

Statement for the Record
Of
VIETNAM VETERANS OF AMERICA



Submitted by

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Chair, Women Veterans Committee

Before the

House Veterans' Affairs Committee
Subcommittee on Health

Regarding

Cultural Barriers Impacting
Women Veterans' Access to Healthcare

May 2, 2019

Good morning, Madam Chairwoman Brownley, Ranking Member Dunn and distinguished members of the Subcommittee on Health. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record regarding “Cultural Barriers Impacting Women Veterans’ Access to Healthcare.”

“By March 1973 and the withdrawal of US troops and the remaining WACs, an estimated four million people had died in the Vietnam War. For most returning veterans there was no welcome home. Being heckled and spat on at the airport was the beginning of their private aftermath. Women, especially, learned to keep silent about being in 'Nam. Many just tried to get on with life, careers and families, burying their inward and outwards scars, shame or pride, horror or honor, all mixed up with memories of friendships forged and loves found. Many have died without daring to reveal they served in Vietnam. All believe it changed their lives, for better or worse, but certainly forever.” -- *The Women Who Served in Vietnam BBC 2016*

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 (VA) 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

VA-eligible women veterans are entitled to complete health care including care for gender-specific illnesses, injuries and diseases. The VA 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. What would be routine primary care in the community is referred out to specialty clinics in the VA. Over the last five years the percent 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; the age of a

Vietnam woman veteran is 72.

VVA will continue its advocacy to secure appropriate facilities and resources for the diagnosis, care and treatment of women veterans at all VA hospitals, clinics, and Vet Centers. We ask the VA Secretary ensure senior leadership at all facilities and all regional directors be held accountable for ensuring women veterans receive appropriate care in an appropriate environment. Further, we seek that the Secretary ensure:

- 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 an environment is created 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 differences in the quality of care;
- That general mental health care providers are located within the women's and primary care clinics to facilitate the delivery of mental health services;
- Ensure that sexual trauma care is readily available to all veterans;
- Provide support services for women veterans seeking legal assistance;
- Require VA to report on availability of prosthetics for women;
- 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;
- 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 their needs;
- That all Community-Based Outpatient Clinics (CBOCs) which do not provide gender-specific care arrange for such care through VA outsourcing or contract in compliance with established access standards;
- That 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, Assistant Secretary for Operations and Management, the VISN directors, regional directors, facility directors, and providers;
- That legislation be enacted to ensure neonatal care is provided for up to 30 days as needed for the newborns of women veterans receiving maternity/delivery care through the VA;
- That H.R. 840, the Veterans Access to Child Care Act, introduced by Congresswoman Brownley, is enacted into law.

HOMELESS WOMEN VETERANS

Over the past several decades, we have become increasingly more vested in the recognition of the situation of homelessness among veterans. VVA well remembers the time when the VA acknowledged that as many as 275,000 veterans were homeless on any given night. Currently the VA cites that the number of homeless veterans has been reduced to 37,878 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 snapshot: it is impossible to have on record all 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 Accountability 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 vets:

- They are not aware of the opportunities available to them;
- 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;
- Some 24 percent of VA Medical Center homeless coordinators indicated they have no referral plans or processes in place for temporarily housing homeless women while they await placement in HUD-VASH and GPD programs;
- Nearly two-thirds of VA HGPD programs are not capable of housing women with children;
- The expense of housing women with children is a disincentive for providers.

VVA believes that the VA’s “plan” to end homelessness among veterans is quite ambiguous, and that it needs to address several key 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 these needs? 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 veterans program. The influx of women in the military – one of every ten soldiers *-serving* in Iraq is a woman – the female homeless population will only grow, making the need for additional facilities dedicated to women.

WOMEN VETERANS RESEARCH

Because women veterans have historically been a small percentage of the veteran population, many issues specific to them 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 12% of the veteran population by 2020 and 15% by 2025.

Vietnam Veterans of America asks the Secretary to conduct several studies specific to women 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 VA for women;
- 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;
- 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

VVA requests that any proposed legislation should include language to increase the time for 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. If the infant must have extended hospitalization, it would allow time for the case manager to make the necessary arrangements for necessary medical and social services assistance for the woman and her child. This has important implications for our rural women in particular. And there needs to be consideration given for a veteran's service-connected disabilities, including toxic exposures and mental health issues, especially during the pre-natal period, or in cases of multiple births or 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.

VVA asks the Secretary to ensure:

- That leadership in all VA Regional Offices is cognizant of and kept current on women veterans' issues; that they provide and conduct aggressive and pro-active outreach activities to women vets; and that VBA leadership ensures oversight of these activities;
- That a national structure be developed within VBA for the Women Veteran Coordinator (WVC) positions at each VARO;
- That VBA establish consistent standards for the time allocated to the position of WVC based on the number of women veterans in the VARO's catchment area;
- 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 are needed;
- That all claims 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 women's needs for privacy, safety, and emotional and physical comfort;
- That the 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 2017 Handbook 1330.01, Health Care Services for Women Veterans, defines the responsibilities of both the VISN and VAMC directors. Additionally, both WVPM positions are further defined in the VA 2018, 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 victims.

According to the DoD Sexual Assault Prevention and Response Office (SAPRO), 71% of survivors of MST are under 24 years old and of lower rank; whereas just under 60% of assailants are between 20 and 34 years old and of a higher rank. 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.

VVA is aware that this issue is outside the purview of the House Veterans' Affairs Committee. However, VVA would urge members who sit on the House Armed Services Committee to join your colleagues in pursuing legislation that reassigns MST complaints by service members and all alleged perpetrators outside of their immediate chain of command.

Suicide Risk

Suicide has become a major issue for the military over the last decade. Most research by the Pentagon and the Veterans Affairs Department has focused on men, who number more than 90% of the nation's 22 million former troops. Little has been known about female veteran suicide until recently. According to an *LA Times* article in July 2016, the suicide rates are highest among young female veterans -- for women ages 18 to 29, veterans kill themselves at nearly 12 times the rate of non-veteran women. And, according to the *Times*, among the cohort of nearly 174,000 veteran suicides in 21 states between 2000 and 2010, the suicide rate of female vets closely approximates that of their male counterparts -- women vets 28.7 per 100,000 vs 32.1 per 100,000 male vets.

VVA would like to thank Congresswoman Brownley for her hard work and dedication to women veterans, and we thank this subcommittee for the opportunity to submit our views for the record.

IN CLOSING

More than 250,000 women served during the Vietnam era worldwide; eight women are listed on the Vietnam Veterans Memorial here in our nation's Capitol. The Angels on the Wall listed below served with honor and made the ultimate sacrifice. Please remember them and all the women who served during the Vietnam War.

- 1st Lt. Sharon Ann Lane
- 2nd Lt. Pamela Dorothy Donovan
- Col. Annie Ruth Graham
- Mary Therese Klinker
- 2nd Lt. Carol Ann Elizabeth Drazba
- 2nd Lt. Elizabeth Ann Jones
- Eleanor Grace Alexander
- 1st Lt. Hedwig Diane Orlowski

VIETNAM VETERANS OF AMERICA

Funding Statement

May 2, 2019

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 Corps 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 and currently serves as the Chair of VVA Women Veterans Committee.

Currently retired and lives in Petaluma, CA.