TESTIMONY

OF

DAWN HALFAKER

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

"EXAMINING ACCESS AND QUALITY OF CARE AND SERVICES FOR WOMEN VETERANS"

APRIL 30, 2015

Mr. Chairman and Members of the Committee:

Thank you for holding this hearing and for inviting me to testify. I've come to appreciate how vital this Committee's oversight has been to beaming a spotlight on the unique challenges facing women Veterans and to developing important legislation to meet those needs. Yet women Veterans continue to confront serious gaps in government programs, as you have acknowledged in convening this hearing.

This morning's testimony raises issues that have long been of deep concern to me. I began a military career after graduating from West Point in 2001 which was cut short after being seriously wounded in combat while serving in Iraq in 2004. Though no longer in uniform, I've continued to advocate for my fellow Wounded Warriors, Veterans and their Families through my affiliation with several nonprofit organizations such as USO and Wounded Warrior Project as well as my own Service Disabled Veteran Owned small business where I employ Veterans and Wounded Warriors.

My testimony today reflects some of what I've learned as a volunteer and advocate; but most of what I'll share with you reflects what I've learned as a patient in the VA medical system.

I use that system proudly, recognizing that VA care is an entitlement and a promise for those of us who served. I want the system to work, to help our Veterans and to ensure that this promise is kept for all Veterans. And I welcome the opportunity to share the observations and insights I've gained as a VA patient and beneficiary. In doing so, I've tried to be fair in applauding VA's successes while relating its failings.

I do recognize the progress that's occurred in just a generation from a time when there was no VA women's program, and where VA hospitals couldn't provide women patients even the most basic privacy. VA has really come a long way. Yet the Department still has a way to go to close the gaps DAV has ably portrayed in its excellent report, "Women Veterans: The Long Journey Home."

My own contribution to this dialogue is probably best focused on my recent experience receiving maternity care through the VA. While the DAV has done the Committee a great service with its panoramic overview of government programs, there is something to be said for drilling down to examine particular problem areas. Maternity care is an instance of an almost hands-off approach that leaves women Veterans without sufficient support during a particularly vulnerable period. Overall, VA's administrative stewardship of maternity care is poor, and causes unnecessary trauma. I believe the problems I encountered are largely systemic in origin and I know my experience was not unique. In short, I believe my experience holds important lessons that beg for changes I hope you'll elect to champion.

Providing maternity care is, of course, not a VA pilot program or something VA has just started up. To the contrary, maternity benefits have been included in VA's medical benefits package since 1996. The Veterans Health Administration (VHA) has also published detailed procedures for furnishing and coordinating maternity care for women veterans.[1] Importantly, VHA states that "[t]hese procedures establish a VA-wide standard of practice for maternity care and its coordination."[2] And it emphasizes to field staff the likelihood that their facilities' patients will include pregnant veterans. This is "[b]ecause women Veterans are the fastest growing group of new users of VA health services."[3] VHA's directives for maternity care set very clear expectations:

- Benefits begin with confirmation of pregnancy and continue through the postpartum visit;
- Maternity care will typically be delivered by non-VA providers in accredited non-VA facilities;
- Women Veterans continue to receive care through VA facilities during their pregnancies either for management of co-existing conditions, for lab-testing, or medication management;
- "Coordination of care and information sharing between all providers, including non-VA and VA providers, is critical to patient safety;" and
- "Each facility must ensure seamless coordination of non-VA maternity care with VA care."[4]

On the face of it, VA's expectations for maternity care as set out in these required procedures look great. But they fall short in what they <u>fail</u> to require. And just as important, while they set an appropriately high bar on paper, some of the most critical of those expectations are piled on a single individual, the medical center's Maternity Care Coordinator. (VHA identifies more than a dozen specific tasks for which the coordinator is responsible.[5]) In my case, certainly, that individual failed at critical points to meet key responsibilities. So rather than experiencing

[1] Veterans Health Administration, "VHA Handbook 1330.03: MATERNITY HEALTH CARE AND COORDINATION," Oct. 5, 2012.
[2] Id., sec. 1.
[3] Id., sec. 3.a.
[4] Id., secs. 3, 5.
[5] Id., sec. 10.

seamless coordination of my maternity care, I felt abandoned at times during this emotionally vulnerable period -- left alone to navigate some difficult challenges and to advocate for myself.

Where did things go wrong? At the outset, my VA Maternity Care Coordinator handed me a list of DC-area maternity-care providers, though quickly warned, "we can't really make any endorsement and you need to find a Doctor who will sign this VA contract…which pays Medicare rates." Surely, even if it wouldn't endorse anyone, I thought the medical center would have had a network of OB/Gyn providers with whom it contracts for maternity care, and that I wouldn't have to find a provider who was willing to accept VA's terms. So I was surprised to learn that the DC VA hadn't established a contract with any of these providers, not even with facilities with which it had long-established formal relationships like George Washington University Hospital Medical Faculty Associates (GWU) where I ultimately elected to get care. As it turned out, I was lucky to have chosen a GWU physician, as her office had previously treated another Veteran patient, and had learned how VA operates. That office showed a sensitivity and compassion that, unfortunately, I didn't experience from my VA care coordinator.

While my maternity and obstetrical care were excellent, I soon learned the implications of the VA's administrative process, or seeming lack of process. VA is simply a maternity-care bill-payer. But it doesn't carry out even that limited role very efficiently. For example, my doctor routinely had lab work done with each of my office visits, and I'd receive copies of each bill the lab-services company, LabCorp, sent VA. But because VA was exasperatingly slow in paying bills, LabCorp began billing me. This might have been understandable, had it been a one-time snafu. But since my care-coordinator didn't or couldn't fix the problem, the unpaid bills kept mounting. I was soon getting collection notices that nonpayment would jeopardize my credit. (I'd be pleased to provide for the record copies of these notices or other pertinent documents.)

This wasn't the only instance of being stuck in the middle of a tug of war between a provider of medical services and VA. During the pregnancy my doctor was concerned by signs suggestive of a fetal heart problem, and urged that I get an echocardiogram. She referred me to Children's Hospital for this procedure. I knew that VA's policy in such situations required advance notification and pre-treatment approval. But my Maternity Care Coordinator's response to my notifying her of the referral to Children's was anything but helpful. Approval would take several weeks, she advised, because the DC VA had no previously established relationship with Children's. I was both incredulous and alarmed. I remain amazed that with its busy women's clinic, the VA medical center had no relationship with nearby Children's Hospital and its specialized services. But, with my child's well-being potentially at risk, the prospect of waiting "weeks" to get an okay for a needed procedure was just not right, prior relationship or not. It apparently would have taken weeks if I hadn't been able to advocate for myself. In fact, it wasn't until I insisted that I would record our conversation and bring it to the attention of my Congressman that my Coordinator took action, and VA finally did arrange with Children's for the procedure.

The good news was that the testing revealed that there was no cardiac abnormality. But soon I was again stranded in the middle and getting bills, this time from Children's Hospital. It took some eight weeks and a conference call with VA officials in the local fee-basis office and in

Austin, TX, to clarify that VA had paid Children's. But I finally also learned that VA's payment had covered only a small fraction of the hospital's charges. Children's demanded that I pay the difference of $1,719.60!

In reaching out unsuccessfully to my maternity care coordinator to help resolve this "catch-22," I eventually learned that she'd been out for several weeks with her own pre-natal issues. (Not only was maternity care a single person's responsibility, but there was apparently no back-up in the event of this individual's absence, and no mechanism to alert patients to her unavailability.) I was very lucky to have been contacted during this period by my VA OIF/OEF case manager (who reaches out periodically). After I explained the problems I'd been having and asked for his help, he stepped in and essentially took over my maternity care coordinator's job.

With VA appearing to place increasing reliance on purchased care, VA patients should not have to rely on good luck to have a successful experience. I was lucky to have gotten help from a VA employee who went beyond his job description to help solve a problem. And I was lucky that I was in overall good health during my pregnancy and did not have to depend on VA clinical staff coordinating with my non-VA physician, as I got no indication as to who would manage any needed coordination.

I don't want to make too much of my own frustrations. My real concern is for the many others who may confront similar problems, and particularly for those who lack the tools to navigate through such challenges. Who are these Veterans? One large VA study found that of more than 43,000 women Veterans under 50 enrolled in VA care from October 2001 through April 2008, the more than 2900 with a pregnancy tended to differ significantly from those without a pregnancy. Among those differences, those with a pregnancy were more likely to be younger, unmarried, to have less education and more likely to have been enlisted than officers. Veterans with a pregnancy were also more likely to have a service-connected disability and more likely to have one or more distinct mental health diagnoses (32% vs. 21%). The most common diagnoses among those with a pregnancy were anxiety, depression and PTSD. Surely this is a vulnerable population.[6] This study raises other real concerns. Among them is the finding that rates of anxiety, depression and PTSD were twice as high among pregnant women Veterans as among those who were not pregnant. The study authors note that "because VHA does not provide routine prenatal care at most of its locations, we were unable to determine if the women were receiving prenatal care or the degree to which prenatal care was coordinated with ongoing VHA mental health care."[7] I would echo the concern the study authors voice regarding what amounts to a dual system of care when pregnant Veterans get VA care for mental health and other problems and prenatal care through non-VA providers. They caution that "[t]his…may lead to lack of coordination among care providers, which may present problems for management of pregnancy if non-VHA obstetrical providers are unaware of women Veterans' mental health problems or medications they may be taking for these problems."[8]

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[6] Kristin Mattocks et al., "Pregnancy and Mental Health Among Women Veterans Returning from Iraq and Afghanistan," 19 Jnl of Women's Health 12, (2010)

[7] Id., 2163.

[8] Id., 2160.

We have, of course, seen improvements in VA's care of women Veterans, but at what pace? We're often reminded that "this is not your father's VA." That's certainly true of the DC VAMC, where the women's clinic serves about seven thousand women Veterans today. Unprecedented numbers of women have served in the military during Operation Iraqi Freedom and Operation Enduring Freedom, and been deployed to these war zones. Studies suggest that OEF/OIF women Veterans are among the fastest growing segments of new VHA users.[9]

With those developments, I'm troubled by a response from a VA official to systemic problems regarding women Veterans' care that says "the good news for our health care system is that as the number of women increases dramatically, we are going to continue to adjust to these circumstances quickly."[10] I'd suggest that the time for "adjustment" is now, particularly with respect to maternity care.

Let me offer the following recommendations relating to my experience for your consideration:

1. Women Veterans should be afforded access to high quality maternity care. The burden should not be on the veteran to find qualified obstetrical care.

2. Obstetrical care should not start with a pregnancy test; it should start with pre-conception counseling to ensure a woman Veteran is as healthy as possible before conception to promote her health and the health of her future children.

3. If VA is going to outsource that care, it must be seamless. VA medical centers should contract with a single high-quality provider, such as GWU, or network of providers, so that the Veteran can be assured of receiving excellent care where experienced clinicians are sensitive to the unique needs of Women Veterans and the Veteran does not bear any burden or cost associated with that care.

4. Pregnancy is a vulnerable period during which the woman veteran should have reliable, ongoing support; there cannot be a single point of failure. I applaud VA's direction that pregnant Veterans be assigned a maternity care coordinator, but that requires not only an adequate level of staffing, but appropriate training to assure a high quality and consistent level of 24/7/365 service.

The adoption of these recommendations would address only one of a number of important issues facing women Veterans. But the underlying principles have wider application as VA places greater emphasis on purchased care. VA's reliance on outsourcing care must not place the veteran-patient in financial peril. Purchasing care, particularly where VA is managing aspects of a veteran's care and a non-VA provider is managing other aspects, is likely to require real coordination and dialogue, not simply exchanging treatment records weeks after care-delivery.

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[9] Id.

[10] Garance Burke quoting Dr. Patricia Hayes, "VA Falls Short on Female Medical Issues," Associated Press (June 22, 2014), accessed at http://bigstory.ap.org/article/ap-impact-va-falls-short-female-medical-issues

In these circumstances, case-management is critical. These represent real challenges that will not be met simply by publishing directives.

Women Veterans look to you and to your oversight to help ensure that VA meets these challenges

Thank you for the opportunity to share my perspective.