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STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
WOMEN VETERANS TASK FORCE
UNITED STATES HOUSE OF REPRESENTATIVES
DECEMBER 9, 2020

Chairwoman Brownley and Members of the Women Veterans Task Force:

Thank you for inviting DAV (Disabled American Veterans) to participate in the Roundtable discussion on the 2020 Report of the Department of Veterans Affairs (VA) Advisory Committee on Women Veterans (ACWV or Advisory Committee).

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, DAV has had a long-standing commitment to addressing the health consequences of military service that service-disabled veterans face. We have also focused our efforts on 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. In this statement, we are pleased to offer our views on the recommendations and activities of the VA Advisory Committee on Women Veterans under consideration by the Women Veterans Task Force.

Madame Chair, first I want to thank the Task Force for the significant contribution it has made during the past two years to better understand the needs of women veterans and to improve VA programs and services on their behalf. As you are aware, while progress has been made—there is still much work to do to ensure women veterans have equal access to health care and the unique readjustment programs and services VA offers. For these reasons, DAV is pleased that the Task Force will continue its work in the 117th Congress.

We also want to acknowledge and thank the members of the VA Advisory Committee on Women Veterans for their thoughtful and deliberative work and the well-reasoned recommendations they have proposed for many years. By serving as the eyes and ears of our nation's women veterans, this Committee contributes greatly to our ability to understand the impact of military service on women who serve, their transition and health care needs, VA programmatic assets and deficiencies along with recommendations to improve and tailor services to better meet their unique needs. As

such, we appreciate that the Task Force is highlighting their important work and recommendations.

DAV is similarly impressed with the significant amount of data the Advisory Committee collected from its site visits—the most recent of which occurred in April 2019, in Durham, North Carolina and other VISN 6 VA facilities. These site visits clearly allow the Advisory Committee to see first-hand the important programs in place for women veterans and to meet with Women Veteran Program Managers, other staff and women veterans to learn about challenges and accomplishments that may help identify trends throughout VA. The site visit to VISN 6 highlighted the significant growth in women veterans treated by VA and the challenges the VA has had in keeping up with demand for care even as it has created and expanded many specialized programs focused on women veterans' needs.

The 2020 Report of the VA Advisory Committee on Women Veterans included ten recommendations to address emerging issues affecting women veterans. We have included comments on each recommendation.

Recommendation 1: *That the Department of Veterans Affairs (VA) support legislation to provide academic "break pay" for women Veterans utilizing their GI Bill education benefits.* **VA Response: Non-concur.**

The Advisory Committee noted that under the current post-9/11 GI Bill education benefit, a veteran must be enrolled year-round to receive benefits that cover expenses such as housing, and that the benefit stops during academic breaks causing undue hardship on women veterans. The ACWV argued that women veterans are often primary caregivers to their families and proportionately disadvantaged compared to their male veteran-peers because of higher enrollment rates and greater numbers of women veterans who are unemployed and enrolled in school compared to their non-veteran women peers. Additionally, the Advisory Committee proposed supporting legislation that would provide break pay to relieve the financial burden and stress of trying to find employment during academic breaks to improve women veterans' access to education benefits and to promote financial stability.

VA did not concur with this recommendation and argued that students issued payments during academic break periods may be unable to complete their educational program due to the early exhaustion of their entitlement, given the current requirements to charge a veteran according to their training time. While DAV has no specific resolution related to break pay, we understand that this issue is often a key concern for student veterans. However, we believe any changes to the program should be gender neutral—applying to both male and female student veterans.

Recommendation 2: *That the Veterans Benefits Administration's (VBA) Education Service collaborates with the Veterans Experience Office to examine barriers that exist for women Veterans, in relation to accessing education benefits across all formats*

(traditional/online/hybrid academic environments), enrollment in academic programs and continuation of higher education. **VA Response: Concur.**

We are pleased that VBA and the Veterans Experience Office (VEO) are collaborating to study existing barriers for women veterans seeking higher levels of education/certification through a new survey tool—Vsignals. The women veteran's focus groups established to map the patient experience and satisfaction rates of women using VA care has helped VA to better understand the overall experience of women and to make appropriate adjustments in care and delivery of services. We agree this new tool, developed to gauge the overall experience and satisfaction of women veterans (in various age groups) trying to access their education benefits, could also be beneficial to help VA identify existing barriers for women specifically and improve the administration and oversight of education program services based on specific customer feedback.

Recommendation 3: *That VBA modernize the Women Veteran Coordinator (WVC) position, by establishing it as a duty with measurable position standards.* VA **Response: Concur-in-Principle.**

The Advisory Committee notes**,** that while there are basic duties outlined for WVCs in a VBA procedures reference document, it does not suggest the amount of time that coordinators should be allotted to carry out duties. Likewise, there are no established guidelines for measuring their performance and overall success. DAV concurs that establishing recommended minimum time allotments that should be dedicated to carrying out the WVC duties (based on the number of women veterans in their respective catchment area) along with measurable performance standards for this collateral duty position would help better define this role and clarify the responsibilities associated with the position. We look forward to VA's update on capturing and analyzing relevant data to better assess WVC outreach efforts.

Recommendation 4a: *That VA form a working group to recommend names for VA undedicated facilities to honor women Veterans, and that for all new facilities women Veterans names be considered.* **VA Response: Non-concur.**

Recommendation 4b: *That VA support legislation that promotes the renaming of VA facilities to honor women who have made significant contributions to military service, to recognize the impact of women who serve and to promote inclusiveness and cultural transformation.* **VA Response: Concur-in-principle.**

Recommendation 4c: *That VA support H.R. 1925 to designate the Manhattan Campus of the New York Harbor Health Care System of the Department of Veterans Affairs as the "Margaret Cochran Corbin Campus of the New York Harbor Health Care System."* **VA Response: Concur-in-principle.**

For the above noted recommendations, VA restates the scope of the ACWV and finds that, "inclusionary branding of and recommending names for undedicated VA facilities does not fall within the scope of [the Advisory Committee's] statutory purpose."

The Department comments that while it agrees in concept with the recommendation that calls for VA to support legislation that promotes the renaming of VA facilities to honor the service of women who have made significant contributions in military service, it has limited naming authority for its medical centers, regional offices and cemeteries. VA further states that only Congress has the authority to name a federal property after an individual veteran based on existing statute, title 38, United States Code, § 531.

While DAV has no specific resolution related to these recommendations, the ACWV has made a compelling argument and we urge Congress and VA to work together to ensure that women veterans who have made significant contributions in military service are recognized and considered when naming a VA facility.

Recommendation 5: *That the Veterans Health Administration (VHA) incentivize VA health care providers to become designated women's health providers (DWHP), to improve access to care for women Veterans.* **VA Response: Non-concur**

VHA has made progress in filling gaps in the overall distribution of these essential personnel through its mini-residency training program for DWHPs. However, VA still has some health care facilities that lack these key providers for various reasons. VA points to reasons other than training that may account for the service gaps, but does not refute the underlying assumption that there are such gaps. It seems incongruent for VA to disagree that improving the supply of knowledgeable providers would improve women's access to care when not all VA facilities have a DWHP. In a report from the Office of Inspector General, VHA was not able to document how more than half of its DWHPs met existing guidance for experience with women's health issues and their panel sizes were smaller than VA recommended.[1] We are pleased to learn that VA is using some of the $50 million in designated funding for FY 2021 for Women's health programming—and plans to hire key personnel needed to ensure there is a full Patient Aligned Care Team in Women's clinics.

Women Veterans Program Managers are also essential to ensuring access to services and benefits for women veterans. In 2018, the ACWV made the recommendation: *VA should examine the current utilization of women Veterans program managers (WVPMs) across the enterprise, to ensure that they are functioning in the role as defined in the position description*. **VA Response**: **Concur-in-principle**.

WVPMs are often the gateway between women veterans and necessary care and yet, DAV is aware that even though VA is required to have a full-time designated program manager at all VA medical facilities (in accordance with VHA Directive 1330.02, Women Veterans Program Manager),[2] a few VA medical centers do not and others rely on interim or part-time program managers. VA must ensure that every network and medical center has a program manager assigned to fulfill the duties, for the specified time allocations, of these essential positions as well as an established

[1] U.S. 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] file:///C:/Users/se01/Downloads/1330_02_D_2018-08-10.pdf accessed Nov. 30, 2020

alternate to cover required duties during routine sick time, vacation days and family medical leave periods.

Recommendation 6: *That VHA establish a national strategic plan for breast imaging services that covers the evolving needs of women Veterans.* **VA Response: Concur**

While VA continues to make progress toward this goal and currently offers on-site mammography services at 64 of its health care systems, a needs assessment would help VA plan, prioritize and distribute resources to locations with high demand that lack them. VA recently announced the creation of a National Women's Veterans Oncology System of Excellence that will bring VA, the National Cancer Institute, Duke University and Baylor University together to provide women veterans access to state-of-the-art cancer care and clinical trials. We are excited about this new partnership and the opportunity it will provide women veterans to receive expert oncological care services.

Looking at other opportunities to improve breast health for women veterans, DAV recommends that VA ensure there are mammography coordinators to adequately address demand at all women's health clinics. These coordinators are responsible for assisting women veterans in scheduling mammography services, communicating with community partners to ensure diagnostic findings are recorded in the VA's electronic health record and coordinating necessary follow-up care for patients.

In its 2018 Report, the ACWM also recommended: *VA examine and document occupational and other hazardous exposures women Veterans encounter during their military service.* **VA Response: concur**. While VHA concurred with this recommendation, we believe it could be more aggressive in raising awareness among women veterans about participating in VA research and health registries, and about current study findings and possible health conditions that may be associated with specific hazardous exposures.

The 1991 Gulf War was the first major military deployment where female troops were integrated into almost every military unit, except for combat ground units. VA's War Related Illness and Injury Study Center (WRIISC), part of VA's Post Deployment Health Services, was established as a national program dedicated to veterans' post-deployment health concerns and unique health care needs.

While this group has been working closely with the military and VA research on post-deployment health issues, research often lags—sometimes years—before health consequences can be accurately identified and assessed. For example, VA is still monitoring and identifying the potential long-term health impact of certain toxic exposures including: depleted uranium, biochemical weaponry, vaccinations, pesticides, and toxins emitted from burn pits. VA presumptively recognizes medically unexplained illnesses referred to as Gulf War Syndrome as associated with military service in the Southwest Asia theater of military operations.

All Gulf War veterans, including those from Operation Iraqi Freedom and Operation New Dawn may voluntarily participate in appropriate health registries including the Gulf War Registry, in addition to those for more specific exposures such as burn pits, depleted uranium, and toxic embedded fragments. The purpose of these registries is to share information including emerging research and determinations about associations between specific exposures and health conditions. Certain cohorts have already been studied extensively. For example, the Follow-up Study of a National Cohort of Gulf War and Gulf Era Veterans is the third in a series of surveys that examines the health of veterans who deployed to the Gulf War in 1990-1991 and veterans who served elsewhere during the same period. Approximately 30,000 veterans were invited to participate in the initial survey in 1995 and a second survey in 2005. A third survey began in 2012.

VA researchers have begun exploring the gender-specific effects of exposure to environmental toxins on women veterans and several interesting findings on women deployed to the Gulf have emerged from these longitudinal studies. For example, a 2019 study found that Gulf War era women veterans, regardless of deployment, reported lower health status than male peers. Women who served in the Gulf also reported poorer health than men who served. Both era and deployed Gulf women veterans reported greater prevalence of migraine, hypertension, major depressive disorder, arthritis and dermatitis.[3] Another study found that women Gulf veterans also reported more miscarriages than era veterans who did not deploy to the Gulf respective controls, although these reports were not considered to be statistically significant. Both men and women deployed to the Gulf theater of operations reported significant excesses of birth defects among their live-born infants. Research participants also reported their live-born infants were also more likely to have "moderate to severe" birth defects.[4] Women versus men who served in the Gulf also expressed different types of health problems. Research findings included that women veterans were more likely to report osteoporosis, bipolar disorder, depression, migraines, irritable bowel syndrome, asthma and thyroid disorders while men reported more hypertension, tinnitus, and diabetes.[5]

We are just beginning to see possible health impacts from toxins related to burn pit exposures in veterans deployed to Iraq and Afghanistan. According to VA, one in three veterans report a definite or probable toxic exposure during military service and one in four report persistent health concerns to due to deployment exposures.[6]

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[3] Dursa EK, Barth SK, Porter BW, Schneiderman AI. Health Status of Female and Male Gulf War and Gulf Era Veterans: A Population-Based Study. Womens Health Issues. 2019 Jun 25;29 Suppl 1:S39-S46. doi: 10.1016/j.whi.2019.04.003. PMID: 31253241.

[4] Han Kang, Carol Magee, Clare Mahan, Kyung Lee, Frances Murphy, Leila Jackson, Genevieve Matanoski, Pregnancy Outcomes Among U.S. Gulf War Veterans: A Population-Based Survey of 30,000 Veterans, Annals of Epidemiology, Volume 11, Issue 7, 2001, Pages 504-511.

[5] Brown MC, Sims KJ, Gifford EJ, Goldstein KM, Johnson MR, Williams CD, Provenzale D. Gender-based Differences among 1990-1991 Gulf War Era Veterans: Demographics, Lifestyle Behaviors, and Health Conditions. Womens Health Issues. 2019 Jun 25;29 Suppl 1(Suppl 1):S47-S55. doi: 10.1016/j.whi.2019.04.004. PMID: 31253242; PMCID: PMC6668031.

[6] Individual Longitudinal Exposure Record (ILER) Briefing to Office of Research and Development and Clinical Staff Oct 24, 2019 Eric Shuping, MD MPH Director, Post 9/11 Era Environmental Health Program; SME Post Deployment Health Services Veterans Health Administration. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3699-notes.pdf Accessed Nov. 30, 2020.

VA is working on better ways to link toxic exposure data with individual veterans. One such tool is a web-based application accessible to VA and DoD—the Individual Longitudinal Exposure Record (ILER). This web-based application allows detailed information to be entered about length of service, military occupational status, and locations of service and provides the opportunity to link various exposures and possible health effects with individual veterans.[7] However, this application is limited to what exposure information is available and input into the program. There are known deficiencies in monitoring the health of deployed troops, and military and individual health recordkeeping capabilities during periods of war are often not sufficient to determine who might have been exposed to any given environmental or wartime health hazard.[8]

As a nation, we need to find viable solutions to ensure the health of our service members is protected, to the extent possible, and that environmental exposure data is tracked and readily made available for gender-specific research and/or treatments for veterans made ill due to toxic exposures during military service.

Recommendation 7a: *That VHA provide a plan for projecting future demand and capacity requirements that would enable VA to meet the anticipated needs of women Veterans onsite, versus having to utilize community care or care through the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act.* **VA Response 7a: Concur**

Recommendation 7b: *That VHA provide annual reporting to the Committee regarding metrics on comprehensive care--to include screenings, annual physical exams, bloodwork, reproductive health screening, geriatric screenings, mental health screening, and preventive treatment--and measures to ensure that comprehensive care provided to women Veterans are equal in quality and type to the services provided to male Veterans.* **VA Response 7b: Concur**

Recommendation 7a is consistent with requirements in the VA MISSION Act of 2018 (Public Law 115-182), which calls for VA to perform market area assessments to determine what services are being provided in-house, current demand and capacity levels and what routine and specialty health services are available in the community. Unfortunately, VA is, as of now, more than a year late in completing these assessments.

Moving forward, VA requires adequate market assessments to ensure that it is placing women's services in-house where patient volumes are sufficient. Making smart decisions about allocating resources requires good market plans using current data and utilization trends when demand is not suppressed (for example, COVID-19 has changed many health utilization patterns; demand can also be suppressed when there are

[7] Individual Longitudinal Exposure Record (ILER) Briefing to Office of Research and Development and Clinical Staff Oct 24, 2019 Eric Shuping, MD MPH Director, Post 9/11 Era Environmental Health Program; SME Post Deployment Health Services Veterans Health Administration. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/3699-notes.pdf Accessed Nov. 30, 2020.
[8] A national obligation: Planning for Health Preparedness for the Readjustment of the Military after Future deployments https://clintonwhitehouse5.archives.gov/textonly/WH/EOP/OSTP/NSTC/html/directive5.html

access problems). VA should carefully look at these plans to determine whether it now has the demand to offer some services to women veterans that it currently offers through community providers.

Recommendation 7b from the 2020 ACWC report also corresponds with a recommendation from its 2018 report, that "VA should conduct a comprehensive needs assessment of the women Veterans population." While VA concurred with these recommendations, it declined to take further action stating that it would use VA's WATCH report to assess demand and need. It also cited a study Booz, Allen, Hamilton completed in 2016 to determine if VA was complying with its directive (VHA 1330.01) on providing comprehensive care to women veterans. In our opinion, it does not appear that either of these studies is actually a needs assessment, nor do they project demand for the purpose of maintaining the majority of clinical services for women in VA.

The WATCH report appears to provide a snapshot of the resources available in medical centers at a point in time. We understand that VA also gathers information from surveys to collect data from women veterans and looks at wait-time data to assess satisfaction with services and timely access to care. While DAV appreciates these efforts and believes they are necessary for informing planning, we do not believe that the WATCH report or other databases used to inform strategic planning, are sufficient for a true needs assessment the Advisory Committee suggested. For example, veterans' need for in-vitro fertilization services is not adequately reflected by looking at existing utilization and VA programming.

A broader assessment would be necessary to identify the needs of the total population and the evaluation of existing/potential barriers to access to these services such as eligibility for services, cost, and service availability. We believe that a true needs assessment would also explore: 1) the needs of women veterans who do not use VA health care (also looking at why); 2) the services required to fill gaps in existing VA services; and 3) services that are currently not being offered by VA but determined by women veterans to impact their ability to access care and/or overall health. For example—having access to child care services, weekend clinic hours and legal services may be paramount for meeting the needs of some women veterans; however, these services are typically only offered on a limited basis at VA through pilot programs.

Recommendation 8a: *That VHA increase women Veteran-centric pain management training for providers and increase women Veterans' access to diverse modalities of treatment for co-occurring chronic pain and substance abuse for women Veterans.* **VA Response: Concur-in-principle.**

The ACWV provided excellent data and justification in its recommendation for increasing gender-specific pain management training for providers and increasing treatment options for women veterans' with co-occurring chronic pain and substance abuse. It is unclear why VA concurred "in principle." VA listed a number of ongoing efforts to address the issue of pain management in women patients and acknowledged a significant prevalence of chronic pain in women patients and an ongoing need to

"ensure providers within pain management and addiction medicine are aware of and able to address their [women veterans] unique needs."

DAV fully concurs with the action plans set forth by VA in response to recommendation 8a, but suggests a more aggressive approach in provider training (that includes not only training for VA clinicians but Veterans Community Care Network partners as well) to address this issue in the women veterans population.

Recommendation 8b.: *That VHA continue to research how pain management impacts women Veterans differently than male Veterans, as well as the links between pain management and substance abuse in women Veterans.* **VA Response: Concur-in-principle.**

Again, it is unclear why VA concurs "in principle" versus simply concurring to recommendation 8b. VA notes it is engaged in ongoing research efforts to address gender-specific differences in pain management and substance abuse, and lists research conducted on higher rates of pain, poorer satisfaction with pain treatment and decreased maintenance of pain treatment gains observed in women veterans relative to men. VA also cites research findings in its response that suggest women veterans with chronic pain experience a disproportionately higher burden of psychiatric comorbidity, psychological challenges and stigma. Finally, VA acknowledges that, "in light of these stark realities, further research is necessary to elaborate the nature of these gender differences, to address the unique pain treatment needs of women veterans, to examine response to treatments, and where necessary, to develop new treatment modalities for women and tailor existing treatments to women veterans' needs." VA goes on to list a number of ongoing research projects that will examine gender differences in pain management, where women veterans are oversampled to allow researchers to stratify data and draw conclusions about variances in effectiveness of interventions/treatment for chronic pain between genders.

We strongly believe further exploration of this issue is essential to ensuring women veterans have access to care and services that meet their unique, gender-specific needs. Therefore, VA should continue to research the need for and use of gender-specific pain management practices as well as gender differences between pain management and substance abuse in women veterans, in order to make adjustments in clinical training and treatment as appropriate.

Recommendation 9: *That VHA and VBA establish a memorandum of understanding with State Departments of Veterans Affairs to create collaborative partnerships between VHA's women Veterans program managers, VBA's women Veterans coordinators and states' women Veterans coordinators, to enhance women Veterans' access to local, state and Federal Veterans benefits and services.* **VA Response: Concur-in-principle.**

VA notes that collaborative partnerships among federal, state and local women veterans' directors, coordinators and managers are important but that a sufficient MOU exists between the Department and the National Association of State Directors of

Veterans Affairs. VA did agree to update its M27-1 manual and include a requirement that VBA Women Veterans Coordinators regularly engage VHA's WVPMs and state partners to foster collaboration and ensure consistency. This seems to be a sufficient compromise.

Recommendation 10: *That VHA conduct an assessment of its End Harassment campaign, to ascertain its effectiveness and to devise a plan for modernization of the effort to resolve the ongoing problem of sexual assault and harassment physical violations against women Veterans in VA facilities moving forward*. **VA Response: Concur-in-principle.**

While VA agreed in principle with the Advisory Committee recommendation that it should complete an assessment of its End Harassment campaign, it indicated it could not concur about how to effectively define, measure or evaluate cultural transformation. As a health organization, it is a reasonable expectation that VA should be able to measure the effectiveness of this very critical initiative aimed at culture change. The Women Veterans Health Care Modernization Integrated Project Team (VA formed to address culture change) should have the authority to collaborate with various experts to accomplish its goal. Awareness and education campaigns and training can be measured through brief surveys before, during and after campaigns to evaluate effectiveness, but to define and measure culture change as perceived by veterans requires direct feedback from this population.

It is clear that sexual harassment is a long-standing and difficult problem, but ensuring the safety and comfort of all VA patients in waiting rooms or other patient care environments should not be. We understand that VA is taking additional steps in concert with its National Center on Organizational Development and its research program to reassess its efforts with the End Harassment campaign.

We were pleased that VA broadened its End Harassment campaign into Stand Up to Stop Harassment Now! and in addition, introduced a virtual bystander intervention training tool in all its facilities—an approach to teaching staff and providers how to intervene when witnessing inappropriate behaviors. Initial research findings, based on the training, have been positive, indicating a significant increase in acknowledging harassment is in fact a problem and increased comfort and intention to intervene post-training.

While we appreciate VA's strong messaging campaign, training initiative and commitment to ensuring all VA facilities foster a safe and welcoming environment and culture that is free of harassment for all veterans—we urge the Department to make this issue a priority and institute measures to hold VA facility leadership accountable for meeting this goal. As VA notes, harassment in any form is disruptive to the overall veteran experience and negatively impacts access to care.

We would also like to take this opportunity to mention several other issues that DAV believes are essential components to improving VA care for women veterans,

including gender-specific research, peer support, care coordination and monitoring health outcomes and quality of care related to women veterans' care in the community.

We urge the Task Force to continue to engage in dialogue with the VA Women's Health Research Network. This Network has allowed VA to recognize and address emerging needs of women veterans—issues such as eating disorders, intimate partner violence, the need for gender-tailored mental health care services, and their findings related to women veterans care in the community. The Women's Health Research Network welcomes feedback and ideas about how to outreach and recruit more women to participate in the critical research they do, including the Million Veterans Program.

We would also encourage both the Advisory Committee and the Task Force to remain vigilant about the VA's increasing use of community care and how it affects the quality of care and health outcomes for women veterans. With the passage of the MISSION Act and implementation of its Veterans Community Care Network (VCCN), VA is just beginning the long road toward becoming a fully integrated service network. Essential IT tools necessary for integration are still in development including a shared information system which allows VA and VCCN providers to easily exchange patient information.

To fill this void, VA is relying on a variety of coordinators to facilitate care and communications with patients receiving care in the community. For women whose access to care for such services as breast health and reproductive health—including IVF services, other gynecologic care and maternity care—is often dependent upon access to community providers. These coordinating roles are critical and yet in most VA medical centers these are part-time positions or collateral duties. Also lacking in the VCCN are uniform ways to measure and assess quality and access. VA providers have many mandatory training requirements and must meet specific quality standards that are not required for VCCN partners. For these reasons, we urge the Task Force to continue its oversight of care in the community for women veterans.

DAV has also strongly advocated the use of peer support specialists within VA. Used appropriately, peers can make VA a more welcoming, culturally sensitive and less bureaucratic environment that enhance veterans' satisfaction with care and help them engage in treatment and recovery. DAV also recently supported legislation to provide some women veterans using maternity care with doulas who serve as an adjunct to the medical team to help women—especially those who lack supportive networks of friends and family—cope with the often challenging experiences of pregnancy, delivery and becoming a new parent. Peer specialists may be increasingly important as VA sees a more culturally diverse population, particularly among women, and serves more minority veteran populations including veterans identifying as LGBTQ. We urge both the Advisory Committee and Task Force to explore the appropriate and expanded uses of these professionals throughout VA.

In closing, we commend Congress for providing dedicated funding to VHA's Women Health Services program to improve health care for women veterans. We

understand that these funds will help to increase staffing levels, support an initiative to provide oversight of women's health clinics along with support teams to help develop solutions to ongoing challenges and fix deficiencies. We commend the Task Force for its ongoing oversight and attention to women veterans' issues and for the resulting legislation focused on improving VA services for this population. I would also like to express our strong support for enactment of the Deborah Sampson Act prior to the 116th Congress adjourning. We appreciate this Committee's hard work on developing meaningful legislation to improve services for women veterans throughout this Congress culminating in the House passage of H.R. 3224. We remain hopeful that the Senate will take action on this comprehensive measure to improve VA programs and services for women veterans and ensure its enactment before Congress adjourns.

Finally, we thank the Advisory Committee on Women Veterans for its continued efforts to improve services for our nation's women veterans through its 2020 Report and thoughtful recommendations.

Madame Chairwoman, this concludes my statement and I am happy to answer any questions the Committee or Task Force members may have.