VIA EMAIL: cynthia.harvey-pryor@va.gov March 25, 2013

Cynthia Harvey-Pryor
Veterans Health Administration (10P7BFP)
Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Re: OMB Control No. 2900-NEW,
Women Veterans Healthcare Barriers Survey

Dear Ms. Harvey-Pryor:

The following comments are provided on behalf of a diverse, statewide coalition of individuals and organizations that work on behalf of women veterans in California.

Under the Caregivers and Veterans Omnibus Health Services Act of 2010 (Health Services Act of 2010),[1] the Secretary of Veterans Affairs must conduct a "comprehensive study of the barriers to the provision of comprehensive health care" by the Department of Veterans Affairs (VA) on behalf of women veterans. As part of this comprehensive study, the Secretary must survey women veterans who seek or receive health care services provided by the VA as well as women veterans who do not seek or receive such services.[2] The proposed survey must build upon a prior national survey of women veterans conducted in 2008-2009.[3] The Secretary was given $4 million dollars and 3 years to carry out this federal mandate.[4]

The Veterans Health Administration (VHA) has drafted the required survey and is calling for comments regarding its quality and utility.[5] We appreciate the opportunity to comment on this very important issue. While the number of women veterans who use VA health care facilities has increased over the years, women are still about 30 percent less likely to enroll in the VHA than men.[6] Many women veterans either delay needed health services or never get them at all.[7] We submit the following comments in the hopes of improving these statistics.

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[1] Pub. L. No. 111-163, § 201, 124 Stat. 1140, 1140-1142 (2010).
[2] *Id.* at 1140-1142.
[3] *Id.* at 1142; *see also*, Department of Veterans Affairs, *Assessment of the Health Care Needs and Barriers to VA Use Experienced by Women Veterans* (Executive Summary) - provided under a Freedom of Information Act request by Cacilia Kim at the California Women's Law Center from Jenelle Happy, FOIA Officer, Department of Veterans Affairs, Greater Los Angeles Healthcare System, 11301 Wilshire Boulevard, Los Angeles, CA 90073 on February 14, 2013 ("2008-2009 National Survey, Executive Summary"). Prior national surveys were conducted in 1985 and 2008-2009.
[4] *Id.* at 1142. According to Justification A, accompanying the draft survey, the survey is a three-year project with a projected cost of $1,127,030.96.
[5] Proposed Information Collection; Women Veterans Healthcare Barriers Survey Activity: Comment Request, 78 Fed. Reg. 4983 (January 23, 2013).
[6] Department of Veterans Affairs, *Women Veterans Task Force: Strategies for Serving Our Women Veterans*, (2012) at p. 6.
[7] Donna L. Washington et al., *Access to Care for Women Veterans: Delayed Healthcare and Unmet Need*, Journal of General Internal Medicine, 26(Supp. 2): 655-61, 657 (2011).

I. Practical Utility of the Survey[8]

Regarding the survey's practical utility, we offer the following:

We wholeheartedly support a comprehensive study and assessment of the multiple, complex barriers that women veterans have and continue to face in accessing health care services from the VA. The mandate under The Health Services Act of 2010 requires no less. However, the proposed survey has neither the breadth nor the substance to meet these requirements. Moreover, this is the third national survey of women veterans.[9] Prior surveys were conducted in 1985 and 2008-2009.[10] The Health Services Act of 2010 requires the proposed survey to *build* on the work of the 2008-2009 survey.[11] Despite these facts, the proposed survey is -- like its predecessors -- simply focused on documenting the multiple barriers that have *for decades* prevented women veterans from accessing VA-provided health care services. It neither builds on the findings of the prior survey nor moves the focus to the next, important level – which is to gather the necessary information to develop solutions and interventions to address the known barriers.

For example, the 2008-2009 survey found that an "[a]ttrition of women Veterans from [the] VA occurs after pregnancy."[12] The current survey asks women veterans who are pregnant if they have received any care from the VA since their pregnancy, with a basic "Yes" or "No" response format.[13] But there are no critical follow-up questions to understand *why* women veterans either chose to continue getting health care services from the VA after their pregnancy or, as the 2008-2009 survey found, decided not to seek any further services post pregnancy. Without knowing *why* there is an attrition of women veterans from the VA after pregnancy, we are no closer to designing an intervention to address this barrier (despite several years and two national surveys).

Missing from the proposed survey is any serious attempt to gather the necessary information to finally move beyond simply documenting the barriers and actually doing something to address them. This failure is particularly vexing since multiple outside agencies and sources have repeatedly informed the VA of the problems that women veterans have had and continue to face in accessing health care services at its facilities. Over 30 years ago, the United States General Accounting Office (GAO) found widespread deficiencies in the availability and quality of care for women veterans in the VA health care system.[14] The GAO report found that immediate action was needed to insure that women had access to basic health services – such as treatment programs and gender-specific medical care.[15]

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[8] Per the comment request noted in fn. 5, the VHA invites "comments on: (1) Whether the proposed collection of information is necessary for the proper performance of VHA's functions, including whether the information will have practical utility . . . "

[9] Pub. L. No. 111-163, § 201 at p. 1141. *See* also fn. 3.

[10] *Id.*

[11] *Id.*

[12] 2008-2009 National Survey, Executive Summary. *See* fn. 3.

[13] *See* question E12 of draft survey.

[14] U.S. Gen. Accounting Office, Actions Needed to Insure that Female Veterans Have Equal Access to VA Benefits, GAO-82-98, (1982).

[15] *Id.*

Since then, numerous studies, including subsequent GAO reports, have repeatedly alerted the VA to the multiple barriers that continue to plague and prevent women veterans from accessing needed health services.[16] Although some progress has been made, the pace and scope of the improvements have been slow, fragmented and often cosmetic. Three decades later, women veterans are still grappling with VA facilities that lack even the most basic safety and privacy accommodations. For example, the latest GAO study on health care barriers found that some *mixed-gender* inpatient and residential units still lack private bathrooms and shower facilities with secured locks.[17]

Women veterans are disillusioned with the endless parade of surveys, focus groups and questionnaires (at the local, state and federal level) that repeatedly ask them to reveal private health information and discuss sensitive, difficult topics but lead to few -- if any -- concrete, systemic changes in how the VA provides health services to women. Many women veterans believe that the VA is already aware of the barriers; it simply lacks the will and commitment to make the necessary changes – which will, no doubt, require substantial resources and effort. They believe that instead of tackling this difficult task head on, the VA has opted to waste valuable time and resources on half-hearted, perfunctory efforts that seem more for show (and to claim that something, however, minimal, is being done) without any sincere efforts to make systemic changes.

The proposed survey will do nothing to counter these beliefs. It is far too limited in breadth, depth and scope to lead to any concrete solutions or interventions. It is grossly inadequate for a survey that is not the first -- but the third of its kind, with access to over 30 years of knowledge and insight from numerous studies and reports highlighting the multiple barriers that women veterans have and continue to face in accessing health services from the VA. Three decades is enough time to research and document barriers. The focus must shift to gathering information to identify and implement interventions to address these long-standing problems.

II. Accuracy of Burden on Female Veterans[18]

Women veterans should be compensated for their participation. The proposed survey requires women (yet again) to reveal private health and other sensitive information by telephone for an estimated 45 minutes. This is not an easy, comfortable or short task. Part of the 4 million dollars that was allocated to the VA to conduct this survey[19] should be provided to women veterans out of respect for their time and in recognition of the importance of the information that they provide. Providing payment might also encourage women veterans who might otherwise be

[16] *See*, *e.g.*, U.S. Gen. Accounting Office, VA Health Care for Women: Despite Progress, Improvements Needed, GAO-92-93, (1992); Office of the Inspector General for Health Care Inspections, Report of Inspection of Women Veterans' Health Care Program, 3HI-A99-129 (1993); Office of the Inspector General for Health Care Inspections, Report of Inspection of Women Veterans' Health Care Programs, Privacy-Issues-Part II, 4HI-A19-042 (1994); U.S. Gen. Accounting Office, Progress Made in Providing Services to Women Veterans, GAO-99-38, (1999); U.S. Gen. Accounting Office, VA Health Care: Preliminary Findings on VA Provision of Health Care Services to Women Veterans, GAO-09-884T, (2009).

[17] U.S. Gen. Accounting Office, VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes, GAO-10-287 (2010) at p. 23.

[18] Per the comment request noted in fn. 5, the VHA invites comments on: "(2) the accuracy of VHA's estimate of the burden of the proposed collection of information . . . "

[19] *See* fn. 4.

turned off by yet another survey to participate. It might also convey a more positive message about the VA's commitment and seriousness to this endeavor. Finally, even nominal compensation will raise the rate of responses, increasing the validity and utility of the survey.

III. Ways to Enhance the Quality, Utility and Clarity of the Information Collected[20]

Regarding ways to enhance the quality, utility and clarity of the information collected, we offer the following comments:

A. The Survey Design Must Include the Knowledge of Women Veterans

The purpose of the proposed survey is to identify the "comprehensive" barriers that prevent or hinder women veterans from accessing health care services at VA facilities. Despite this purpose, the survey was apparently designed without the insight or knowledge of the women who have first-hand experience with these barriers. According to the survey methodology, several stakeholder meetings were held with VA researchers and other experts to develop the survey's structure, content and design.[21] However, the voices and opinions of women veterans were missing from these critical meetings. Only after a draft questionnaire was already created, *five* women veterans were invited to provide comments, which resulted in some minor cosmetic changes to the survey.[22]

Women veterans must be included from the start -- during the initial design and creation of the survey. They know where the problems are, what issues to focus on and are the unparalleled experts not only on the difficulties of accessing care at VA facilities but also the interventions that will get women veterans to the VA. Focus group discussions with women veterans, at least one per Veterans Integrated Service Network (VISN), should be conducted to identify the key barriers and issues from the women veteran's perspective.[23] The current survey should be revised based on the information gathered from these discussions. The revised survey should then be reviewed by a small working group of women veterans to assist with how questions and responses are phrased, how questions and topics are ordered and other similar revisions. Moreover, before the survey is finally implemented, it should be piloted with a small sub-sample of women veterans to allow for last minute adjustments.

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[20] Per the comment request noted in fn. 5, the VHA invites comments on: "(3) ways to enhance the quality, utility, and clarity of the information to be collected . . . "

[21] *See* Women Veterans Health Care Barriers, Justification B. "Collections of Information Employing Statistical Methods" accompanying the proposed survey at p. 5.

[22] *Id.*

[23] The focus groups should be conducted by third-party researchers with female facilitators, include only female veterans and provide the utmost privacy and confidentiality for participants. No representatives from the VA should be present at any of the focus groups.

B. The Study Design Must Include the Knowledge of VA Providers and Staff

To be truly "comprehensive", the proposed survey must assess barriers not only at the patient level, but also at the provider and institutional level as well.[24] As such, it must include the voices and opinions of the VA clinicians and staff who deliver health care services to women veterans. Their input is critical, particularly on the built-in institutional barriers and restrictions that impact the quality of care that is provided. In some instances, unwritten informal policies and directives from superiors actually require staff -- because of significant backlogs and cost-of-care issues -- to rush patients through appointments and provide a lower quality of care than needed. Such informal policies significantly impact the day-to-day delivery of care to women veterans and override any stated public policies to improve services.

Input from VA providers and staff is also important to uncover unintentional barriers as well. For example, the most recent GAO report focusing on care barriers found that many VA providers, like their female patients, still do not know about the various specialized programs and services that are currently available to women veterans at VA facilities.[25] As such, focus group discussions with VA clinicians and staff, similar to the ones with women veterans, should be conducted to fold this critical cohort into the survey design.

C. The Survey Design is Too Limited in Breadth, Scope and Content

The numerous, interrelated barriers that prevent women veterans from having equal access to VA-provided health services is a multi-dimensional problem, involving complex issues that are difficult to assess based on answers to simple "yes" or "no" questions or forced choices on a ratings scale. This is particularly true for mental health issues, which manifest in complex ways (often with comorbid problems), occur in disproportionately high numbers among women veterans and impact how women veterans perceive and access VA-provided health services.[26] Despite this, the proposed survey superficially addresses complex mental health issues with a handful of questions, without defining special terms used, such as traumatic brain injury, and refers broadly to post-traumatic stress disorder (PTSD), without specifying whether the PTSD stems from combat, sexual trauma or other conditions.[27]

For example, it is estimated that between 14 to 41 percent of women in the military have experienced sexual assaults and other violence during their service. Many were assaulted more than once – often by more than one assailant.[28] The majority of these women never reported these crimes.[29] Moreover, experiences with sexual trauma and other violence significantly

[24] Indeed, this multi-level focus is at the core of the CREATE initiative, administered by the VA's Office of Research and Development, Health Services Research and Development Service. *See* http://www.hrsd.research.va.gov/create/womens_health.cfm (last visited March 21, 2013).
[25] U.S. Gen. Accounting Office, VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes, GAO-10-287 (2010) at p. 16.
[26] Elizabeth M. Yano et al., *Using Research to Transform Care for Women Veterans: Advancing the Research Agenda and Enhancing Research-Clinical Partnerships*, 21-4S Women's Health Issues, S73, S78 (2011).
[27] *See* draft survey questions MH1 to MH 9 (pp. 19-20).
[28] Sharon Valente and Callie Wight, *Military Sexual Trauma: Violence and Sexual Abuse*, Military Medicine, Vol. 172, Issue 3, pp. 259-265 (2007).
[29] *Id.*

impacts how women veterans interact with and perceive the VA health care system and other military institutions.

Prior research, including the results from the 2008-2009 national survey of women veterans, found that women who have experienced military sexual assaults are more likely to delay or forgo needed health care services, and among those who seek services, have more negative experiences and poorer ratings of VA provided care.[30] Yet, the proposed survey asks just 5 questions that relate to sexual assaults in the military, with only one question that even asks about how these experiences impact their interactions with the VA and willingness to access services.[31] For example, question MH9 asks: "Did you ever avoid using the VA because of this (these) experience(s)?" It is unclear how helpful the limited information gathered from this single question will be or how it builds on similar information already gathered from the 2008-2009 survey results.[32]

While we applaud the VHA for recognizing that sexual assaults in the military are a critical problem for women veterans and an obstacle to accessing health care services, we have definite concerns about how the survey proposes to gather this information (discussed further in Section IV below). This is a very complex and difficult issue to tackle through a telephone survey. We agree that it is an important issue that must be addressed, given its sheer prevalence among this group, but it must be approached with much more thought, consideration ***and*** input from women veterans. Moreover, the purpose must be to gather robust, substantive and useful information that can be translated into concrete interventions.

If the VHA is going to ask women veterans about this very difficult subject, they must do so both thoughtfully and thoroughly, with the goal of gathering concrete, substantive information that will lead to interventions and solutions. The sexual assault questions in the proposed survey are extremely limited and have been visited many times before. Handling this issue poorly or superficially not only wastes valuable time and resources but can also re-victimize survey participants.

Many women veterans also experience *multiple* levels of trauma, at rates that are significantly higher than their counterparts in the civilian population.[33] However, the proposed survey fails to include other traumas, beyond just sexual, that are also known barriers to care. For example, domestic violence is another pervasive problem in the military community and a significant factor that impacts whether women veterans will access care from VA facilities.[34] It

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[30] *See, e.g.*, Elizabeth M. Yano et al., *Using Research to Transform Care for Women Veterans: Advancing the Research Agenda and Enhancing Research-Clinical Partnerships*, 21-4S Women's Health Issues, S73, S78 (2011); Donna L. Washington et al., *Access to Care for Women Veterans: Delayed Healthcare and Unmet Need*, Journal of General Internal Medicine, 26(Supp. 2): 655-61, 657 (2011).

[31] *See* draft survey questionnaire, questions MH7-MH9, p. 20.

[32] The value of this question is further undermined by the fact that participants who find this line of questions stressful or unpleasant can skip them.

[33] U.S. Dept. of Labor, Women's Bureau, Trauma-Informed Care for Women Veterans Experiencing Homelessness at p. 11 at http://www.dol.gov/wb/traumaguide.htm#2 (last visited March 21, 2013); Alysha D. Jones, *Intimate Partner Violence in Military Couples: A Review of the Literature*, Aggression & Violent Behavior, Vol. 17, Issue 2, pp. 147-157 (2012).

[34] *See, e.g.* Jacquelyn Cambell et al., *Intimate Partner Violence and Abuse Among Active Duty Military Women*, Violence Against Women, Vol. 9, Issue 9, pp. 1072-1092 (2003); Mary Forgey and Lee Badger, *Patterns of Intimate Partner Violence Among Married Women in the Military: Type, Level, Directionality and Consequences*, Journal of Family Violence, Vol. 21,

is a well-hidden epidemic on multiple fronts -- women veterans do not report it, VA clinicians do not recognize or treat it and military institutions do not document it.[35] Like military sexual trauma, women veterans who have experienced domestic violence have a host of physical and mental ailments and these experiences directly impact whether they will access care from VA facilities.[36] The proposed survey is unacceptably silent on this issue.

D. The Survey Fails to Ask the Right Questions

The proposed survey fails to ask the right questions to get at the current barriers to care. It misses opportunities to gather critical information. Necessary follow-up questions are inexplicably absent from a survey striving to assess the "comprehensive" barriers to care. For example, question E11 of the draft survey asks women veterans who have used VA-provided services in the past 24 months to opine on how helpful they believed the VA was in coordinating their health care services and provides a range of responses from "Extremely helpful" to "Not at all helpful".[37] Yet there are no follow-up questions inquiring why the veteran found the coordination of care helpful, not helpful or something in between.

The proposed survey is also heavily weighted with demographics and questions with tedious 5-point Likert-scale response formats (*e.g.*, strongly agree, somewhat agree, neither, somewhat disagree, strongly disagree). It is questionable whether there are distinct enough differences between the responses to merit the actual choices. Moreover, there are so many tedious questions before the respondent gets to the heart of the matter – question G3[38] – that the respondent may be fatigued or fed up with the survey and fail to provide quality input. The survey can be significantly improved by allowing for more open-ended responses, like under question G3, early on and throughout the survey. This would lend much-needed depth and context to the simple forced-choice response format currently being suggested.

E. Sampling Methodology is Unclear

Very little information about the sampling methodology that will be used in the proposed survey was provided. Based on the limited information, we have the following concerns and questions:

Issue 6, pp. 369-380 (2006); Alysha D. Jones, *Intimate Partner Violence in Military Couples: A Review of the Literature*, Aggression & Violent Behavior, Vol. 17, Issue 2, pp. 147-157 (2012).

[35] *See, e.g.*, Sharon Valente and Callie Wight, *Military Sexual Trauma: Violence and Sexual Abuse*, Military Medicine, Vol. 172, Issue 3, pp. 259-265 (2007); Keith Klostermann et al., *Intimate Partner Violence in the Military: Treatment Considerations*, Aggression & Violent Behavior, Vol. 17, Issue 1, pp. 53-58 (2012); Anne G. Sadler et al., *Life Span and Repeated Violence Against Women During Military Service: Effects on Health Status and Outpatient Utilization*, Journal of Women's Health, Vol. 13, Issue 7, pp. 799-811 (2004).

[36] *See, e.g.*, Sharon Valente and Callie Wight, *Military Sexual Trauma: Violence and Sexual Abuse*, Military Medicine, Vol. 172, Issue 3, pp. 259-265 (2007); Anne G. Sadler et al., *Life Span and Repeated Violence Against Women During Military Service: Effects on Health Status and Outpatient Utilization*, Journal of Women's Health, Vol. 13, Issue 7, pp. 799-811 (2004).

[37] Possible answers also include "Don't Know" or "Refused."

[38] Question G3 (p. 21) at the end of the draft survey finally provides survey participants with an opportunity to provide a more substantive, open-ended response. G3 asks: "Before the final section, I want to provide the opportunity for you to share any feedback you may have regarding your perceptions of, or experiences with, the health system within the Department of Veterans Affairs. What would you like the VA to know?"

- Assuming a 5 percent margin of error and 95 percent confidence interval (typical for social science research), the survey's proposed sampling strategy of 200 participants within each cell may be inadequate.
- An analysis of the variance within the VISN stratification scheme is not indicated in the proposed methodology. There is likely to be important differences that will be missed if variance is not considered. California, followed by Florida then Texas, has the largest veteran population in the country and also some of the most extreme geographical and demographic differences. One VISN in the state could potentially service several large metropolises as well as very remote tribal lands with little access to the outside world. If the VA is interested in bettering their system of care for women veterans, it would be helpful to know how to shape services and offer care for veterans who live in the same VISN, yet whose lives may differ drastically with regard to culture, geography and access to resources.
- The current sampling methodology does not adequately include small, underrepresented populations of women veterans. This is a significant oversight, as these sub-populations of veterans are often the ones who are most in need of care yet face the most barriers. Moreover, some underrepresented populations of female veterans may be proportionally represented, but not statistically significant in terms of analyzing data. To remedy this, underrepresented populations should be oversampled as part of the sampling methodology. Doing this will avoid the use of weights during statistical analysis, which when applied to a small number of cases can inflate bias.
- How will the sampling methodology account for low response rates? Will there be oversampling in areas where access may be difficult?
- Does the current methodology rely on data from the U.S. Census Bureau? The U.S. Census Bureau's American Community Survey and the Current Population Survey are both administered on an ongoing basis, nationally. These databases are different than the decennial census administered every ten years. The data is organized geographically by population size, contains information related to health care access and veteran status, and provides other important demographic information useful to understanding the makeup of each VISN and in designing a more strategic sampling methodology.

F. The Survey Must Include Underrepresented Populations

The current methodology makes no mention of how it intends to include the participation of marginalized communities of women veterans, such as those who are homeless, live in rural areas or on Tribal territories. In fact, homeless veterans were specifically not included in the 2008-2009 survey.[39] This is a problematic exclusion as homelessness among women veterans has been linked to important health issues and barriers, such as military sexual trauma and other disabilities.[40] It is a growing epidemic among women veterans and increased by more than 140

[39] 2008-2009 National Survey, Executive Summary (*see* fn. 3).

[40] U.S. Gen. Accounting Office, Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing, GAO-12-182 (2011) at pp. 1, 30.

percent between fiscal year 2006 and 2010 (compared to a 45 percent increase for male veterans).[41]

In fact, women veterans are the fastest growing segment of the homeless population and are at higher risk of homelessness than their male counterparts.[42] It is a community in great need that must not be ignored (again). The current survey, which must build on the 2008-2009 survey, must include these marginalized communities of women. Participation by these women is particularly important because they are the veterans who are most likely to encounter *multiple* barriers to accessing health care services at the VA.

Moreover, the VHA should foster active partnerships with state and local organizations in each state, similar to the successful collaboration between federal and state entities under the United States Interagency Council on Homelessness.[43] Working with organizations at the state level, particularly those that have a counterpart in every state, like the state Employment Development Department, allows the VHA and survey organizers to leverage state resources that have already built the necessary infrastructure and trust to connect with women veterans in their communities. Prior trust and relationships are particularly important in reaching out to marginalized communities or other hard to reach groups of women. This will avoid a skewed sample, include important cross-sections of women veterans and ensure the most representative participants.

G. Allow Alternate Methods of Survey Collection

The survey methodology indicates that only women veterans with access to private, residential telephone landlines will be included in the current survey. This will under-sample important sub-populations of veterans, such as younger women veterans who communicate by cell phones, texting and the internet, exclude women in transition and lose individuals who object to discussing private medical information by telephone.

Moreover, focusing on women veterans with access to private, residential landlines will likely over-sample the most economically, physically and mentally stable veterans who are much better able to navigate the VA health care system than their less stable counterparts. Thus, the proposed methodology will actually undermine the survey's main goal – to focus on women with barriers to accessing VA medical care and under-sample its primary target population. The 2008-2009 national survey was also done by telephone, and survey administrators acknowledged that this methodology would under-sample those without a telephone -- a group likely to have significant access barriers.[44] As the current survey must build upon the prior survey, alternate methods of survey participation must be allowed this time around.

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[41] *Id*. at 31. The data represents only those homeless veterans identified by the VA and are not generalizable to the population of homeless women veterans.

[42] Department of Veterans Affairs, Women Veterans Task Force: Strategies for Serving Our Women Veterans, (2012) at p. 6.

[43] United States Interagency Council on Homelessness, http://www.usich.gov/ (last visited Feb. 28, 2013).

[44] *See* Donna L. Washington et al., *Access to Care for Women Veterans: Delayed Healthcare and Unmet Need*, Journal of General Internal Medicine, 26 (Supp. 2): 655-61, 660 (2011).

Moreover, consideration for disabled women veterans, many of whom were in combat zones, further requires alternate methods for survey participation. Hearing loss, paralysis, amputations and traumatic brain injury (TBI) must be considered when designing the survey methodology. Those with hearing loss may not be able to participate in a telephone interview. Paralyzed female veterans and amputees may desire an electronic survey so that they can get assistance when participating. Certain traumas, like TBI or PTSD, affects attention span and makes people vulnerable to triggers. Providing a paper or electronic survey will allow female veterans with such conditions to participate in the survey privately -- and at their own pace.

To ensure the broadest participation by women veterans, participants should be allowed to take the survey by phone, email/online or through paper surveys with pre-paid, return envelopes. This will allow women veterans without private, telephone access or those who do not wish to discuss difficult topics on the telephone to nevertheless participate in the survey. Accommodations for veterans for whom English is not their native language should also be provided. Making these allowances will ensure that the greatest number of women veterans will have an opportunity to participate and, at the same time, increase the response rate, sample size and validity of the study. It would also bolster the VA's sincerity to addressing the current barriers to health care access.

H. The Survey Leaves Out Barriers Faced *Before* Entrance Into VA System

The survey does not ask any questions about the myriad of administrative and bureaucratic hurdles that women veterans face *before* even being allowed entrance into the VA health care system – which can take years. The initial claims process to receive health care services can be a minefield of problems and delays, particularly for those veterans who must file multiple claims and receive services at multiple VA facilities – which apparently do not communicate with one another.

I. The Survey Questions Regarding Military Service is Unclear and Leaves Out Women Who Served

The baseline questions in the proposed survey that relate to military service are unclear and confusing. For example, the distinction between active duty service and Guard/Reservist service is unclear. Moreover, many veterans have served in both capacities. Also, no distinction is made between state veteran health care services versus federal services. Finally, the proposed survey leaves out important groups of women who have served, such as those in the Commissioned Corps of the United States Public Health Service and the National Oceanic and Atmospheric Administration.

IV. Minimize the Burden on Women Veteran Survey Participants[45]

Regarding methods to minimize the survey burden on women veterans, we offer the following comments:

A. Respect Women Veterans' Health and Safety

We are deeply concerned about the potential negative impact of the mental health questions in the proposed survey, particularly those that relate to sexual assaults while in the military. As established in the research literature, experiences and memories regarding these assaults can be very painful and "trigger" negative reactions in veterans.[46] However, no information is provided regarding how survey providers will support and assist women veterans who become upset by these questions – other than that participants can skip or refuse to answer them. This approach is inadequate, as some women may not become upset or not know that they will be upset until after they begin to answer the questions. Some participants may become upset just by the mention of sexual assaults. Survey organizers should have a therapist or other qualified individual available for each call shift who can intervene on the call if needed (or other similar support). This individual needs to be knowledgeable about military sensitive referrals in case a woman veteran respondent needs immediate support.

B. Survey Interviewers Must be Properly Trained

Similarly, interviewers must be properly trained to conduct the proposed survey, particularly given the sensitive topics in the survey (*e.g.*, sexual assaults, gender discrimination, etc.) and the length of the survey, which makes it likely that respondents will go off-topic.

Proper training should include how to respond respectfully, redirect, allow for venting and identify any women veterans who are in distress and in need of assistance. A working group of women veterans should be involved in both designing and giving the training to potential interviewers so that the interviewers can ask questions and get an accurate understanding of how to interact with this population.

C. Respect Women Veterans' Time and Privacy

In order to maximize study participation and respect for women veterans' time and privacy, we request the following:

- Include an initial screening question to make sure women veterans are in a safe and private place to talk. If not, make an appointment and call back. Similarly, if the respondent is upset by cold calls, schedule an appointment for their interview. Individuals are more likely to be honest if they can be in a place that is comfortable and

[45] Per the comment request noted in fn. 5, the VHA invites comments on: "(4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology. "

[46] United States Department of Veterans Affairs, Section on Military Sexual Trauma, http://www.ptsd.va.gov/public/pages/military-sexual-trauma-general.asp (last visited Feb. 28, 2013).

private. If the veteran refuses an interview, offer an alternate method to take the survey (*e.g.*, electronic or paper).

- If calling residences, daytime calls may not be most productive if respondents work outside of the home. Consider evening or weekend phone calls.
- Phone calls should never be made on holidays that honor military service (*i.e.*, Memorial Day, Veteran's Day, 4th of July). These days elicit much emotion for veterans. The same respect should be observed for other cultural communities. Calls should also not be made on significant days of worship.

V. Study Results Should Be Made Public

This will be the third national survey of the needs of women veterans since 1985.[47] The results and survey instruments from the first two surveys were not made easily accessible to the general public. Information about the two prior surveys had to be cobbled together from a number of sources, including documents obtained through a Freedom of Information Act request and a special search request to the California Research Bureau. Numerous hours were also spent searching the internet and various academic repositories for studies discussing the prior surveys.

According to the Health Services Act of 2010, the findings and results of the proposed survey will also be funneled to a small number of individuals and entities and will not be made widely or easily accessible.[48] This is a mistake. The unmet health care needs of women veterans are a pressing public policy and health issue and the public, particularly women veterans, have a right to be informed about its findings. Moreover, public oversight and scrutiny is necessary to ensure that the results of this third national survey will not be buried like its predecessors and will lead to concrete interventions and improvements. At the very least, women veterans who participated in the survey should be guaranteed the opportunity to view the survey results.

For over 30 years, the VA has known about the multiple barriers that prevent women from accessing needed health services. Women are now the fastest growing cohort within the veteran community and will make up over 10 percent of the veteran population by 2020.[49] The VA can no longer be content with just documenting barriers. It must remove the obstacles that prevent women veterans from accessing health services. Public accountability will more likely ensure that this will happen.

[47] *See* 2008-2009 National Survey, Executive Summary (*see* fn. 3).
[48] Pub. L. No. 111-163, § 201, 124 Stat. 1140, 1141-1142 (2010).
[49] Department of Veterans Affairs, Women Veterans Task Force: Strategies for Serving Our Women Veterans, (2012) at p. 2.

If you have any questions regarding these comments, please contact Cacilia Kim at the California Women's Law Center at 323-951-9642 or cacilia.kim@cwlc.org. We thank you for the opportunity to be involved in this very important endeavor.

Respectfully,

Cacilia Kim
Senior Staff Attorney
California Women's Law Center

Mary Ellen Salzano
Founder
California Statewide Collaborative for our Military and Families

Melissa Tyner
Senior Staff Attorney
Homeless Veterans Project
Inner City Law Center

Elizabeth Kristen
Director, Gender Equity & LGBT Rights Program
Senior Staff Attorney
Legal Aid Society – Employment Law Center

Tara Jones
President
National Women Veterans Association of America

Amy N. Fairweather, Esq.
Policy Director
Swords to Plowshares

Irene Cruz
Director
Women Veterans Strategic Alliance

Paula J. Caplan, Ph.D.
Clinical and Research Psychologist, Women's Advocate, Veterans Advocate and Head of
The Welcome Johnny and Jane Home Project and The Welcome Johnny and Jane Home Coalition (whenjohnnyandjanecomemarching.weebly.com)
Author of triple award-winning book, *When Jonny and Jane Come Marching Home: How All of Us Can Help Veterans*