National Service & Legislative Headquarters
807 Maine Avenue SW
Washington, DC 20024-2410
Phone: 202-554-3501
Fax: 202-554-3581

***STATEMENT OF***
***ASHLEIGH A. BYRNES***
***DEPUTY NATIONAL COMMUNICATIONS DIRECTOR***
***BEFORE THE***
***COMMITTEE ON VETERANS' AFFAIRS***
***SUBCOMMITTEE ON HEALTH***
***UNITED STATES HOUSE OF REPRESENTATIVES***
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Chairwoman Brownley, Ranking Member Bergman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's hearing on "Beyond Deborah Sampson: Improving Healthcare for America's Women Veterans in the 117th Congress." DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. As an organization, we are committed to ensuring women veterans have equitable access to VA benefits, health care and the specialized programs and supportive services developed for readjustment and recovery of our nation's ill and injured veterans.

Madam Chairwoman, while we recognize the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has evolved over time to meet the needs of its increasingly diverse patient population, it is well recognized that gaps remain in access, usage rates and health outcomes among women and other minority veteran populations. This includes racial, ethnic, sexual orientation and gender identity minorities—as well as the intersections of those groups—underscoring the need for continued focus on the causes of such disparate rates and implementation of practices and policies to improve them.

DAV has prioritized women veterans' issues, voicing the need to ensure that VA is not only a safe and welcoming place for this population, but that it also adapts its programs, services and policies to meet their unique needs. We have seen significant progress over the past several years, with much emphasis on the subject by this subcommittee, the full House Veterans' Affairs Committee and their respective leadership, to include the creation and subsequent work of the Women Veterans Task Force and passage of the comprehensive provisions included in the Deborah Sampson Act during the previous Congress.

We must push for timely implementation of this critical legislation and closely monitor progress as these provisions take effect. And while DAV is grateful for this continued momentum and though we look forward to the significant changes we believe

will come as a result of the Deborah Sampson Act provisions, we know that our work here is far from done and many significant issues remain.

**Residential Treatment Programs and Alcohol Use Intervention**

An estimated one in four women veterans accessing VA health care engages in unhealthy alcohol use. For nearly two decades, VA has conducted annual alcohol screenings for veteran outpatients and implements brief interventions for many of those individuals who screen positive for unhealthy alcohol use. A 2020 VA study shows roughly 60% of the overall number of women veterans who screen positive for alcohol use risk receive brief intervention from VA—a significant improvement over the past ten years. However, only 34% of those who screen positive at lower risk levels are offered brief intervention to address this issue. And unfortunately, women veterans who screen positive and also have more complex medical needs are not being offered brief intervention at any more significant rate than their peers with fewer medical issues.[1]

Women veterans face a unique set of challenges associated with their military service that elevates their risk for developing SUDs, including post-traumatic stress disorder (PTSD), often due to military sexual trauma (MST). Women who identify as LGBTQ also have an increased risk of developing SUDs; in fact, the National Survey on Drug Use and Health showed bisexual veterans reported greater lifetime odds of having misused prescription opioids compared to heterosexual peers, with bisexual women veterans reporting elevated risk past 12-months of misuse.[2]

SUDs are associated with family instability, decreased worker productivity and declining health, and increased risk for suicidal behavior in veterans, especially in women. Women's bodies also respond differently to substance use and withdrawal, and their reasons for both using substances and stopping or reducing their substance use may be different than those of men. Understanding these differences is important to providing effective care. Additionally, while access to more tailored care is necessary for improving screening and SUD services for women veterans, it is critical that VA ensures safe and private therapeutic settings conducive to their recovery. Women are shown to be more likely than male veterans or non-veteran women to have co-occurring psychiatric and medical impairments, in many instances linked to history of sexual trauma or domestic violence.

Though VA reports the number of women veterans entering treatment programs is on the rise, they are still less likely to be treated for SUDs than male counterparts. We believe providing a robust array of SUD treatment services and enhancing prevention and early intervention efforts is crucial to addressing this growing issue, especially among the newest generation of women veterans coming to VA for care.

These complex problems are best addressed by a system like VA that offers a comprehensive set of services including routine preventative and motivational

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[1] https://www.sciencedirect.com/science/article/abs/pii/S0740547220305146
[2] https://www.sciencedirect.com/science/article/abs/pii/S037687161930571X

screenings along with brief interventions, primary care, specialized mental health and rehabilitation programs for treating addiction and co-occurring disorders like PTSD, evidence-based treatments, peer support and a number of other supportive services for veterans. However, VA needs to dedicate more resources for gender-tailored substance use disorder treatment programs for women veterans and make them more accessible.

With these considerations in mind, DAV supports H.R. 344, the Women Veterans Transitional Residence Utilizing Support and Treatment—or TRUST—Act, which would require the VA Secretary to conduct a nationwide study of the need for women-specific programs to treat and rehabilitate women veterans with drug and alcohol dependency. Following that analysis, the Secretary would be required to select at least three VA networks to carry out a pilot program to treat and rehabilitate women veterans with drug and alcohol dependency. We recommend the Subcommittee advance this legislation to increase understanding of the unique needs and preferences of women veterans, as well as to identify best practices specific to this population when treating SUDs.

## Women Veterans Health Coordinators

As VA works to assess changing needs and improve the availability of health services specific to women veterans within its own facilities, continuity of care is essential particularly for women who are often compelled to use community-based care. The usage of sex-specific care services in VA's community network heightens the need for the Department to complete the modernization of electronic health records in order to facilitate efficient and effective communication between VA and outside providers, without placing the burden to transfer information on the veteran themselves. Until this process is complete, VA must have dedicated women veterans coordinators for women-specific issues, especially at sites that are unable to offer in-house services for basic gynecological care and mammography as well as specialized reproductive health services including maternity care, in-vitro fertilization (IVF) and other assistive reproductive technologies (ART).

Providing high-quality, coordinated maternity care is an integral part of comprehensive care for women veterans as demand continues to increase. Many women who use VA health care have conditions that put them at higher risk for adverse birth and health outcomes, including advanced age, physical disabilities, and mental health conditions to include PTSD, depression, anxiety and substance abuse. While VA's maternity care coordination has proven highly effective in some areas, according to VA's 2018 WATCH Report, only 11% of VA facilities have a dedicated full-time maternity care coordinator, and in many facilities, this role is assigned as an ancillary duty.

This coordination is especially important for women veterans with high-risk pregnancies, comorbid conditions and for pregnant women living in rural communities who often have poorer physical health than urban counterparts and a shortage of local providers. Maternity care coordination programs are linked to improved health outcomes

both for mother and baby as well as decreased medical costs in the first 60 days after birth, particularly among those with chronic or pregnancy-related physical and or mental health conditions and social vulnerabilities. However, a 2019 study found that nearly one-third of women veterans at VA reported problems accessing early prenatal care as soon as they would have liked, this includes women with histories of depression as well as some racial minorities.[3]

To this end, DAV recommends further investment in and implementation of maternity care coordination programs and offer our support for H.R. 958—the Protecting Moms Who Served Act. This legislation would codify maternity care programs within VA by requiring training and support for community providers specific to the needs of pregnant women veterans, authorize additional funding for the maternity care coordination program and require a GAO (Government Accountability Office) report on maternal mortality and maternal morbidity among women veterans, placing emphasis on racial and ethnic disparities in veterans' maternal health outcomes.

## Caring for Sexual Trauma Survivors

Due to the high prevalence of histories of trauma among women veterans, it is imperative for VA staff and its community care network partners to adopt trauma-informed care practices. These practices are founded on the principles of safety, choice, collaboration, trustworthiness and empowerment and involve the support of all staff in providing an atmosphere that is welcoming and ensures adequate privacy; informs patients of their rights; works with patients to develop mutually agreeable treatment plans; and ensures that respectful and professional boundaries are maintained between the staff and patients. Though VA and DoD have developed a clinical practice guideline concerning trauma informed care, it is unclear how this is implemented in practice and we believe VA still has work to do in ensuring its providers adhere to this guidance in delivering care.

Stranger harassment remains a significant problem in VA facilities causing women veterans—especially those who are younger, more likely to come from minority groups or have been exposed to military sexual trauma—to delay or forego needed care. Improvements in the privacy provided within VA patient care environments is another area that must be addressed for women to feel safe and respected. Even simple gestures such as adjusting speaking tone and volume, explaining procedures as you go to avoid startle responses or avoiding environments that make patients feel trapped or exposed can build trust and help patients feel valued and create therapeutic environments that are conducive to recovery.

## Improving Access to IVF and ART

Veterans' eligibility for IVF treatment remains extremely limited. Only veterans with service-connected injuries affecting their ability to procreate are eligible, and then

[3] https://www.sciencedirect.com/science/article/abs/pii/S1049386718302998

they must be legally married to an opposite sex partner who can produce their own genetic material. The small numbers of applicants for this benefit reflect these overly exclusive criteria, which omit many veterans who do not meet the criteria for social reasons (lack of an opposite sex spouse) or because their infertility may be caused by a condition that could be related to their service (such as post-traumatic stress disorder or conditions associated with toxic exposures) that are not addressed in regulations.

Whether reproductive issues arise due to injury or illness, stress, toxic exposure or other inexplicable factors, the impact on individuals unable to start a family can be devastating. We need to better understand these links to reproduction and DAV recommends further research into infertility of unknown origin.

While we will no doubt learn more about infertility among women veterans from the study authorized by the Deborah Sampson Act—to include the availability and need for services, as well as challenges accessing them—waiting for this or other studies does little to assist veterans who would like to access these services. This remains particularly true among those veterans who rely solely on VA for their health care and are financially unable to seek out ART on an out-of-pocket basis, and those excluded by discriminatory policies.

While more current research is needed, a 2015 study showed that female OEF/OIF veterans who had infertility diagnoses were more likely to be young, obese, and African American or Hispanic. Compared with women VA users without infertility diagnoses, those with infertility diagnoses were younger, obese, black, or Hispanic, had a service-connected disability rating, a positive screen for military sexual trauma, and a mental health diagnosis.[4] Additionally, a 2019 study of VA patients found that racial minority women veterans were more likely than white veterans to self-report infertility (24% vs 18%), but only 40% of racial minority veterans who were evaluated for infertility reported being treated for infertility compared with 73% of white veterans.[5]

This same study found racial minority veterans were more likely to have received all of their health care from VA and were less likely to have access to private health insurance. Additionally, while many white and minority women veterans cited medical or social reasons for not accessing reproductive care, more than twice as many racial minority participants cited a lack of awareness that evaluation and treatment were available to them.

We are pleased that some Members, including the Chairwoman, have expressed interest in broadening the eligibility for ART, including IVF, as many veterans who have or may have service-connected conditions are ineligible under the current criteria. DAV supports broadening the eligibility to include any service-connected disabled veteran who requires these services, to include veterans with an infertility diagnosis of unknown etiology or conditions that affect fertility that may be due to service-connected toxic exposures or mental health conditions like PTSD.

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4410265/

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6909692/

## Ensuring Health Equity for Women and Minority Veterans

In 2020, the Agency for Healthcare Research and Quality released its Chartbook on Healthcare for Veterans. While the data shows that by and large veterans using VA are reporting better or similar care than non-veterans, this does not necessarily hold true among women veterans.[6] One VA study found different levels of satisfaction between men and women veterans within racial and ethnic groups across several areas. Compared to black male veterans, black women veterans expressed less satisfaction with pharmacy services and specialist care. White women veterans expressed lower satisfaction with outpatient care, respect and costs than white male veterans.[7]

According to the report, fewer women veterans—across all age groups—report very good or excellent health than non-veteran women. Women veterans also report higher rates of smoking, chronic pain and not being rested. Among women veterans aged 18-64, rates of hypertension were higher, as were high cholesterol, heart disease and arthritis. For those aged 65-79, they were less likely to have high cholesterol, heart disease, diabetes and cancer, but more likely to have arthritis and asthma.[8]

For women veterans using VA care, the data indicates women veterans have distinct health-related experiences and concerns when compared to their male counterparts. This includes lower scores by women veterans for quality and access to care across 39% of measures compared to male VHA users. These outcomes include important measures such as timely access to routine or preventive care with a primary care provider, ease of contacting a care provider by phone, receipt of follow up after diagnostic measures and the ability to receive needed care during non-business hours. Interestingly, women veterans had better mortality rates than men on 80% of measures including colorectal cancer, HIV and suicide. Racial gaps also exist, according to the report, showing Hispanic veterans report worse quality and access to care on 39% of measures than non-Hispanic white VHA users. A 2020 study noted that women veterans of OIF/OEF receiving VA health care in Puerto Rico showed higher occurrences of physical illness and depression, and utilized VA health care services at higher rates than U.S. counterparts.[9]

VA is currently working to enhance its efforts including minority veteran populations to include racial, ethnic and gender minorities, in its research programs, which includes recent announcements to introduce genomic testing tools as part of the Million Veteran Program (MVP) to better understand how genetic variants impact health. VA has also made a public push to encourage women veterans to take part in the

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[6] https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/veterans/2020qdr-chartbook-veterans.pdf

[7] https://www.ncbi.nlm.nih.gov/pubmed/29313226

[8] https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/veterans/2020qdr-chartbook-veterans.pdf p. 28.

[9] https://www.sciencedirect.com/science/article/abs/pii/S1049386719304803

program as participation has been lower than desired. For women veterans, MVP is focused on researching genetic and clinic markers to help predict risk for breast cancer among women veterans, as well as diseases that disproportionately affect women veterans like depression, heart disease, hypertension and osteoarthritis, among others. DAV believes research like this is critical to identify the best strategies to tailor health care in ways that are both clinically effective and culturally aware.

Sexual orientation and gender identity matter in health care. In addition to gender, ethnic and racial minority groups within the overall veteran population, there are an estimated one million lesbian, gay and bisexual veterans in the United States, and VA reports roughly 9,000 transgender veterans have accessed VA for health care. DAV believes every veteran who has honorably served this nation is entitled to safe, welcoming and dignified care that meets their individual needs. We are pleased to see that VA Secretary McDonough has prioritized this goal, initiating important steps to reform the culture within VA to help promote inclusiveness and equity in care across the organization.

VA acknowledges that women veterans who identify as LGBTQ have more chronic health conditions and report worse health compared to heterosexual women veterans and non-veterans, and that ethnic and sexual minority women veterans experience higher levels of distress than white sexual minority women. Current studies are also reviewing health outcomes of transgender veterans. Preliminary data suggests they are more likely to commit suicide—suicide is the fourth leading cause of death among transgender veterans compared with the tenth leading cause of death for non-transgender veterans.[10]

However, a 2020 GAO[11] report showed VA lacks a standardized approach to collecting sexual orientation or gender identity data among veterans, potentially leaving critical gaps in patients' medical history that could better inform providers and help them identify and address unique health disparities.

According to VA, the LGBTQ Data Collection Subcommittee of the VHA Diversity & Inclusion Committee has been established and is working to address this issue. We support this effort and believe it is of the utmost importance for VA to begin implementing a mechanism for veterans to personally and securely enter information regarding their sexual orientation and gender identity as soon as possible, as well as self-reporting options for gender, race and ethnicity. It is imperative that VA's files allow for extraction of data capturing cross-sections of the veteran population in order to make appropriate medical decisions and determine if these populations are getting fair treatment as well as equitable access to programs, services and benefits.

[10] https://www.hsrd.research.va.gov/publications/inprogress/aug19/default.cfm?InProgressMenu=aug19-2

[11] https://www.gao.gov/assets/gao-21-69.pdf

## Conclusion

As the population of women and minority veterans grows and their access to VA services and benefits increases, VA needs to anticipate and address known challenges, disparities in care and barriers to accessing services.

Passage of the provisions included in the Deborah Sampson Act and its implementation moving forward represent a significant victory in our fight to close the gaps that exist for the women who have served this nation. Now, we must continue to focus the lens on those disparities that remain and use this momentum to ensure we are serving women veterans effectively with the programs and services that best meet their needs.

Madam Chairwoman, in closing, General Ann Dunwoody is quoted as saying, “The most important element is trust. Without trust in each other and trust in the institution, you will not be able to realize your vision.” It is encouraging that we are all working together here in earnest to realize this great vision: to ensure that the VA is an institution that women and minority veterans have faith in; an institution that earns that trust; and an institution that prioritizes their needs now and in the future.

This concludes my testimony and I am happy to answer any questions the Subcommittee may have.