about resources VA may have available for women veterans that community providers may not be aware of. For example, women veterans who have received maternity care from community providers are eligible to receive breast pumps and other prosthetic items to meet post-natal care needs. Referrals to programming for women who are homeless, are LGBTQ+, or those with substance use disorders, exposures to military sexual trauma (MST), post-traumatic stress disorder (PTSD) or intimate partner violence are also often necessary for women veterans. VA is often the only resource available for this specialized supportive wraparound programming and information on trauma-informed care.

Because community care is an important part of many women veterans' health care delivery, it is also critical to ensure that community providers in VA's integrated network can provide similar quality of care and health outcomes to VA. A recent RAND report, however, calls that into question.⁵ Because many of VA's community care partners lack the informatics that VA medical centers have in tracking quality, it is unclear that health outcomes are similar. The RAND report also questions the readiness/expertise of private sector providers in treating veterans for veteran-specific conditions such as suicidal ideation, mental health conditions related to combat and/or MST such as PTSD or conditions potentially associated with toxic exposures. While VA has training modules for many, if not all, of these conditions, community providers are not mandated to complete this training. Some providers have stated that caseloads of veterans referred by VA are not substantial enough to warrant investing time into additional training.

Along with its care coordination, screening for conditions more likely to occur with women veterans is a hallmark of VA's whole health care model. VA recommends screening for suicidal ideation, substance use, depression, MST, PTSD, obesity, HIV/AIDS and high blood pressure for all veterans.⁶ Only by identifying these risks, can VA make effective individualized patient care plans that meet veterans' unique needs.

Congress has been responsive to the calls for addressing VA's deficiencies in environment of care standards, but sometimes VA fails to submit adequate survey data

³ Rasmussen, Petra and Carrie M. Farmer, *The Promise and Challenges of VA Community Care: Veterans' Issues in Focus*. Santa Monica, CA: RAND Corporation, 2022. <https://www.rand.org/pubs/perspectives/PEA1363-5.html>.

⁴ Department of Veterans Affairs. Budget Submission for FY 2023: Vol. 2. P. 312.

⁵ Rasmussen.

⁶ [Get Recommended Screening Tests and Immunizations - National Center for Health Promotion and Disease Prevention \(va.gov\)](#) accessed 9/8/2022.

to identify these deficiencies timely.⁷ Addressing deficiencies is important to ensure that women veterans' privacy is protected and that they feel welcome, safe and respected when they use VHA's resources. DAV has actively promoted the White Ribbon and anti-harassment campaigns in VHA. All veterans who want and need to use VA must be guaranteed a safe, welcoming, harassment-free environment at all VA facilities. Ultimately, it is the responsibility of each medical center director to ensure this right. While we are pleased with the work of the Veterans Experience Office there are indications that women do not believe clerical staff are always helpful or treat them with respect⁸—VA's Veterans Experience Office should continue its work to ensure that all frontline staff receive training in basic customer service and gain a better understanding of the roles of women who have served to address this issue.

Unfortunately, as is so often the case in VA, access to excellent programming is not universally available throughout the system—particularly in rural and other underserved communities and may not meet the needs of women of all ethnic and racial backgrounds or those who are LGBTQ+ equitably. In general, rural Americans are at risk of poorer health outcomes and women have greater risks of adverse maternity outcomes.⁹ Veterans in rural America are more likely to be older, service-disabled and reliant on VA health care than suburban and urban peers.¹⁰ Assuring adequate transportation options, including travel benefits, telehealth options and care coordination with community partners are particularly important issues for ensuring barriers to care are addressed for this population.

For minorities, Black women veterans with breast cancer die at significantly higher rates than non-Hispanic white peers.¹¹ Other data indicates Black women veterans have more circulatory and infectious disease than non-Hispanic white women peers.¹² Some research indicates that LGBTQ women veterans die from all causes at higher rates than heterosexual women peers.¹³ The reasons for these disparities are unclear, but more research is needed to understand and address them.

In addition to care coordination and a whole-veteran approach to care, research is another hallmark of VHA medicine and improved health care outcomes. Finding differences in veterans among the general US population would be virtually impossible, but within VHA, finding these distinctions, not only in comparison to non-veterans, but within distinct subpopulations of veterans, such as women, leads to rapid, invaluable

⁷ GAO (2016). VA Health Care: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans. Washington, DC. GAO-17-52.

⁸ [Chartbook for Healthcare for Veterans: National Healthcare Quality and Disparities Report \(ahrq.gov\)](#)

⁹ Lisonkova S, Haslam MD, Dahlgren L, Chen I, Synnes AR, Lim KI. Maternal morbidity and perinatal outcomes among women in rural versus urban areas. *CMAJ*. 2016 Dec 6;188(17-18):E456-E465. doi: 10.1503/cmaj.151382. Epub 2016 Sep 26. PMID: 27672220; PMCID: PMC5135522.

¹⁰ Office of Health Equity. Veterans Health Administration. Department of Veterans Affairs. ACCESS TO CARE AMONG RURAL VETERANS.

¹¹ [Chartbook for Healthcare for Veterans: National Healthcare Quality and Disparities Report \(ahrq.gov\)](#)

¹² Ward RE, Nguyen XT, Li Y, Lord EM, Lecky V, Song RJ, Casas JP, Cho K, Gaziano JM, Harrington KM, Whitbourne SB, On Behalf Of The VA Million Veteran Program. Racial and Ethnic Disparities in U.S. Veteran Health Characteristics. *Int J Environ Res Public Health*. 2021 Mar 2;18(5):2411. doi: 10.3390/ijerph18052411. PMID: 33801200; PMCID: PMC7967786.

¹³ [K.E. Lynch, B. Viernes, E. Gatsby, S.J. Knight, S.L. DuVall, J.R. Blosnich](#). All-Cause and Suicide Mortality Among Lesbian, Gay, and Bisexual Veterans Who Utilize Care through the Veterans Health Administration. First published: 20 August 2020 <https://doi.org/10.1111/1475-6773.13402>

bedside adaptations in health care policies, practices and protocols. Unfortunately, VA researchers indicate that it is often difficult to recruit a sufficient number of women into its research initiatives. In particular, the groundbreaking Million Veteran Program (MVP) is taking extra measures to recruit women veterans and have adequate representation to ensure findings are statistically significant for this population. More outreach and education must be done to recruit women into MVP and other VA research projects.

Equal access to VA's highly specialized care services to overcome physical or mental trauma experienced during military service is essential for recovery and regaining one's fullest potential. Veterans put their lives on the line to protect the freedoms we all enjoy as Americans. Sustaining a life changing injury or illness as a result of the dangers inherent to military service is traumatic. Veterans going through recovery need to know they are supported through specialized programs and health services that can help them achieve their goals for independent living and a meaningful life. For many veterans, that means choosing to start a family. VA has recently requested legislative authority to broaden its authority to provide IVF to certain veterans with grave disabilities that affect their ability to procreate. In accordance with DAV Resolution No. 328, we support a more inclusive benefit for IVF than that proposed by the Administration. While the VA's proposal would ensure more equity in the narrowly defined population eligible for IVF, it does not address certain service-connected conditions, such as PTSD, that may affect a veteran's ability to procreate. We agree that an IVF benefit must be available to any service-disabled veteran regardless of marital status. We support H.R. 1957, the Veterans Infertility Treatment Act, because we believe other military exposures such as burn pits and trauma can often affect fertility.

Even for the limited group now eligible for the IVF benefit, DAV is aware that veterans are often required to travel significant distances (sometimes beyond closer IVF providers due to cost) for complex care and services that may require daily or weekly visits. While there are often significant travel times involved with highly specialized care, VA must work with eligible veterans to ensure that there are reasonable travel times for any IVF benefit.

DAV understands that there are still significant issues in women's health that need to be addressed and therefore we are extremely pleased that the Committee has re-authorized the Women Veterans Task Force. The work being undertaken by the Task Force is critical and will benefit current and future generations of women veterans and hopefully ensure their access to a full complement of health services through the veterans health care system. We look forward to continuing our support of that work and addressing the many more important issues affecting women veterans.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions you or members of the Committee may have.