



Department of Veterans Affairs Office of Inspector General

Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

Introduction

As directed by the Conference Report to Accompany the Consolidated Appropriations Act of 2010 (Public Law 111-117), we conducted a review to assess the Department of Veterans Affairs' (VA) capacity to address combat stress in women veterans. We assessed women veterans use of VA health care for traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and other mental health conditions, and whether the Veterans Benefits Administration (VBA) properly adjudicated women veterans' disability claims for these conditions. We also assessed whether VBA developed and disseminated military sexual trauma (MST) training and reference materials and policies to claims processors and the feasibility of requiring MST training and testing as part of VBA's claims processor certification.

To conduct this review, we analyzed integrated data from VA and the Department of Defense (DoD) for almost 500,000 male and female veterans who separated from the military from July 1, 2005, to September 30, 2006 for their experience transitioning to VA and using VA healthcare and compensation benefits through March 31, 2010. Nearly half of these veterans served in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) before their separation. Using integrated data from VA and DoD, we described veterans' experience transitioning to VA and using VA health care and their compensation benefits through March 31, 2010.

We interviewed VA officials and reviewed relevant policies and procedures. We interviewed experts in VA, DoD, and academia who conduct research on combat injuries and spoke with representatives from veterans service organizations and women veterans' groups. We reviewed a random statistical sample of about 750 veterans' claims files—to examine VBA's disability award and denial decisions—and conducted site visits at 4 VBA regional offices. We also conducted a national survey of VBA's local Women Veterans Coordinators.

Results

Female Veterans Generally Were More Likely To Transition to and Continue Using VA Health Care Services. As of March 31, 2010, 199,301 (40 percent) veterans in the study population and 52 percent OEF/OIF veterans used or transitioned to VA health care. Higher proportions of female veterans transitioned to VA care than their male counterparts, except for the non-OEF/OIF reserve component cohort in which proportions of females and males were the same. In addition, 23 percent used DoD care (including TriCare), although they did not use VA care.

Among veterans who transitioned to VA health care, female veterans generally were more likely to use VA health care and used it more frequently than male veterans. We examined individuals' numbers of VA outpatient visits by year for the 3 years after military separation to assess whether veterans continued their use of VA health care after their initial decision to use VA. Female veterans continued more frequent use of VA care than their male counterparts by years after separation. Increasing trends of utilization were observed for male and female veterans diagnosed with mental health issues, PTSD, and TBI and veterans with MST.

Higher Proportions of Female Veterans Generally Were Diagnosed with Mental Health Conditions by VA after Separation, but Lower Proportions Were Diagnosed with PTSD and TBI. VA diagnosed about 22 percent of the study population with mental health conditions, with higher proportions of female veterans generally diagnosed than their male counterparts. Overall, VA diagnosed more than 9 percent of the population with the specific mental health condition of PTSD. The proportion of OEF/OIF veterans VA diagnosed with PTSD was at least 3 times higher than those of their non-OEF/OIF counterparts. However, VA diagnosed fewer female veterans with the specific mental health condition of PTSD except for the veterans in the non-OEF/OIF active duty cohort.

VA diagnosed over 2 percent of the study population with TBI. The proportion of OEF/OIF males diagnosed with TBI was twice as high as those of females across military component. The proportion of OEF/OIF veterans diagnosed with TBI was more than 3 times greater than their non-OEF/OIF counterparts.

Higher Proportions of Female Veterans Generally Were Receiving Disability Benefits for Mental Health Conditions, but a Lower Proportion for PTSD and TBI. As of March 31, 2010, nearly 126,500 (26 percent) veterans in the study population were receiving compensation for their service-connected disabilities. Higher proportions of female veterans were receiving service-connected disability compensation and receiving some compensation for mental health conditions, except for the OEF/OIF reserve duty component cohort in which the corresponding proportion of females was about 1 percentage point lower than that of males. However, lower proportions of females generally were awarded disability compensation with a component for the specific mental health condition of PTSD. Less than 1 percent of the veterans in the study population were awarded service-connected TBI disability, with lower proportions of females than their male counterparts.

Among the veterans awarded disability compensation, 30 percent of them were receiving some disability award for mental health conditions. For OEF/OIF veterans, PTSD was the most common disability award component for both women and men, while major depression was the most prevalent for the non-OEF/OIF veterans. Higher proportions of

female veterans received some disability compensation than their male counterparts for each of the five prevailing mental disability award components, except for PTSD.

Gender-Based Biases Not Identified in VBA’s Adjudication of Male and Female Disability Claims, but Data Limitations Affect a Full Assessment of Some Outcomes.

Our review of a random statistical sample of veterans’ claims files found similar patterns. Overall, gender was not a significant factor in VBA’s disability claims decisions for veterans filing claims for TBI, PTSD, or other mental health conditions. We found that VBA’s adjudication of male and female veterans’ disability claims for these conditions was consistent with medical evidence on record and current policies and procedures. We noted, however, that at most regional offices, veterans may not be aware that Women Veterans Coordinators are available to assist them because the regional offices do not post signs describing services provided by the coordinators.

We observed minor gender differences in some disability outcomes. The claims file review supported that VBA granted service connection for a greater proportion of female veterans who filed disability claims for PTSD as a result of MST. VBA granted service connection for PTSD as a result of MST to 9 percent of female veterans who were service-connected for a mental health disorder, compared to only 0.1 percent of male veterans. However, we did not find any significant differences in the disability percentages VBA granted to male and female veterans for PTSD as a result of MST. VBA’s disability compensation is not specific to the disabling conditions; that is, veterans with the same overall disability rating receive the same monthly compensation regardless of their specific disabilities. For example, a veteran with a disability rating of 30 percent for PTSD receives the same monthly compensation as a veteran with a disability rating of 30 percent for major depression.

We found differences in VBA’s denial rates among male and female veterans’ claims for PTSD or other mental health conditions. Specifically, VBA denied female veterans’ disability claims for PTSD more often and denied male veterans’ disability claims for other mental health conditions (excluding PTSD) more often. Because veterans who initially apply for PTSD may actually receive disability compensation for a different mental health condition, we combined data on veterans who applied for PTSD disability compensation with data on veterans who applied for disability compensation for other mental health conditions. We examined VBA’s denial rates for male and female veterans for all mental health conditions—including PTSD—and found when taken as a whole, VBA’s denial rates are almost the same for both genders. We were unable to fully assess how often VBA denied male and female veterans’ disability claims for conditions as a result of MST and if VBA reversed its denials on appeal more frequently for male or female veterans because VBA does not retain historical data on its denial decisions.

VBA Has Guidance and Training for Evaluating MST Claims, but Sensitivity Training is Needed for Claims Processors and Women Veterans Coordinators.

VBA has issued guidance to regional offices about processing MST-related claims, and information on processing MST-related claims is included in VBA's PTSD training. However, some claims processors and Women Veterans Coordinators stated that they need more training to better prepare them to effectively communicate with veterans who may become distressed or emotional during interactions regarding their MST-related disability claim. In an effort to standardize processing of MST claims, VBA is increasing its direct interaction with veterans who file MST-related claims by requiring Women Veterans Coordinators to call each veteran who files such a claim. Female veterans may be unaware of services available through Women Veterans Coordinators, because few regional offices post signs describing these services. To increase female veterans awareness of the assistance Women Veterans Coordinators can provide them, VBA regional offices should post signs detailing services available through a Women Veterans Coordinator. To better assist claims processors, VBA should also take steps to improve the accessibility of reference materials pertaining to TBI, PTSD, other mental health conditions, and MST. VBA officials told us they are in the process of improving on-line reference materials for claims processors and expect these improvements to be complete sometime in FY 2011.

VBA Has Not Assessed the Feasibility of Requiring MST-Specific Training and Testing.

VBA has not assessed the feasibility of implementing MST-specific training and testing for claims processors who work on MST-related claims because it has not analyzed available data on its MST-related workload and how consistently these claims are adjudicated. Without a complete assessment of its MST workload and outcomes, VBA cannot determine if additional MST-specific training and testing is necessary. Most of VBA's training on MST is related to PTSD, and VBA requires both newly hired and more experienced claims processors to complete training on MST as related to PTSD claims. However, VBA's current claims processor proficiency certification examination does not always include questions on MST.

Conclusions

Based on the integrated data from VA and DoD, we characterized the population of nearly 500,000 veterans discharged from active military duty between July 1, 2005 and September 30, 2006, and we described their experience transitioning to VA and using VA health care and compensation benefits through March 31, 2010. We observed that, with variations in degree, female veterans generally were more likely to use VA health care. They were also more likely to continue using VA health care services—even years after separating from active military service—and to use it more frequently. We noticed that VA generally diagnosed higher proportions of female veterans with mental health conditions after separation, but lower proportions were diagnosed with the specific mental health condition of PTSD and with TBI. These patterns corroborated our findings from our data analyses and from our review of claims files that higher proportions of

female veterans generally were awarded disability for mental health conditions other than PTSD, and a higher proportion of men were generally awarded disability for PTSD and TBI.

Our data analyses of the study population indicated that VBA denied females more often for PTSD, and denied male veterans more often for a mental health condition other than PTSD, although the denial rates for male and female veterans for all mental health conditions were almost the same. From our review of veterans' claims files, we did not find any evidence that claims processors applied VBA's current policies and procedures differently when evaluating male and female veterans' disability claims.

Our review identified several issues pertaining to MST that require VBA leadership's attention. Because VBA does not retain historical data on its denial decisions, we were unable to fully assess how often VBA denied male and female veterans' disability claims and if VBA reversed its denials on appeal more frequently for male or female veterans. We also found that most regional offices do not post signs informing veterans about the services available through the Women Veterans Coordinators. Furthermore, many of the Women Veterans Coordinators and claims processors we spoke with stated that they often felt unprepared to communicate effectively with veterans who may be distressed or emotional during discussions regarding their MST-related disability claims. These regional office employees stated that additional training would be beneficial. Lastly, we found that although VBA does provide some training on processing MST-related claims as part of its training on PTSD, it has not assessed the feasibility of requiring additional MST-related training and testing.

Recommendations

1. We recommended the Acting Under Secretary for Benefits, in on-going efforts to modernize the Rating Board Automation data system, develop reporting capabilities to capture longitudinal data on veterans' claims activity.
2. We recommended the Acting Under Secretary for Benefits require regional offices to post signs making veterans aware of services and assistance provided by Women Veterans Coordinators.
3. We recommended the Acting Under Secretary for Benefits provide claims processors and Women Veterans Coordinators military sexual trauma sensitivity training.
4. We recommended the Acting Under Secretary for Benefits perform an analysis of military sexual trauma claims volume, assess the consistency of how these claims are adjudicated, and determine whether additional training and testing on processing these claims is needed.

Comments

We did not make any recommendations to the Veterans Health Administration. However, we did provide the Under Secretary for Health an opportunity to review and comment on our results. See Appendix A for the full text of the Under Secretary for Health's comments. The Acting Under Secretary for Benefits agreed with our findings and recommendations. We consider the planned actions acceptable and will follow up on their implementation. See Appendix B for the full text of the Acting Under Secretary for Benefits' comments.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General for
Audits and Evaluations

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Purpose

As directed in the Conference Report to Accompany the Consolidated Appropriations Act of 2010 (Public Law 111-117), the VA Office of Inspector General (OIG) conducted a study to assess VA's capacity to address combat stress in women veterans. The study objectives were to determine:

- Whether women veterans are properly evaluated by VA for post-traumatic stress disorder (PTSD), military sexual trauma (MST), and traumatic brain injury (TBI).
- Whether the Veterans Benefits Administration (VBA) is properly adjudicating combat stress as a service-connected disability.
- Whether VBA has developed and disseminated materials and policies to claims adjudicators that address claims involving MST.
- The feasibility of requiring training and testing as part of VBA's certification of claims processors who adjudicate MST claims.

Background

Women in the Military and Women Veterans. As of September 2009, there were 1,418,542 U.S. men and women in the active duty military. Women represented approximately 14 percent (203,375) of active duty military personnel.¹ At the end of September 2009, the estimated number of women veterans exceeded 1.8 million, which represented 8 percent of the overall veteran population.² Women are a rapidly growing segment of the veteran population, and, by 2023, the number of women veterans is expected to exceed 2 million.³

VA Disability Compensation. Disability compensation is part of VBA's Compensation and Pension (C&P) program. It provides a tax-free monetary benefit paid to veterans who are disabled by injuries or diseases that were incurred or worsened during their military service. These disabilities are considered to be service-connected. Disability compensation varies with the degree of disability and the number of a veteran's dependents and is paid monthly. This benefit compensates veterans for the average loss in earnings capacity in civilian occupations commensurate with the severity of the

¹ DoD Personnel and Procurement Statistics, <http://siadapp.dmdc.osd.mil/personnel/MILITARY/miltop.htm> (accessed 10/25/2010)

² VetPop Data, <http://www1.va.gov/VETDATA/Demographics/Demographics.asp> (accessed 10/26/2010)

³ VetPop Data, <http://www1.va.gov/VETDATA/Demographics/Demographics.asp> (accessed 10/26/2010)

service-connected conditions. Generally, service-disabled veterans who were discharged from military service under other than dishonorable conditions are entitled to compensation benefits, regardless of their income or employment status.

The amount of monthly monetary compensation depends on the veteran's degree of service-connected disability, the number of dependents (spouse, children, and dependent parents), and whether the veteran has a seriously disabled spouse. As of December 1, 2009, the basic monthly compensation payments ranged from \$123 for a 10 percent-disabled veteran to \$2,673 for a 100 percent-disabled veteran. For disability ratings of 30 percent or higher, VA pays additional benefits for veterans' dependents. For example, if a 60 percent-disabled veteran has a spouse and one child, the monthly payment increases by \$155, from \$974 to \$1,129. For very serious disabilities, such as the loss of limb(s), VA pays additional special monthly compensation.

Compensation payment rates are not proportional to the corresponding degrees of disability—higher disability ratings have disproportionately larger monetary benefits than lower ratings. For example, the basic monthly 100 percent disability compensation payment rate of \$2,673 is 21.7 times more than the 10 percent disability payment rate of \$123. In contrast, the 100 percent disability payment rate is 3.5 times more than the 50 percent disability payment rate of \$770.

Post-Traumatic Stress Disorder. PTSD is a recognized anxiety disorder resulting from exposure to direct or indirect threat of death, serious injury, or a physical threat which causes a person to feel intense fear, helplessness, or horror. The events that cause PTSD are called "stressors" and can result from combat, personal trauma, or other life threatening situations. PTSD may develop hours, months, or years after the stressor event occurred. Symptoms of PTSD can include recurrent thoughts of a traumatic event, reduced involvement in work or outside interests, emotional numbing, hyper-alertness, anxiety, and irritability. The disorder can be more severe and longer lasting when the stressor is a human-initiated action such as war, rape, or terrorism.

Prior to a July 2010 policy change, VBA regulations provided that service connection for PTSD be granted when evidence showed: (1) a veteran had been diagnosed with PTSD, (2) a credible stressor occurred during military service, and (3) current PTSD symptoms were linked to that stressor. If a veteran had received a combat decoration (such as a Purple Heart, Combat Action Badge, or Combat Infantry/Infantryman Badge), VA would presume that the veteran engaged in combat with an enemy, unless there is clear and convincing evidence to the contrary, and concede that the stressor occurred. If a veteran had not received a combat decoration, sufficient information about the claimed stressful event would then have to be provided by the veteran. The information that VBA requested veterans to provide in order to confirm a stressful event included:

- Date of the incident (within a 2-month time frame)
- Place of the incident
- Unit of assignment at the time of the incident
- Detailed description of the event
- Medals or citations received as a result of the incident
- Name and other identifying information concerning any other individuals involved in the event, if appropriate

The previous regulations required VBA to undertake extensive record development to corroborate whether a veteran actually experienced the claimed in-service stressor. However, the new regulation for PTSD, which went into effect on July 13, 2010, revised the standard to grant service-connected PTSD by eliminating this requirement when the claimed stressor is related to “fear of hostile military or terrorist activity” and is consistent with the places, types, and circumstances of service. A VA or contract psychiatrist or psychologist must also confirm the claimed stressor is adequate to support a diagnosis of PTSD. The new regulation will simplify and streamline the processing of PTSD claims, with the intent of providing veterans more timely decisions. We were not able to measure the effect of this policy on VBA’s PTSD disability decision outcomes because the policy was so recently introduced.

Traumatic Brain Injury. TBI is an injury to the brain from an external force that results in immediate effects such as loss or alteration of consciousness, amnesia, and sometimes neurological impairments. The potential residuals of TBI fall into three main categories of impairment: cognitive, emotional/behavioral, and physical. TBI is classified as mild, moderate, or severe based on classification at, or close to, the time of initial injury using either the Glasgow Coma Scale (GCS), length of loss of consciousness, or length of post-traumatic amnesia. Symptoms of TBI include headaches, irritability, sleep disorders, memory problems, slower thinking, and depression.

In October 2008, VBA updated its criteria for evaluating residuals of traumatic brain injury. Previously, VBA regulations limited compensation for TBI (disability code 8045), defined as a “brain disease due to trauma,” to a maximum disability rating of 10 percent based on a veteran’s reported symptoms only. After VBA’s policy change, VBA can evaluate and assign separate evaluations to additional residual conditions of TBI (such as migraines or tinnitus) and can rate these conditions up to 100 percent. Importantly, this policy change also redefined the conditions that could be captured under VBA’s disability code 8045. Prior to October 2008, this disability code may have captured information on claims filed for conditions related to TBI as well as claims filed for conditions that were not related to TBI. After October 2008, VBA’s disability code 8045 was used exclusively to capture information on claims filed for TBI. This policy

change affected our ability to reliably measure VBA's award and denial rates for veterans who filed disability compensation claims for TBI.

Military Sexual Trauma. VA uses MST to refer to the experiences of "physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while a Veteran was serving on active duty or active duty for training."⁴ Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." Both males and females can experience MST, and the perpetrator can be of the same or of the opposite gender. Like other types of trauma, MST can negatively impact a person's mental and physical health, even many years later.

The Veterans Health Care Act of 1992 (Public Law 102-585) authorized VA to provide outreach and establish MST counseling and treatment programs for women veterans who experienced incidents of sexual trauma while on active duty. In 1994, VA's authority was expanded to include counseling and treatment for men (Public Law 103-452). The Veterans Health Program Improvement Act of 2004 (Public Law 108-422) extended VA's authority to provide MST treatment permanently and extended MST counseling and related treatment to veterans whose MST occurred while serving on active duty or active duty for training. Based on these statutes, Veterans Health Administration (VHA) Directive 2005-015, *Military Sexual Trauma Counseling*, dated March 25, 2005, mandated universal screening of all enrolled veterans for a history of MST and mandated that each VA medical facility appoint an MST Coordinator to oversee the screening and treatment referral process.

Directive 2005-015 also recommended the use of clinic stop code 524 so that collection of MST treatment data is accessible and consistent across the VA system. Clinic stop codes are identifiers used in VHA's managerial cost accounting system, the Decision Support System (DSS), to indicate the primary clinical group providing the services. DSS is a congressionally-mandated resource management tool. Implementation began throughout VHA in 1994.

In 2010, at the request of Senate Veterans' Affairs Committee Chairman Daniel K. Akaka, the OIG conducted the *Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma*,⁵ which investigated allegations of charging veterans at the Austin Outpatient Clinic for treatment as a result of MST. The investigation found that the clinic stop code specifically designated for MST-related care was inconsistently implemented at VHA medical facilities. In response to the OIG report recommendation, VHA Directive 2010-033, *Military Sexual Trauma (MST) Programming*, dated July 14, 2010, replaced the 2005 Directive. The revised Directive requires checking an

⁴ Title 38, United States Code (USC), Section 1720D, *Counseling and treatment for sexual trauma*

⁵ VAOIG report number 09-01110-81, issued February 4, 2010, <http://www4.va.gov/oig/54/reports/VAOIG-09-01110-81.pdf>

MST indicator box on the encounter form if the treatment or counseling is related to MST, instead of using clinic stop code 524.

Under VA's universal screening program for MST, all veterans seen at VHA facilities are asked whether they experienced sexual trauma during their military service. The brief screening instrument contains the following two questions:

- Did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks?
- Did someone ever use force or threat of force to have sexual contact with you against your will?

Patients are considered positive for MST if they respond affirmatively to either screening item. It is important to note that only veterans who have chosen to seek VA health care are screened for MST. Therefore, MST positive screen rates cannot be used to make any estimate of the MST rate among all those serving in the U.S. Military, nor does a positive response indicate that the perpetrator was a member of the military.

VA provides free, confidential counseling and treatment for veterans' mental and physical health conditions resulting from MST. Veterans do not need to have reported the incident when it happened or have other documentation that the incident occurred. Appropriate services are provided for any injury, illness, or psychological condition resulting from MST. In addition, veterans do not need to be service-connected and may be able to receive this benefit even if they are not otherwise eligible for VA health care benefits.

Scope and Methodology

The study population included all veterans aged 17–64 who were discharged from active military duty between July 1, 2005 and September 30, 2006. We followed them through March 31, 2010, regardless of whether they enrolled in VA health care or applied for VA benefits after discharge. That is, our study population included both VA and non-VA users. The time period of our study population allows us to capture information on the transition to and use of VHA care and VBA disability benefits immediately following discharge from the military as well as several years after leaving the military. It also allows us to account for the time it generally takes for veterans to apply for VA benefits and services and for VA to make eligibility decisions for benefits and services. Furthermore, this population encompasses some Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) era veterans, as well as veterans from other service eras (non-OEF/OIF), such as Operations Desert Shield and Desert Storm. As a result, the outcomes that we observed in this population may be different from outcomes for only OEF/OIF veterans or for cohorts of veterans who more recently separated from the military.

To address the study objectives, we interviewed VHA and VBA officials and reviewed pertinent policies and procedures. We also interviewed experts in VA, the Department of Defense (DoD), and academia who conduct research on combat injuries, such as PTSD and TBI. In addition, we spoke with representatives from veterans service organizations and women veterans' groups. We also conducted site visits to four VBA regional offices (Providence, RI; Winston-Salem, NC; Milwaukee, WI; and Waco, TX). Our site selection criteria included the number of awarded and denied claims that were processed at each regional office, geographic location, and the overall size of the regional office. We surveyed Women Veterans Coordinators at each of VBA's 57 regional offices, obtaining a 100 percent response rate. We also reviewed a random statistical sample of veterans' claims files.

Study Population and the LC Database. We included all veterans aged 17–64 in the LC database for this review. The population-based LC database identifies and captures information on all veterans who were separated from active military duty during July 1, 2005–September 30, 2006, whether or not they enrolled in VA healthcare or applied for VA benefits after separation (VA users or non-VA users).

The LC database was created by and is maintained by the OIG. It is derived from more than 30 files acquired from VA and DoD and integrates details from both VA and DoD data on nearly a half million discharged service members. The LC database is the first and, to date, the only available population-based, comprehensive analytic database that integrates both VA and DoD data on these recently discharged veterans. This population-based approach eliminates potential bias in the selection of veterans. For example, veterans who are VA users may differ from non-VA users in fundamental ways that impact veterans' decisions to transition to VA care and impact policy, planning, and resource decisions. In addition, VA outreach efforts could be better targeted if more information were available on non-VA users.

Updates to the LC Database. OIG report *Quantitative Assessment of Care Transition: The Population-Based LC Database*⁶ describes the LC database in detail, including an overview of its structure, the methodology used to create it, data confidentiality issues, and the opportunity it provides for VA to make decisions using an evidence-based approach. We also used the LC database as part of our work to respond to a congressionally requested evaluation of veterans' access to mental health care and reported our results in *Access to VA Mental Health Care for Montana Veterans*.⁷

⁶ VAOIG report number 07-00380-202, issued 9/13/2007, <http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf>

⁷ VAOIG report number 08-00069-102, issued 3/31/2009, <http://www.va.gov/oig/54/reports/VAOIG-08-00069-102.pdf>

We updated the database to include information through March 31, 2010, the most recent time period available for us to meet our reporting requirement. DoD medical treatment data was available only through March 31, 2009. We also added information that indicates if individual veterans sought any MST-related care at VA. Updates to the LC database are summarized below.

VA Disability Compensation. Because of compensation payment variations for given disability ratings and dual eligibility for both compensation and pension, we chose to work with disability ratings directly. We added to the LC database up to nine impairment-specific disability ratings and the combined total disability rating as of the end of March 2010. Note that the combined disability rating is not a simple sum of each specific disability rating. For example, multiple zero ratings of specific disabilities could result in a 10 percent combined disability rating. These disability ratings were taken from both the extract of the Benefits Delivery Network (BDN) database (referred to as the C&P file) and from the extract of Corporate Data Warehouse's VetsNet database (referred to as the Corporate file), as VBA is transitioning from the BDN database to the Corporate one. We also included information on claim denial decisions from June 2005 through March 2010 from VBA's Rating Board Automation data system (RBA 2000)—which is part of its corporate database. Data on claim denial decisions prior to June 2005 was not available.

Military Sexual Trauma. MST indicators were created from two types of VHA Medical SAS data files—the MST Registry files and the Outpatient files. The MST Registry files were discontinued after FY 2005. The Outpatient files (from FY 2005 forward) contained an MST indicator for each encounter that was checked by health care providers if the treatment or counseling was related to MST. We defined a patient as having MST if the patient was included in any MST registry files or had an MST indicator in any of the Outpatient files. We used the FYs 2001–2005 MST registry files and the FYs 2005–2009 and the FY 2010 through March 31, 2010 Outpatients files to generate the MST indicators.

VA and DoD Treatment Information and Vital Status. Veterans' vital status information was updated through April 2010. All VA (including fee basis care) medical treatment information was updated to the end of March 2010. Limited by the data availability, DoD treatment information was updated to the end of March 2009. The current LC database covers DoD treatment information from FY 2002 through March 2009 and VA treatment information from FY 2004 through March 2010.

In addition to updating the original 11 diagnostic-specific indicators in the LC database, we added new diagnostic-specific indicators. These indicators were created based on patients' specific diagnostic codes of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM), using the same business rules detailed in the our 2007 OIG report, *Quantitative Assessment of Care Transition: The Population-*

*Based LC Database.*⁸ ICD-9-CM groups these disease diagnostic codes into 17 broad categories. We created an indicator for each of the 17 broad ICD-9-CM categories, except for Neoplasms (140–239) that used two indicators, one for Malignant Neoplasms (140–208) and another for Benign Neoplasms (210–239).

Mental Disorders were defined as any ICD-9-CM diagnosis from 290.0 to 319.0, which corresponds to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised* (DSM-IV-R). Indicators were also created for each individual category of mental disorders based on the first three digits of the ICD-9-CM codes.

The category “Psychosocial or Behavioral Problems” was defined based on selected ICD-9-CM V-codes, a supplementary classification used to describe problems that are a focus for mental health treatment but are not considered mental health diagnoses.^{9 10} The specific V-codes included for defining this category are: V15.40–V15.49, V60.0–V60.2, V60.4, V61.0–V61.22, V61.80–V61.83, V61.90, V62.0, V62.2, V62.5, V62.80–V62.89, V63.0, V63.9, V65.2, V65.5, V69.2–V69.8, V70.1–V70.2, V71.0–V71.1, V71.5, V71.81, and V79.0–V79.1.

The updated LC database currently incorporates details about all 493,934 service members discharged or released alive from active military duty during the period July 1, 2005–September 30, 2006. Because of delays in reporting deaths, the total number discharged alive (493,934) in the current database differs from that (494,147) in the 2007 report, *Quantitative Assessment of Care Transition: The Population-Based LC Database*.¹¹

We conducted testing of VA data captured in the LC database by comparing data elements such as discharge date, gender, and military branch to information contained in a random statistical sample of veterans’ disability claims files. We found that data captured in the LC database were accurate based on our comparison. We were unable to test the reliability of DoD data captured in the LC database because there is not independent data source to compare these data against. We determined that the data were sufficiently reliable for the purposes of our review.

⁸ VAOIG report number 07-00380-202, issued 9/13/07, <http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf>.

⁹ Prophet S., *V codes: supplementary classification of factors influencing health status and contact with health services*, Journal of AHIMA (American Health Information Management Association), 1996; 67:16-25.

¹⁰ Hoge CW, Lesikar SE, Guevara R, et al., *Mental disorders among U.S. military personnel in the 1990s: association with high levels of health care utilization and early military attrition*, American Journal of Psychiatry, 2002; 159:1576-1583.

¹¹ VAOIG report number 07-00380-202, issued 9/13/07, <http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf>.

Statistical Analyses

Our analyses included veterans in the LC database who were discharged alive from active military duty during July 1, 2005–September 30, 2006. We excluded veterans whose ages at separation were under 17 or 65 and over. Age at separation was calculated based on date at separation and date of birth. When the date of birth for a veteran recorded in the military discharge files and in the VA and the DoD treatment files did not agree, we reset the birth date to the one that was the same between any two files. Otherwise, we reset the birth date to the first one of the three files with a valid date in the order of the military discharge files, the VA treatment files, and the DoD treatment files. Similarly, we recoded gender when the information in different files disagreed.

We considered a service member as having served in a Reserve/National Guard unit if Reserve/National Guard status was indicated in any of the Reserve Affairs roster, OEF/OIF, or VADIR Reserve files before their separation date.

For service branch, the “Other” category of service combined all branches other than Army, Navy, Air Force, and Marine Corps, including missing branch information.

Service Character was re-categorized as follows:

- **Honorable/General** incorporates “Honorable” and “General, Under Honorable Conditions.” This category also includes those judged “Honorable for VA Purposes” by VBA.
- **Other than Honorable**
- **Bad Conduct/Dishonorable** includes “Bad Conduct” and “Dishonorable” discharges. It also includes those judged “Dishonorable for VA Purposes” by VBA.
- **Uncharacterized** consists of those without character of service listed.

Note that “Bad Conduct/Dishonorable” discharges issued by general courts martial may bar veterans from receiving VA benefits. Therefore, veterans separated administratively under “Other Than Honorable” conditions may request that their discharge be reviewed for possible re-characterization for the purpose of obtaining VA benefits. We excluded veterans with service character of “Bad Conduct/Dishonorable” from the study population because they were generally not eligible for VA benefits.

We grouped Pay Grade into five categories: E1–E4, E5–E9, O1–O3, O5–O10, and “Other.” The “Other” group included W1–W5, codes other than specified above, and missing Pay Grade information.

Our indicator of Mental Health Diagnosis is combined Mental Disorder (ICD-9-CM) and Psychosocial or Behavioral Problems (ICD-9-CM V-codes).

Awards for mental disability conditions contained all awards with VBA's disability condition codes 9100–9599. Awards for PTSD disability were identified by VBA's disability condition code 9411, which is a specific mental disability. In addition, TBI disability awards were defined by VBA's disability condition code 8045.

We performed data analyses using SAS statistical software (SAS Institute, Inc., Cary, North Carolina), version 9.2 (TS1M0). For the claims file review samples we used WesVar software (Replication-Based Variance Estimation for Analysis of Complex Survey Data, version 5.1.17).

Claims File Review

To assess whether VBA's policies and procedures are consistently applied for claims involving PTSD, TBI, and other mental health conditions, we conducted a review of 767 claims files randomly selected from the LC Database. Our review consisted of 487 awarded claims and 280 denied claims.

Women veterans accounted for a relatively small percentage of the total universe of claims. In order to minimize the sampling error of our comparisons of male and female veteran claims, we over sampled women veterans' claims. We selected a roughly equal sized sample of male and female veterans' claims from four strata among both awarded and denied claims. These strata ensured that we would sample claims for PTSD, TBI, and other mental health disorders from both male and female veterans.

For our review of awarded claims we established four strata:

1. Male and female veterans with PTSD service-connected awards and/or service-connected awards for some other mental health condition (VBA disability codes 9400–9521). Veterans with additional service-connected awards for TBI and/or a MST indicator are excluded.
2. Male and female veterans with service-connected awards for TBI. Veterans with service-connected awards in addition to TBI for PTSD; other mental health conditions or a MST indicator are excluded.
3. Male and female veterans with service-connected awards for TBI as well as service-connected awards for PTSD and/or other mental health conditions. Veterans with a MST indicator are excluded.
4. Male and female veterans with MST indicators, with service-connected awards for other mental health conditions and/or PTSD. Veterans with a service-connected award for TBI are excluded.

VBA provided us with data on veterans' denied disability claims from July 2005 through March 2010. We were provided data on all VBA denials for any veterans captured in the LC database, including OEF/OIF and non-OEF/OIF veterans.

For our review of denied claims we also established four strata:

1. Male and female veterans with denials for PTSD only. Veterans with denials also for TBI and other mental health conditions are excluded.
2. Male and female veterans with denials for TBI only. Veterans with denials also for PTSD or other mental health conditions are excluded.
3. Male and female veterans with denials for some other mental health condition. Veterans with denied claims also for PTSD and TBI are excluded.
4. Male and female veterans with combinations of two or more denials for our study conditions.

For our review of awarded TBI claims, we included all women veterans' claims (61 claims). We captured information on claimed conditions, diagnoses, C&P exam attendance, reasons for denials, appropriateness of decisions, and whether or not VBA's decisions were appealed.

The study was performed jointly by our Offices of Healthcare Inspections and Audits and Evaluations from April through October 2010 and in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results and Conclusions

Issue 1: With Variations in Degree, Women Veterans Generally Were More Likely To Transition to and Use VA Health Care and Receive Service-Connected Disability Benefits

Summary of Findings

Based on the integrated data from both DoD and VA, we characterized the population of nearly half a million veterans discharged from active duty during July 1, 2005 to September 30, 2006. We followed them for their experience transitioning to and using VA health care and benefits through March 31, 2010. We compared female veterans' characteristics and disease burdens with those of their male counterparts in this veteran population.

We examined gender differences in the population to assess:

- Transition to VA care
- Patterns of utilization of VA health care
- Status of receiving VA benefits and total service-connected disability ratings
- Association between disease diagnoses, use of VA health care and receiving VA benefits, and total disability ratings

Female Veterans Generally Were More Likely To Transition to VA Health Care.

As of March 31, 2010, 199,301 (40 percent) veterans in the study population and 52 percent OEF/OIF veterans used or transitioned to VA health care. Higher proportions of female veterans transitioned to VA care than their male counterparts, except for the non-OEF/OIF reserve component cohort in which proportions of females and males were the same. In addition, 23 percent used DoD care (including TriCare), although they did not use VA care.

Higher Proportions of Female Veterans Generally Were Diagnosed with Mental Conditions after Separation, but Lower Proportions Were Diagnosed with PTSD and TBI.

About 28 percent of the study population had mental health diagnoses (combined ICD-9-CM mental disorder codes that include PTSD and V-codes indicating psychosocial or behavioral problems) by VA or DoD after their separation from active military service. Regardless of their gender and service component, 29 percent or more OEF/OIF veterans had been diagnosed with mental conditions at VA, over twice the percent of their respective non-OEF/OIF counterparts. The percent diagnosed at VA was

lower for females (by about 1 percentage point) than for males in the non-OEF/OIF reserve cohort only.

Although female veterans generally were more likely to be diagnosed with mental conditions after separation from active military duty, they generally were less likely than their male counterparts to be diagnosed with the specific mental condition of PTSD. The proportions of female OEF/OIF veterans who were diagnosed with PTSD (by VA or DoD) were 12 percent for active component and 16 percent for reserve unit, while the proportions for their male counterparts were about 17 percent for both active and reserve units.

About 3 percent of the veterans had been diagnosed with TBI by VA or DoD after their separation from active military duty. The proportion of OEF/OIF males diagnosed with TBI was twice as high as females across military unit component.

Female Veterans Generally Were More Likely To Continue Using VA Health Care Services. Among veterans who transition to VA health care, female veterans generally were more likely than male veterans to use VA health care. We also examined VA outpatient visits by year for the first 3 years after military separation to assess whether veterans continued their use of VA health care after their initial decision of transitioning to VA. Year by year, female veterans continued to use VA care more frequently than their male counterparts. Increasing trends of utilization generally were observed for veterans diagnosed with mental health issues, PTSD, TBI, and MST.

Higher Proportions of Female Veterans Generally Were Receiving Disability for Mental Conditions, but Fewer for PTSD and TBI. As of March 31, 2010, 126,426 (26 percent) veterans in the study population were receiving compensation awards for their service-connected disability. A higher proportion of female veterans were receiving service-connected disability compensation and receiving some compensation for mental disability conditions, except for the OEF/OIF reserve component cohort in which the corresponding proportion of females were about 1 percentage point lower than those of males. However, a lower proportion of females generally were awarded compensation with a component for the specific mental condition of PTSD.

Among the veterans awarded disability compensation, 30 percent of them were receiving some disability award for mental conditions. For OEF/OIF veterans, PTSD was the most common mental disability award component for both women and men, while major depression was the most prevalent for the non-OEF/OIF veterans. Higher proportions of female veterans received some disability compensation than their male counterparts for each of the five prevailing mental disability award components, except for PTSD.

Less than 1 percent of the veterans in the study population were awarded service-connected TBI disability, with lower proportions of females than their male counterparts.

These patterns establish that although female veterans generally were more likely to be diagnosed with mental conditions, they generally were less likely than their male counterparts to be diagnosed with TBI and the specific mental condition of PTSD.

Veterans with service-connected disability were also more likely to have used VA care in the past 2 years (from April 1, 2008 to March 31, 2010), and higher total disability ratings were associated with higher likelihood of using VA care.

Details of Findings

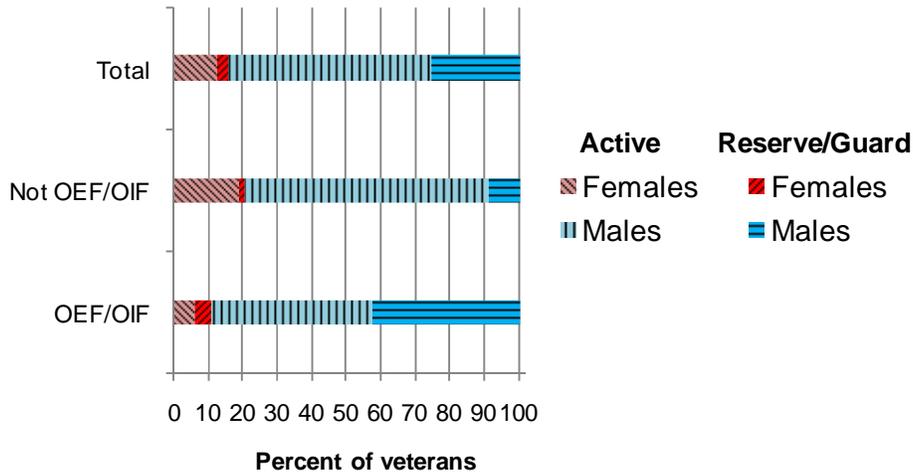
1. Baseline Characteristics of the Study Population

Of the 493,934 veterans in the LC database, we excluded from our analyses a total of 878 veterans, which accounted for less than 0.2 percent of the entire population. The excluded veterans consist of:

- 23 veterans who were reportedly age 16 or under at their time of separation from active military duty
- 73 veterans who were age 65 or over at separation
- 555 veterans whose service characteristics were "bad conduct" or "dishonorable"
- 227 veterans with an unknown gender

OEF/OIF Status and Military Component. About half of the study population was OEF/OIF veterans. Exhibit 1a shows that among OEF/OIF veterans, 53 percent served in the active component, more than 10 percent were women, and about 6 in 10 women served in the active component. In contrast, 89 percent of non-OEF/OIF veterans served in the active unit, over 20 percent of them were women, and 9 out of 10 women served in the active component.

Exhibit 1a. Gender and Military Component Distributions in the Study Population, by OEF/OIF Status



Age at Separation. At their time of separation from active military service, 43 percent of the veterans were 17 to 24 years old (Exhibit 1b). Women veterans tended to be younger than their male counterparts. Veterans who served in the reserve/guard component were older than those who served in the active component, especially in the non-OEF/OIF cohorts—the median age difference was 12 years for both females (23 versus 35) and males (24 versus 36) (Exhibit 1c). The median age of 23 for females, for example, indicates that half of them were younger and half of them were older than 23 at the time of their military separation. All mean ages were greater than the corresponding median ages, indicating the distributions of ages at separation were more towards younger service members than older ones.

Exhibit 1b. Distributions of Female and Male Veterans' Ages at Separation from Active Military Service, by OEF/OIF Status and Military Component

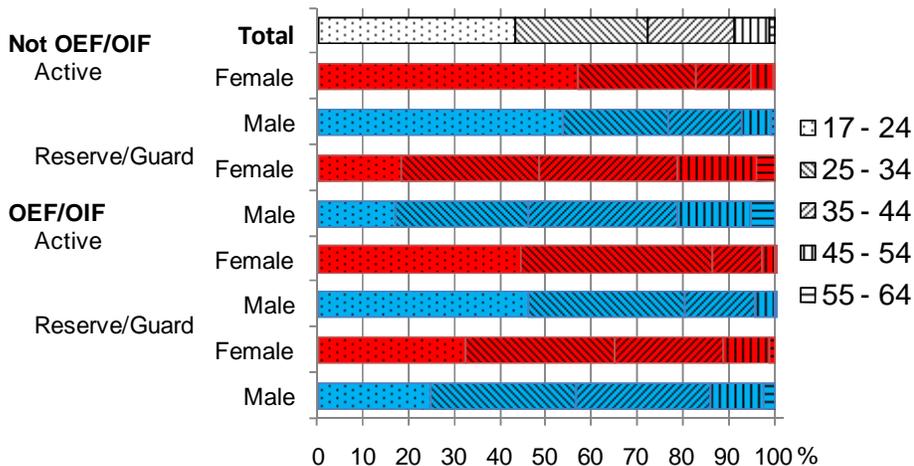
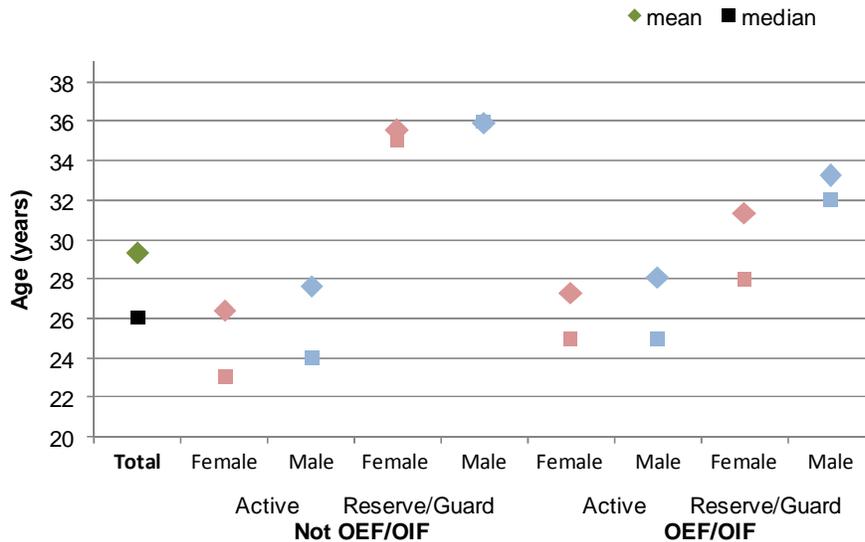


Exhibit 1c. Means and Medians of Female and Male Veterans' Ages at Separation from Active Military Service, by OEF/OIF Status and Military Component



Branches of Service, Character of Service, and Pay Grades. Regardless of gender, over 70 percent of veterans in the reserve component served in the Army, compared with less than 50 percent of active veterans (Exhibit 1d). About 2 percent of OEF/OIF female and male veterans who served in the active component had unknown (uncharacterized) character of service. In contrast, this was unknown over 11 percent of the time for other veteran cohorts (Exhibit 1e). Over 88 percent of the veterans were enlisted, and proportionally fewer women were in the higher pay grades (E5–E9) (Exhibit 1f). Although with some fluctuation, higher proportions of female veterans were officers, except for OEF/OIF reserves, where the proportions (12 percent) were similar.

Exhibit 1d. Distributions of Female and Male Veterans' Military Branches at Time of Separation from Active Military Service, by OEF/OIF Status and Military Component

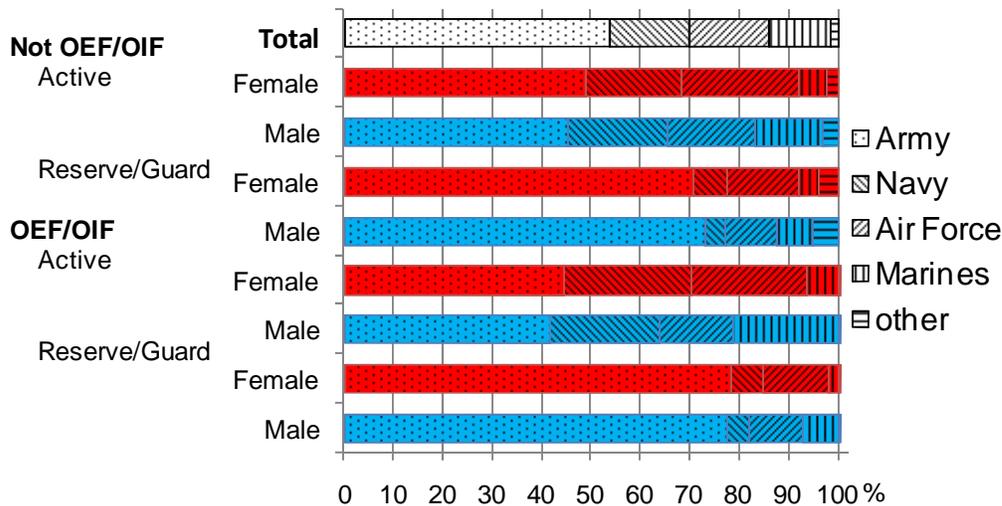


Exhibit 1e. Distributions of Female and Male Veterans' Character of Service, by OEF/OIF Status and Military Component

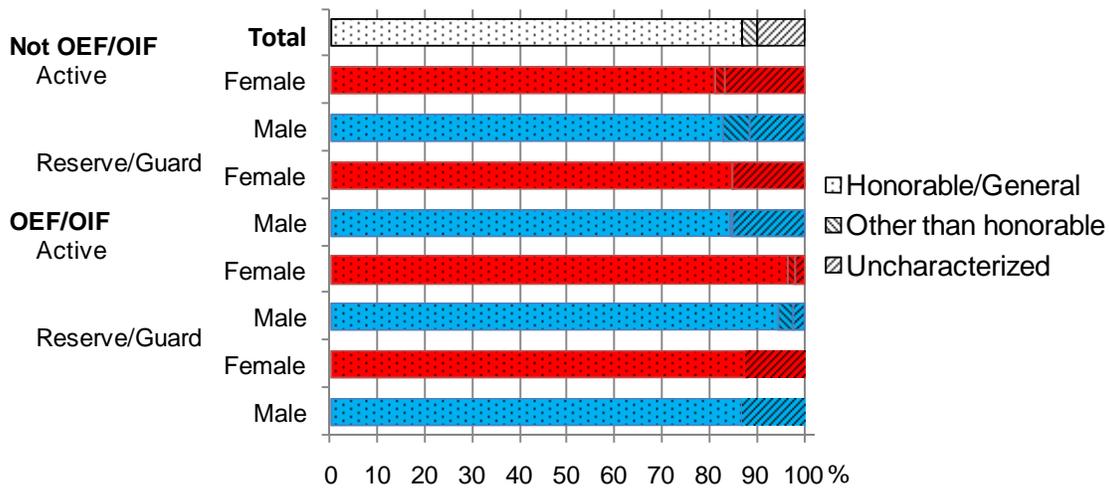
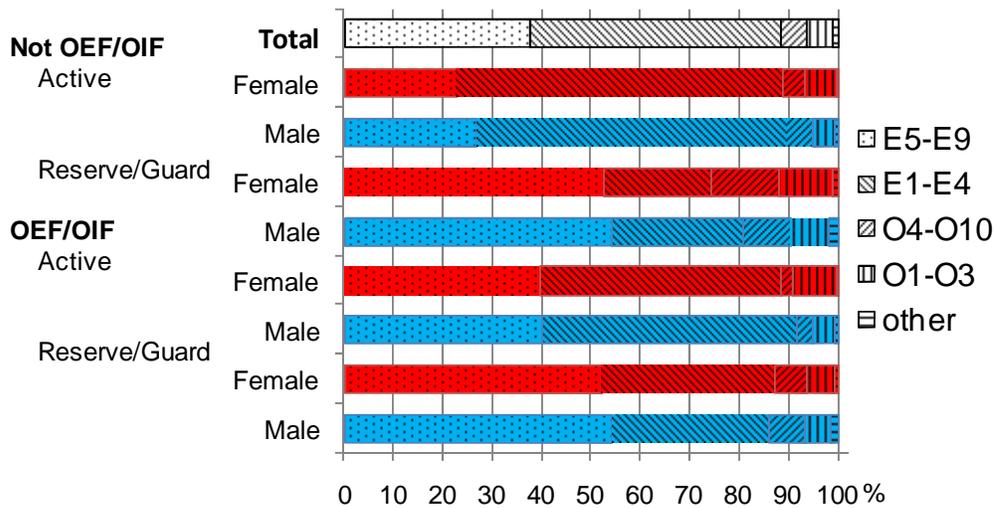


Exhibit 1f. Distributions of Female and Male Veterans' Military Pay Grades at Time of Separation from Active Military Service, by OEF/OIF Status and Military Component



Because of the differences in these baseline characteristics by OEF/OIF status and military component, we conducted our analysis separately by OEF/OIF status and military component, whenever our subgroup population sizes permitted.

2. Status of the Study Veteran Cohort as of March 31, 2010

By the end of March 2010, 40 percent of veterans in the study population used or transitioned to VA health care, and 23 percent used DoD care (including TriCare), although they did not use VA care (Exhibit 2a). A higher proportion of female veterans transitioned to VA care than their male counterparts, but with variations in magnitude among the study cohorts. Specifically, about half or more of veterans in each of our OEF/OIF cohorts used VA care—52 percent of women and 49 percent of men who served in the active component and 57 percent of women and 54 percent of men who served in the reserve unit. In contrast, within each non-OEF/OIF veteran cohort, fewer than 35 percent used VA—31 percent of women and 28 percent of men who served in the active component and about 34 percent of women and of men with service in the reserve unit. The differences between transition patterns to VA care among OEF/OIF and non-OEF/OIF cohorts are likely a reflection of the OEF/OIF veterans' entitlement to VA care.

Exhibit 2a. Current Status (as of March 31, 2010) of the Study Population

		Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
		Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
		Female 45,512 (20.8%)	Male 173,600 (79.2%)	Female 4,740 (17.6%)	Male 22,228 (82.4%)	Female 15,105 (11.5%)	Male 116,256 (88.5%)	Female 10,825 (9.4%)	Male 104,790 (90.6%)
Total	493,056								
Health care utilization for any disease after separation from active military service (%)									
At VA	40.4	30.9	27.6	34.4	34.5	52.4	49.2	57.0	54.1
At DoD only	22.5	24.4	26.4	37.3	34.8	15.1	14.2	22.6	22.3
Did not use health care at DoD or VA	37.1	44.7	46.0	28.3	30.7	32.5	36.6	20.4	23.7
Diagnosed with mental disorders (ICD-9-CM: 290–319) or V-codes indicating a psychosocial or behavioral problem ¹ after separation (%)									
At VA	21.5	13.9	11.6	14.6	15.5	29.0	29.0	33.7	32.3
At DoD only	6.9	9.5	8.9	11.1	9.4	4.0	4.3	6.5	5.2
Diagnosed with PTSD (ICD-9-CM: 309.81) after separation (%)									
At VA	9.4	2.9	2.5	3.5	4.4	12.0	16.1	15.2	16.7
At DoD only	0.4	0.4	0.2	0.7	0.5	0.4	0.4	0.6	0.6
Diagnosed with TBI (ICD-9-CM: 310.2, 800–804, 850–854, and 950) after separation (%)									
At VA	2.4	0.4	0.8	0.6	1.1	1.8	4.3	2.2	4.3
At DoD only	0.4	0.3	0.5	0.6	0.7	0.2	0.3	0.3	0.5
Percent veterans with service-connected disability	25.6	25.3	22.3	18.1	17.1	38.3	36.0	19.4	20.8
Total disability rating, mean	41.2	42.5	41.0	41.3	40.2	39.5	41.2	42.3	41.3
Total disability rating, median	40	40	40	40	30	40	40	40	40
Percent veterans with service-connected mental disability	7.8	7.4	3.7	4.5	3.3	13.6	12.8	8.4	9.3
Total disability rating, mean	58.1	56.3	59.3	58.3	65.1	53.7	57.2	60.3	59.4
Total disability rating, median	60	60	60	60	70	50	60	60	60
Percent veterans with service-connected PTSD	4.5	1.0	0.7	0.8	1.3	5.1	9.2	5.2	7.7
Total disability rating, mean	60.0	61.2	65.1	66.0	66.2	59.5	58.8	61.9	60.5
Total disability rating, median	60	60	70	60	70	60	60	60	60
Percent veterans with service-connected TBI	0.5	0.1	0.2	0.1	0.3	0.3	0.9	0.3	0.9
Total disability rating, mean	63.6	50.9	55.5	56.7	62.0	51.8	63.8	62.9	68.1
Total disability rating, median	70	50	60	60	70	50	65	70	70
Died as of April 1, 2010 (%)	0.8	0.3	0.7	0.2	0.6	0.4	1.3	0.3	0.6

¹ V15.40–V15.49, V60.0–V60.2, V60.4, V61.0–V61.22, V61.80–V61.83, V61.90, V62.0, V62.2, V62.5, V62.80–V62.89, V63.0, V63.9, V65.2, V65.5, V69.2–V69.8, V70.1–V70.2, V71.0–V71.1, V71.5, V71.81, and V79.0–V79.1

About 22 percent of the study population had mental health diagnoses (combined ICD-9-CM mental disorder codes that include PTSD and V-codes indicating psychosocial or behavioral problems) at VA. An additional 7 percent had been diagnosed by DoD. Twenty-nine percent or more OEF/OIF veterans, regardless of their gender and service component, had been diagnosed at VA, over twice the percent of their respective non-OEF/OIF counterparts. The percent diagnosed at VA was lower for females (by about 1 percentage point) than for males in the non-OEF/OIF reserve cohort only.

Over 9 percent of the veterans had been diagnosed with PTSD at VA, with an additional half percent diagnosed at DoD. Except for the veterans in the non-OEF/OIF active cohort, lower proportions of female veterans were diagnosed at VA than their male

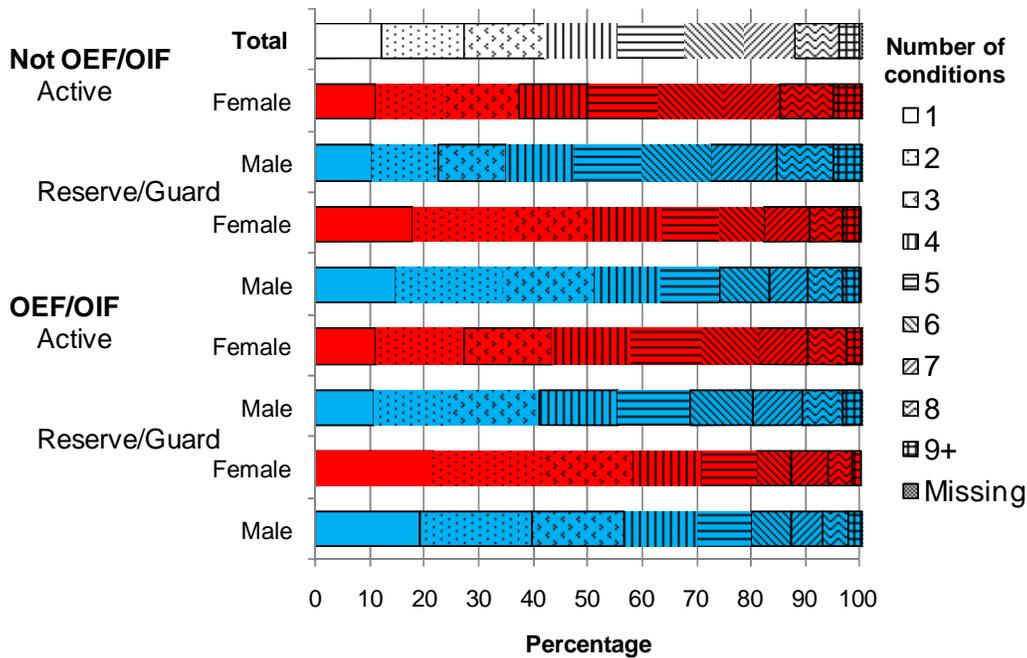
counterparts. The proportion of OEF/OIF veterans diagnosed with PTSD at VA was at least 3 times higher than their non-OEF/OIF counterparts.

Over 2 percent of the veterans had been diagnosed with TBI at VA, with an additional half percent diagnosed at DoD. The proportion of males diagnosed with TBI was twice as high as females across OEF/OIF status and military unit component. The proportion of OEF/OIF veterans diagnosed with TBI at VA was more than 3 times that of their non-OEF/OIF counterparts.

As of March 31, 2010, about 26 percent of the veterans were receiving compensation, with the median disability rating of 40 percent. More OEF/OIF veterans (19–38 percent) received some VA compensation for their service-connected disability than non-OEF/OIF veterans (17–25 percent). A higher proportion of females were awarded compensation than their male counterparts. However, for veterans who served in the OEF/OIF reserve component, the proportion (19.4 percent) of awarded compensation for females was over 1 percentage point lower than that (20.8 percent) of their male counterparts. The median total disability ratings were 40 percent for all cohorts, except for the 30 percent for males who served in the non-OEF/OIF reserve unit.

Exhibit 2b gives distributions of the number of service-connected disability conditions for the 126,426 female and male veterans who were receiving compensation awards, by OEF/OIF status and military component. Across gender and OEF/OIF status, veterans who served in the reserve component were awarded fewer (median of 3) service-connected disability conditions than their active counterparts (median of 4).

Exhibit 2b. Percentages of Female and Male Veterans with Different Service-Connected Disability Conditions for the 126,426 Veterans Receiving Disability Compensation, by OEF/OIF Status and Military Component



About 8 percent of the veterans were receiving disability compensation that included a component for mental disability, with a median total disability rating of 60 percent (Exhibit 2a). More OEF/OIF veterans (8–14 percent) were receiving some compensation for mental disability than non-OEF/OIF veterans (3–7 percent). A higher proportion of females were awarded compensation for mental disability than their male counterparts, except for females who served in the OEF/OIF reserve component whose proportion (8 percent) of awarded compensation was about 1 percentage point lower than that (9 percent) of their male counterparts. The median total disability ratings were 60 percent for all cohorts, except for the higher (70) percent for males who served in the non-OEF/OIF reserve unit and the lower (50) percent for females who served in the OEF/OIF active unit.

Over 4 percent of the veterans were receiving disability compensation that included a component for PTSD, a specific component of the mental disability conditions, with a median total disability rating of 60 percent. Noticeably more OEF/OIF veterans (5–9 percent) were receiving some compensation for PTSD than non-OEF/OIF veterans (about 1 percent). Fewer females were awarded compensation with a specific component for PTSD than their male counterparts, except for females who served in the non-OEF/OIF active component whose proportion of awarded compensation was 1 percent. This was a little more than their male counterparts (0.7 percent). The median total disability ratings were 60 percent for all cohorts, except for the higher (70) percent for non-OEF/OIF males, regardless of their military component.

Less than 1 percent of the veterans were receiving disability compensation that included a component for TBI, with the median total disability rating of 70 percent. Fewer females were awarded compensation for TBI than their male counterparts—0.3 percent for OEF/OIF females and 0.9 percent for OEF/OIF males, regardless of military component and 0.1 percent for non-OEF/OIF active or reserve females, compared to 0.2 percent and 0.3 percent for non-OEF/OIF active and reserve males, respectively. The median total disability ratings for females (50 to 60 percent) were at least 10 percentage points lower than those for males (60 to 70 percent), except for the 70 percent ratings for females and males who served in the OEF/OIF reserve component.

Exhibit 2c gives the percentages of female and male veterans who were receiving some disability compensation for mental disability by each of the 10 most prevalent mental disability conditions or receiving some disability compensation for TBI. Exhibit 2d charts the five most prevailing mental disability conditions and TBI by OEF/OIF status.

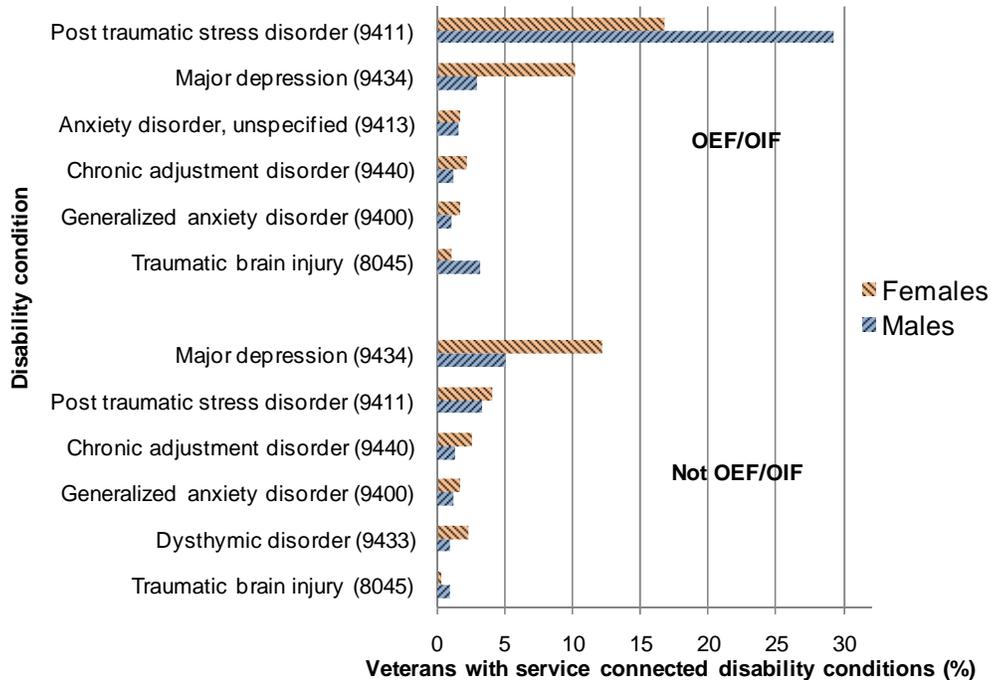
Exhibit 2c. Percentages of Female and Male Veterans with Service-Connected Mental Disability¹ or Traumatic Brain Injury² among 126,426 Veterans Who Were Awarded Compensation as of March 31, 2010, for the 10 Most Prevalent Mental Disability Conditions and Traumatic Brain Injury, by OEF/OIF Status

Disability conditions (%)	Total 126,426	Not OEF/OIF 54,832 (43.4%)		OEF/OIF 71,594 (56.6%)	
		Female 12,389 (9.8%)	Male 42,443 (33.6%)	Female 7,875 (6.2%)	Male 63,719 (50.4%)
Awarded compensation for mental disability	30.3	28.9	16.8	37.7	38.7
Post traumatic stress disorder (9411)	17.4	4.1	3.4	16.8	29.3
Major depression (9434)	5.1	12.2	5.1	10.2	3.0
Chronic adjustment disorder (9440)	1.5	2.7	1.4	2.2	1.3
Anxiety disorder, unspecified (9413)	1.4	1.4	1.0	1.7	1.6
Generalized anxiety disorder (9400)	1.2	1.7	1.2	1.7	1.1
Dysthymic disorder (9433)	0.9	2.3	1.0	1.5	0.4
Dementia due to head trauma (9304)	0.7	0.3	0.5	0.3	1.0
Mood disorder (9435)	0.6	1.1	0.7	1.1	0.5
Bipolar disorder (9206, 9432)	0.6	1.4	0.8	1.0	0.3
Panic disorder and/or agoraphobia (9412)	0.5	0.8	0.5	0.6	0.3
Traumatic brain injury (8045)	2.1	0.4	1.1	1.1	3.2

¹ Disability condition codes: 9100–9599

² Disability condition code: 8045

Exhibit 2d. Percentages of Female and Male Veterans with Service-Connected Mental Disability¹ or Traumatic Brain Injury² among 126,426 Veterans Who Were Awarded Compensation as of March 31, 2010, for the Five Most Prevalent Mental Disability Conditions and Traumatic Brain Injury, by OEF/OIF status



¹Disability condition codes: 9100–9599
²Disability condition code: 8045

Among the 126,426 veterans who were awarded disability compensation, 30 percent of them were receiving some disability award for mental conditions, and 2 percent received some disability award for TBI.

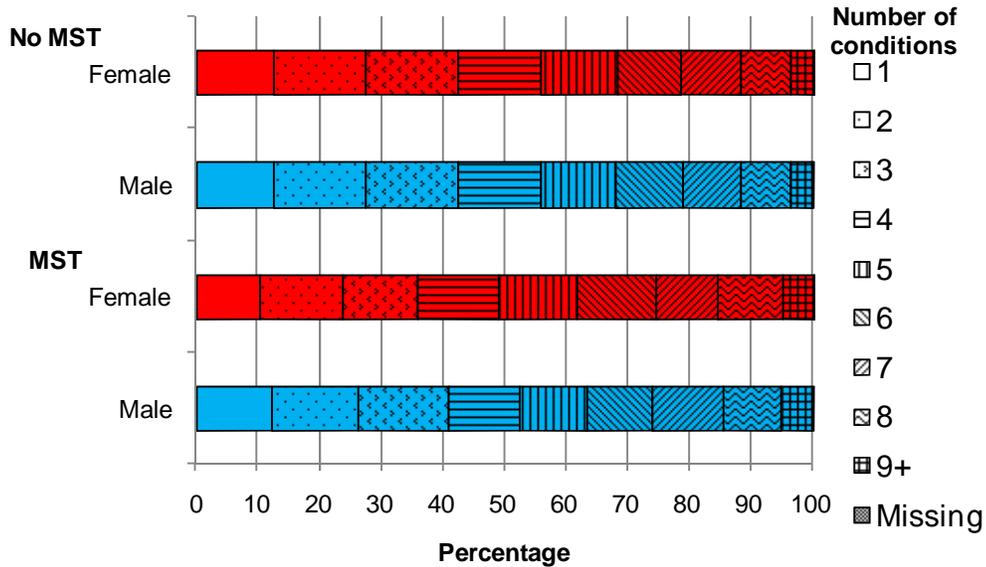
Four out of the five most prevalent mental disability components were the same for OEF/OIF and non-OEF/OIF veterans. Anxiety disorder (unspecified) was the third prevailing mental disability component for OEF/OIF veterans, but it was not in the five most prevalent for non-OEF/OIF veterans. Dysthymic disorder was the fifth prevailing award component for non-OEF/OIF but was not in the five most prevalent for OEF/OIF veterans.

For OEF/OIF veterans, PTSD was the most common mental disability award component for both women and men, while major depression was the most prevalent for the non-OEF/OIF veterans. More women veterans received some disability compensation than their male counterparts for each of the prevailing mental disability award components, except for PTSD. More male OEF/OIF veterans (29 percent) received disability awards with a component for PTSD than their female counterparts (17 percent).

Exhibit 2e gives distributions of the number of service-connected disability conditions for the 126,426 female and male veterans who were receiving compensation awards, by

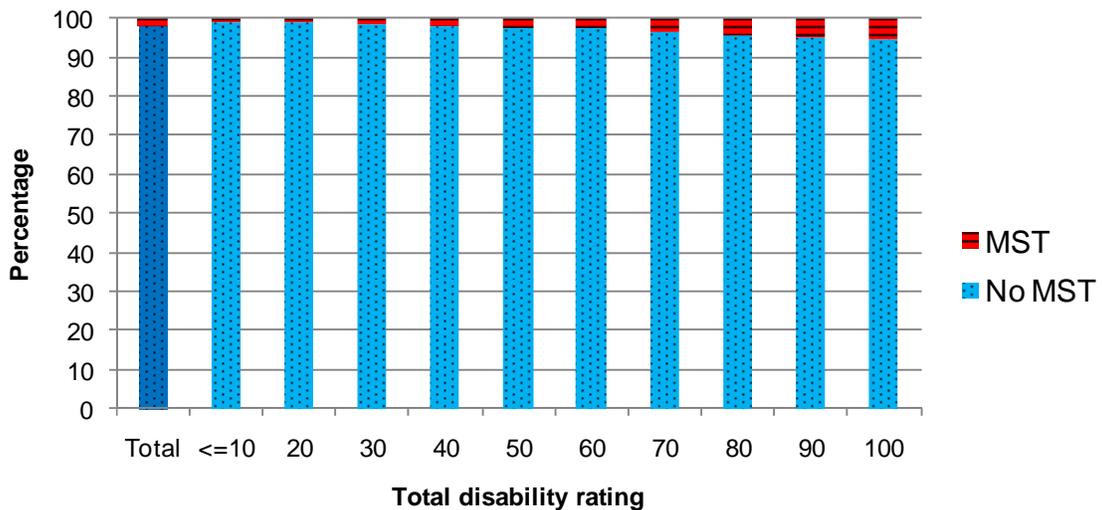
MST status. Across genders, veterans with MST were awarded more service-connected disability conditions than their non-MST counterparts. Exhibit 2f shows that as total disability ratings increase, the proportion of veterans with MST also increases.

Exhibit 2e. Distribution of Different Service-Connected Disability Conditions per Veteran for 126,426 Veterans Who Were Awarded Compensation as of March 31, 2010, by Military Sexual Trauma¹



¹Only veterans who sought VA health care for treatment related to MST

Exhibit 2f. Total Disability Ratings for 126,426 Veterans Who Were Awarded Compensation as of March 31, 2010, for Military Sexual Trauma¹

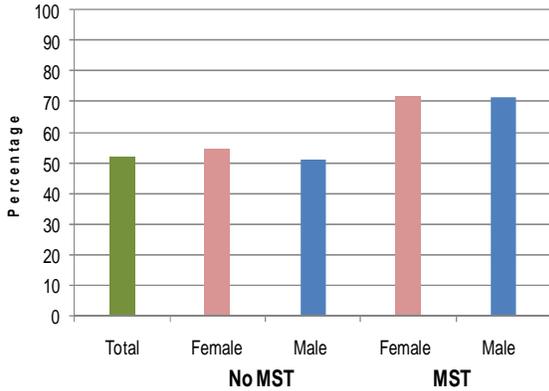


¹Only veterans who sought VA health care for treatment related to MST

Exhibits 2g–2l show, by MST status, among the 199,301 veterans who transitioned to VA health care after separation, the percentages who were receiving any service-connected disability, receiving service-connected disability with a component for mental conditions,

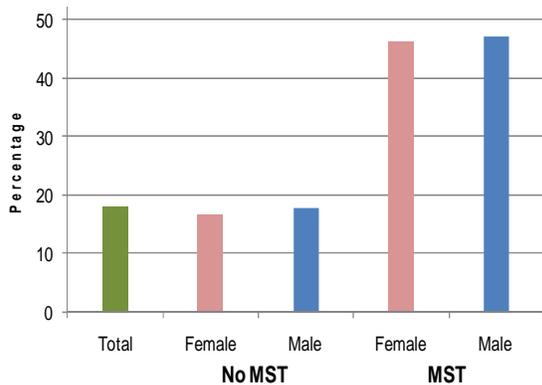
and receiving service-connected disability with a component for PTSD, respectively, and the associated means and medians of their total disability ratings as of March 31, 2010. Across gender, higher proportions of MST veterans were receiving compensation than their non-MST counterparts for any disability and disabilities with a component for mental conditions and PTSD. The means and medians of total disability ratings of MST veterans were also higher than their non-MST counterparts. Across MST the medians were the same for male and female veterans, except for MST veterans with a mental disability component, where the median for men was 10 percentage points higher.

Exhibit 2g. Percentages of Female and Male Veterans Who Had Service-Connected Disability among 199,301 Veterans Who Transitioned to VA Health Care after Separation from Active Military Service, by Military Sexual Trauma¹



¹Only veterans who sought VA health care for treatment related to MST

Exhibit 2i. Percentages of Female and Male Veterans Who Had a Component for Mental Disability Conditions among 199,301 Veterans Who Transitioned to VA Health Care after Separation from Active Military Service, by Military Sexual Trauma¹



¹Only veterans who sought VA health care for treatment related to MST

Exhibit 2h. Means and Medians of Female and Male Veterans' Total Disability Rating among 103,373 Veterans Who Had Service-Connected Disability, by Military Sexual Trauma¹

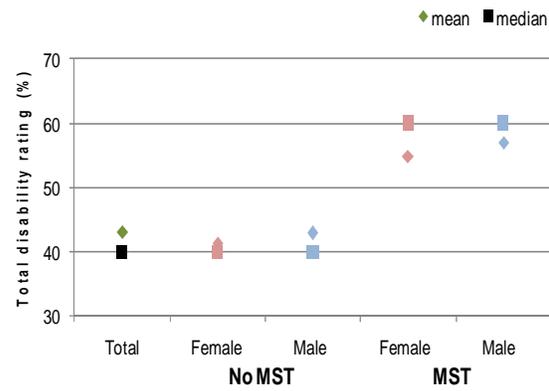


Exhibit 2j. Means and Medians of Female and Male Veterans' Total Disability Rating among 35,936 Veterans Who Had a Component for Mental Disability Conditions, by Military Sexual Trauma¹

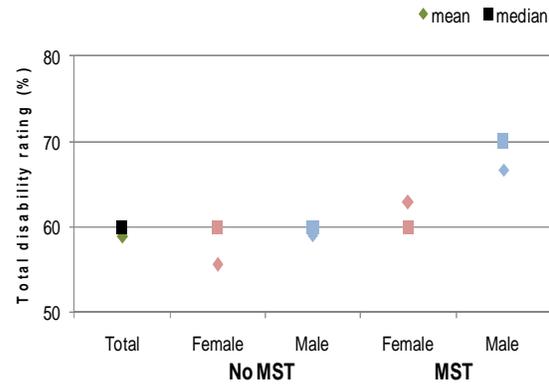
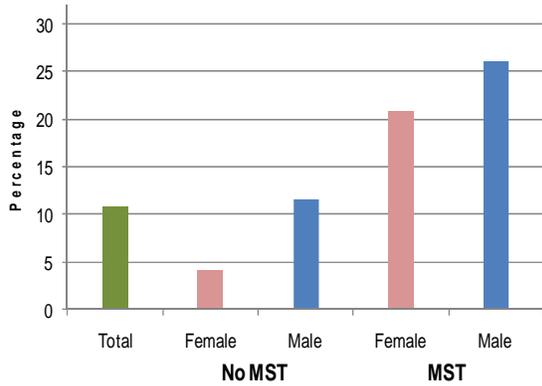
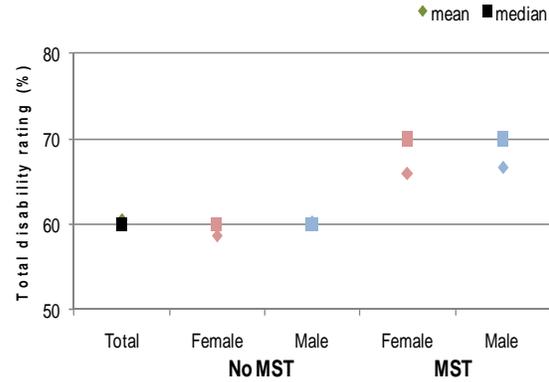


Exhibit 2k. Percentages of Female and Male Veterans Who Had a Component for PTSD among 199,301 Veterans Who Transitioned to VA Health Care after Separation from Active Military Service, by Military Sexual Trauma¹



¹Only veterans who sought VA health care for treatment related to MST

Exhibit 2l. Means and Medians of Female and Male Veterans' Total Disability Rating among 21,326 Veterans Who Had a Component for PTSD, by Military Sexual Trauma¹



3. Burden of Diseases among Veteran Cohorts in the Study Population

Exhibit 3 details the percentages of female and male veterans diagnosed with medical conditions, before and after separation from active military service, for the 15 non-female specific (out of the 17) broad ICD-9-CM diagnostic categories and the V-codes indicating psychosocial or behavioral problems, stratified by OEF/OIF status and military component. The two female-specific categories that were excluded are:

- Complications of pregnancy, childbirth, and the puerperium (ICD-9-CM diagnostic codes: 630–679)
- Certain conditions originating in the perinatal period (ICD-9-CM codes: 760–779)

The diagnoses represented combined data from DoD (October 1, 2003–March 31, 2009) and VA (October 1, 2003–March 31, 2010). The neoplasm category was split into two subcategories:

- Malignant neoplasms (ICD-9-CM codes: 140–208)
- Benign neoplasms (ICD-9-CM codes: 210–239)

Although with some fluctuation in magnitude, a higher proportion of women veterans was diagnosed for each of the disease diagnostic categories than their male counterparts, except for diseases of the circulatory system, which had a lower proportion (18 percent) of reserve OEF/OIF females diagnosed, compared to their male counterparts (20 percent). The proportion of females diagnosed with diseases of the genitourinary system was more

than four-fold that of males, except for non-OEF/OIF reserves where the percentage for females was a little less than 4 times that of males.

Across all cohorts, more than half of the veterans had been diagnosed with diseases of the musculoskeletal system and connective tissues, ranging from 52 percent (for males who served in the OEF/OIF reserve unit) to 72 percent (for females who served in the OEF/OIF active component). Diseases of the nervous system and sense organs were also diagnosed for more than half of the veterans (from 51 percent to 72 percent), except for males (46 percent) who served in the OEF/OIF reserve component.

After separation from active military service, both female and male veterans who served in OEF/OIF were more likely to be diagnosed with mental disorders (30 and 31 percent for females and males in the active component and 37 and 34 percent for females and males in the reserve unit) than their non-OEF/OIF counterparts (19 and 17 percent for females and males in the active component and 22 percent for both females and males in the reserve unit). A similar pattern was shown for psychosocial/behavioral problems.

Exhibit 3. Percentages of Female and Male Veterans Diagnosed with Medical Conditions at DoD (from October 1, 2003 to March 31, 2009) or VA (from October 1, 2003 to March 31, 2009), by OEF/OIF Status and Military Component

Veterans diagnosed (%)	Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
	Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
	Female 45,512 (20.8%)	Male 173,600 (79.2%)	Female 4,740 (17.6%)	Male 22,228 (82.4%)	Female 15,105 (11.5%)	Male 116,256 (88.5%)	Female 10,825 (9.4%)	Male 104,790 (90.6%)
Infectious and parasitic disease (001–139)	45.1	29.1	36.6	22.4	52.6	30.1	30.4	18.8
Before separating from military service	39.0	23.6	26.4	14.5	45.7	22.8	16.7	9.3
DoD diagnosed	38.8	23.5	25.6	13.9	45.7	22.8	15.7	8.7
VA diagnosed	0.2	0.2	1.6	1.0	0.2	0.2	1.8	1.0
After separating from military service	12.5	8.7	18.0	11.3	16.3	11.1	18.7	11.7
DoD diagnosed	7.8	5.7	13.2	7.7	5.4	3.3	9.0	4.9
VA diagnosed	5.2	3.3	5.7	4.1	11.7	8.1	10.9	7.3
Malignant neoplasm (140–208)	1.7	1.5	3.0	1.9	2.1	1.3	1.8	1.4
Before separating from military service	1.1	0.9	1.7	1.1	1.2	0.7	0.5	0.4
DoD diagnosed	1.0	0.9	1.6	1.0	1.2	0.7	0.5	0.4
VA diagnosed	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.1
After separating from military service	1.0	0.9	2.0	1.3	1.3	0.8	1.5	1.1
DoD diagnosed	0.5	0.5	1.3	0.6	0.4	0.3	0.4	0.3
VA diagnosed	0.7	0.4	0.8	0.7	1.0	0.5	1.1	0.9
Benign neoplasm (210–239)	13.8	8.2	19.4	10.1	17.1	9.2	13.9	7.4
Before separating from military service	9.9	5.6	11.3	5.4	11.8	6.1	5.2	2.5
DoD diagnosed	9.8	5.6	10.7	5.2	11.8	6.1	4.8	2.3
VA diagnosed	0.2	0.1	0.9	0.2	0.1	0.0	0.6	0.3
After separating from military service	5.7	3.5	11.3	5.8	7.3	3.9	10.5	5.5
DoD diagnosed	3.0	2.3	7.6	3.5	2.3	1.4	4.1	2.0
VA diagnosed	2.9	1.3	4.2	2.4	5.3	2.5	6.8	3.6
Endocrine, nutritional and metabolic disease, and immunity disorders (240–279)	29.8	22.6	31.6	28.8	35.0	27.5	27.3	26.1
Before separating from military service	23.0	15.7	20.4	15.4	24.6	16.3	8.4	6.6
DoD diagnosed	22.8	15.5	19.2	14.1	24.6	16.3	7.4	5.5
VA diagnosed	0.3	0.3	2.6	2.1	0.2	0.1	1.6	1.5
After separating from military service	13.2	12.5	20.8	21.1	18.9	17.3	23.5	23.4
DoD diagnosed	5.6	6.3	12.3	10.5	3.8	4.5	7.1	6.0
VA diagnosed	8.5	7.3	11.1	12.7	16.2	13.8	18.5	19.2
Diseases of the blood and blood forming organs (280–289)	10.4	3.1	9.8	3.2	11.7	3.2	8.1	2.8
Before separating from military service	7.3	1.9	5.4	1.5	7.2	1.6	2.5	0.8
DoD diagnosed	7.2	1.9	5.1	1.3	7.2	1.6	2.2	0.7
VA diagnosed	0.1	0.0	0.5	0.2	0.1	0.0	0.4	0.1
After separating from military service	4.2	1.4	5.9	2.0	5.8	1.8	6.4	2.1
DoD diagnosed	1.9	0.8	2.9	1.0	1.3	0.5	1.8	0.5
VA diagnosed	2.4	0.7	3.3	1.1	4.6	1.3	4.6	1.6
Mental disorders (290–319)	44.1	35.2	33.6	29.9	49.1	44.4	41.8	37.5
Before separating from military service	35.8	24.9	21.2	15.4	37.0	27.3	14.8	10.2
DoD diagnosed	35.6	24.7	20.0	14.1	36.9	27.1	12.9	8.6
VA diagnosed	1.0	0.8	2.5	2.2	1.0	0.8	3.2	2.5
After separating from military service	18.7	16.8	22.4	22.0	29.7	30.6	36.5	34.1
DoD diagnosed	8.5	8.4	13.0	10.9	6.2	6.3	10.4	8.7
VA diagnosed	12.3	10.2	12.8	13.8	26.4	26.7	30.9	29.5
Diseases of the nervous system and sense organs (320–389)	64.2	55.7	60.1	51.3	72.0	58.6	51.2	46.0
Before separating from military service	58.4	48.4	47.6	35.4	64.8	47.5	28.8	22.8
DoD diagnosed	58.1	47.9	46.5	34.2	64.5	47.0	27.4	21.5
VA diagnosed	1.4	1.8	3.1	2.4	1.4	2.0	2.9	2.2
After separating from military service	23.4	21.6	35.5	31.8	29.7	28.4	37.1	34.8
DoD diagnosed	13.0	13.1	26.5	21.3	8.8	8.4	17.3	13.9
VA diagnosed	12.7	10.6	13.7	14.4	23.3	22.0	24.1	24.7

Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits

Veterans diagnosed (%)	Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
	Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
	Female	Male	Female	Male	Female	Male	Female	Male
	45,512 (20.8%)	173,600 (79.2%)	4,740 (17.6%)	22,228 (82.4%)	15,105 (11.5%)	116,256 (88.5%)	10,825 (9.4%)	104,790 (90.6%)
Diseases of the circulatory system (390–459)	18.1	18.0	24.7	24.9	21.6	20.6	17.9	20.0
Before separating from military service	13.7	12.8	16.6	15.0	15.0	12.8	7.4	7.2
DoD diagnosed	13.5	12.6	15.7	14.0	15.0	12.7	6.6	6.3
VA diagnosed	0.4	0.4	1.9	2.0	0.2	0.3	1.4	1.5
After separating from military service	8.6	10.1	15.5	17.2	11.1	12.7	14.2	16.8
DoD diagnosed	4.1	5.6	9.6	9.4	3.1	4.0	5.0	5.2
VA diagnosed	5.4	5.6	8.1	10.1	8.8	9.7	10.6	13.4
Diseases of the respiratory system (460–519)	66.2	52.8	57.2	42.7	63.7	43.2	51.3	36.1
Before separating from military service	60.5	46.3	46.4	31.5	56.2	33.7	34.7	21.6
DoD diagnosed	60.2	46.0	45.0	30.6	56.0	33.6	33.4	20.7
VA diagnosed	0.7	0.5	3.9	2.1	0.5	0.3	4.0	1.9
After separating from military service	20.6	16.2	30.7	22.1	24.7	18.6	31.7	22.1
DoD diagnosed	11.8	10.9	22.6	15.5	7.9	6.6	15.6	10.3
VA diagnosed	10.3	6.3	11.4	8.2	18.6	13.0	19.7	13.5
Diseases of the digestive system (520–579)	39.7	28.4	38.7	29.3	46.7	33.5	38.6	30.9
Before separating from military service	31.3	19.4	24.6	15.8	34.7	20.1	15.7	10.4
DoD diagnosed	30.8	19.0	22.5	14.1	34.4	19.8	12.4	8.0
VA diagnosed	0.8	0.7	3.3	2.5	0.7	0.5	4.5	2.9
After separating from military service	16.3	14.1	23.9	19.8	23.0	19.9	30.5	25.5
DoD diagnosed	6.9	6.4	12.8	8.5	4.4	4.0	7.7	5.4
VA diagnosed	10.7	8.7	13.3	12.9	19.9	16.8	25.1	21.7
Diseases of the genitourinary system (580–629)	56.3	11.7	53.3	13.8	71.5	14.1	48.0	11.1
Before separating from military service	47.9	7.8	39.9	7.5	63.3	8.9	25.4	3.8
DoD diagnosed	47.6	7.7	38.0	7.0	63.2	8.8	23.4	3.4
VA diagnosed	0.8	0.2	3.6	0.8	0.7	0.1	3.8	0.6
After separating from military service	22.7	5.5	31.5	8.5	30.7	7.0	35.2	8.5
DoD diagnosed	12.5	3.2	21.4	4.4	9.0	2.1	14.5	2.7
VA diagnosed	12.0	2.6	13.5	4.6	24.1	5.2	24.1	6.2
Diseases of the skin and subcutaneous tissue (680–709)	39.3	31.5	38.0	26.5	47.3	32.6	33.4	23.5
Before separating from military service	32.8	24.8	26.0	17.1	38.3	23.3	16.9	11.4
DoD diagnosed	32.6	24.6	25.0	16.3	38.2	23.2	15.9	10.6
VA diagnosed	0.4	0.3	1.8	1.2	0.3	0.2	2.2	1.2
After separating from military service	13.5	11.4	21.1	14.4	19.5	14.7	22.9	15.7
DoD diagnosed	7.4	7.4	15.2	9.6	5.2	4.5	9.5	6.2
VA diagnosed	6.8	4.4	7.2	5.5	15.4	10.8	15.3	10.5
Diseases of the musculoskeletal system and connective tissue (710–739)	70.3	56.4	64.1	55.2	72.0	61.8	60.5	51.6
Before separating from military service	65.2	48.4	51.8	40.4	65.1	50.6	37.9	26.5
DoD diagnosed	64.9	48.1	50.1	39.0	65.0	50.4	36.1	24.8
VA diagnosed	1.2	0.9	5.7	4.5	0.9	0.9	6.0	4.2
After separating from military service	26.5	24.4	40.6	35.7	35.8	34.4	46.1	41.4
DoD diagnosed	14.0	13.8	29.5	22.4	9.5	9.2	19.7	15.3
VA diagnosed	15.8	13.5	18.8	18.8	29.9	28.1	34.4	32.2
Congenital anomalies (740–759)	7.1	4.8	7.4	4.8	8.4	4.9	4.9	3.2
Before separating from military service	5.6	3.6	4.4	2.7	6.7	3.5	2.0	1.2
DoD diagnosed	5.6	3.6	4.3	2.6	6.7	3.5	1.9	1.1
VA diagnosed	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.1
After separating from military service	1.9	1.4	3.4	2.4	2.0	1.7	3.1	2.1
DoD diagnosed	1.2	0.9	2.4	1.6	0.7	0.5	1.6	0.9
VA diagnosed	0.7	0.6	1.0	0.8	1.3	1.2	1.6	1.3
Symptoms, signs, and ill-defined conditions (780–799)	71.7	53.0	67.7	53.0	82.1	58.9	64.0	49.6
Before separating from military service	64.2	43.0	53.6	36.3	75.3	44.9	38.7	24.0
DoD diagnosed	63.8	42.6	52.1	35.0	75.2	44.7	36.8	22.6
VA diagnosed	1.3	0.8	4.5	3.0	0.8	0.8	5.1	2.8
After separating from military service	28.9	23.9	42.0	33.8	38.7	32.8	48.7	38.9
DoD diagnosed	17.0	15.1	30.8	22.4	12.4	10.2	21.8	15.2
VA diagnosed	15.0	11.1	16.9	15.8	30.4	25.2	33.8	28.4

Veterans diagnosed (%)	Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
	Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
	Female	Male	Female	Male	Female	Male	Female	Male
	45,512 (20.8%)	173,600 (79.2%)	4,740 (17.6%)	22,228 (82.4%)	15,105 (11.5%)	116,256 (88.5%)	10,825 (9.4%)	104,790 (90.6%)
Injury and poisoning (800–999)	58.7	51.1	52.5	46.1	61.0	55.9	45.7	38.9
Before separating from military service	52.9	43.3	40.0	33.7	54.1	47.2	30.1	22.0
DoD diagnosed	52.6	43.0	39.2	32.8	54.0	47.1	28.9	21.2
VA diagnosed	0.6	0.6	2.9	2.3	0.5	0.7	3.3	2.0
After separating from military service	16.7	17.0	27.4	24.2	20.0	21.9	27.6	25.4
DoD diagnosed	10.4	11.8	21.4	17.8	6.6	7.4	14.8	12.2
VA diagnosed	7.3	6.2	8.3	8.2	14.4	15.7	15.7	15.4
V-codes indicating a psychosocial or behavioral problem ¹	28.3	20.4	18.9	15.5	33.6	27.2	22.8	21.4
Before separating from military service	21.9	14.4	10.6	7.6	24.8	17.4	8.5	7.8
DoD diagnosed	21.6	14.2	9.7	6.9	24.6	17.2	7.3	6.9
VA diagnosed	0.6	0.5	1.1	0.9	0.3	0.4	1.3	1.0
After separating from military service	11.0	8.5	10.6	9.6	14.3	13.6	16.9	15.9
DoD diagnosed	5.5	4.1	5.3	3.9	2.2	1.7	3.9	2.9
VA diagnosed	5.8	4.6	5.8	6.0	12.5	12.2	13.7	13.6

¹ V15.40–V15.49, V60.0–V60.2, V60.4, V61.0–V61.22, V61.80–V61.83, V61.90, V62.0, V62.2, V62.5, V62.80–V62.89, V63.0, V63.9, V65.2, V65.5, V69.2–V69.8, V70.1–V70.2, V71.0–V71.1, V71.5, V71.81, and V79.0–V79.1

4. Burden of Mental Disorders and Traumatic Brain Injury among Veteran Cohorts

Exhibit 4 displays the percentages of female and male veterans diagnosed by DoD or VA with different mental disorders (based on the first three digits of ICD-9-CM diagnostic codes: 290–319), PTSD, adjustment reaction excluding PTSD, or TBI before and after separation from active military service (during October 1, 2003–March 31, 2010). Although the ICD-9-CM classifies PTSD as a type of adjustment reaction, for purposes of our analyses, we separated PTSD from the adjustment reaction category.

During the period of October 1, 2003–March 31, 2010, higher proportions of females were diagnosed with mental disorders, except for the following five categories where fewer female veterans were diagnosed by at least 1 percentage point:

- Alcohol and drug induced mental disorders (alcohol & drug psychoses) (ICD-9-CM codes: 291 and 292)
- Sexual and gender identity disorders (ICD-9-CM codes: 302)
- Alcohol dependence syndromes (ICD-9-CM codes: 303)
- Non-dependent abuse of drugs (ICD-9-CM codes: 305)
- Specific non-psychotic mental disorders due to brain damage (ICD-9-CM codes: 310)

Although with some fluctuation in magnitude, the most common mental disorder diagnoses across all veteran cohorts were:

- Anxiety, dissociative and somatoform disorders (neurotic disorders) (ICD-9-CM codes: 300)

- Non-dependent abuse of drugs (ICD-9-CM codes: 305)
- Adjustment reaction (excluding PTSD) (ICD-9-CM codes: 309, excluding 309.81)
- PTSD (ICD-9-CM diagnostic code: 309.81)
- Depressive disorders (ICD-9-CM codes: 311)

After separation, regardless of gender and military component, a higher proportion of OEF/OIF veterans were diagnosed with the aforementioned most common medical disorders than their non-OEF/OIF counterparts. The differences were most marked for PTSD diagnoses—the proportion of OEF/OIF veterans ranged from 12 percent to 17 percent, while the proportions for non-OEF/OIF veterans were in the range of 3 to 5 percent.

Fewer female veterans were diagnosed with TBI (ICD-9-CM codes 310.2, 800–804, 850–854, and 950) than their male counterparts. After separation, the proportion of OEF/OIF veterans diagnosed with TBI was more than twice those of their non-OEF/OIF counterparts.

Exhibit 4. Percentages of Female and Male Veterans Diagnosed with Mental Disorders (ICD-9-CM: 290–319) or Traumatic Brain Injury (ICD-9-CM: 310.2, 800–804, 850–854, and 950) at DoD (from October 1, 2003 to March 31, 2009) or VA (from October 1, 2003 to March 31, 2010), by OEF/OIF Status and Military Component

Veterans diagnosed (%)	Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
	Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
	Female 45,512 (20.8%)	Male 173,600 (79.2%)	Female 4,740 (17.6%)	Male 22,228 (82.4%)	Female 15,105 (11.5%)	Male 116,256 (88.5%)	Female 10,825 (9.4%)	Male 104,790 (90.6%)
Alcohol and drug induced mental disorders (alcohol & drug psychoses) (291 and 292)	0.9	1.2	0.8	1.1	1.1	1.8	0.7	1.2
Before separating from military service	0.6	0.7	0.4	0.5	0.7	0.9	0.2	0.2
DoD diagnosed	0.6	0.7	0.4	0.4	0.7	0.9	0.2	0.2
VA diagnosed	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
After separating from military service	0.4	0.5	0.5	0.6	0.4	0.9	0.5	1.1
DoD diagnosed	0.2	0.3	0.3	0.3	0.1	0.2	0.1	0.3
VA diagnosed	0.2	0.3	0.2	0.3	0.3	0.8	0.4	0.8
Episodic mood disorders (affective psychosis) (296)	10.9	5.8	8.3	4.9	14.8	8.7	11.8	7.4
Before separating from military service	7.2	3.4	3.4	1.7	7.5	3.3	2.5	1.1
DoD diagnosed	7.1	3.3	3.0	1.5	7.5	3.2	2.1	0.8
VA diagnosed	0.3	0.2	0.5	0.4	0.3	0.1	0.6	0.3
After separating from military service	5.8	3.1	6.4	3.8	10.2	6.7	10.7	6.8
DoD diagnosed	1.5	0.8	2.5	0.8	1.1	0.6	1.7	0.8
VA diagnosed	4.7	2.5	4.6	3.2	9.6	6.3	9.7	6.3
Anxiety, dissociative and somatoform disorders (neurotic disorders) (300)	15.4	9.0	12.1	7.7	19.3	13.2	15.8	11.4
Before separating from military service	11.0	5.8	6.1	3.1	11.5	5.8	3.9	2.1
DoD diagnosed	10.8	5.6	5.5	2.8	11.4	5.7	3.3	1.6
VA diagnosed	0.4	0.2	0.8	0.5	0.3	0.2	0.8	0.5
After separating from military service	6.9	4.4	8.1	5.6	11.6	9.2	13.7	10.2
DoD diagnosed	2.3	1.4	3.6	1.9	1.6	1.0	2.7	1.7
VA diagnosed	5.0	3.1	5.1	4.0	10.5	8.4	11.9	9.0
Personality disorders (301)	5.8	3.8	1.7	1.3	4.5	2.6	2.1	1.2
Before separating from military service	4.9	3.2	0.9	0.8	3.5	1.8	0.7	0.3
DoD diagnosed	4.9	3.2	0.9	0.7	3.5	1.8	0.7	0.3
VA diagnosed	0.2	0.2	0.1	0.1	0.0	0.0	0.0	0.0
After separating from military service	1.3	0.7	1.0	0.6	1.7	1.1	1.6	0.9
DoD diagnosed	0.5	0.3	0.5	0.2	0.4	0.2	0.4	0.2
VA diagnosed	0.9	0.4	0.6	0.4	1.4	0.9	1.2	0.7
Sexual and gender identity disorders (302)	0.3	2.4	0.2	4.0	0.4	2.6	0.2	3.3
Before separating from military service	0.2	1.1	0.1	1.4	0.2	1.0	0.0	0.6
DoD diagnosed	0.2	1.0	0.1	1.2	0.2	1.0	0.0	0.5
VA diagnosed	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.1
After separating from military service	0.1	1.7	0.1	3.1	0.2	1.8	0.1	2.9
DoD diagnosed	0.0	0.9	0.1	1.7	0.0	0.6	0.0	0.7
VA diagnosed	0.1	0.8	0.0	1.6	0.2	1.3	0.1	2.3
Alcohol dependence syndromes (303)	2.1	3.8	1.5	2.7	3.4	6.9	2.1	4.0
Before separating from military service	1.5	2.7	0.8	1.4	2.1	4.0	0.4	0.6
DoD diagnosed	1.5	2.7	0.8	1.2	2.1	4.0	0.3	0.4
VA diagnosed	0.0	0.1	0.1	0.3	0.0	0.1	0.1	0.2
After separating from military service	0.8	1.4	0.9	1.8	1.7	3.7	1.8	3.7
DoD diagnosed	0.2	0.5	0.3	0.4	0.2	0.4	0.3	0.4
VA diagnosed	0.6	1.0	0.7	1.4	1.6	3.4	1.6	3.4
Drug dependence (304)	1.2	1.6	0.5	1.1	1.4	2.6	1.1	1.6
Before separating from military service	0.7	0.9	0.2	0.5	0.6	0.9	0.2	0.2
DoD diagnosed	0.7	0.9	0.2	0.4	0.6	0.9	0.1	0.1
VA diagnosed	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.1
After separating from military service	0.5	0.8	0.4	0.8	0.9	1.9	1.0	1.5
DoD diagnosed	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1
VA diagnosed	0.4	0.6	0.3	0.7	0.8	1.8	0.9	1.4

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Veterans diagnosed (%)	Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
	Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
	Female	Male	Female	Male	Female	Male	Female	Male
	45,512 (20.8%)	173,600 (79.2%)	4,740 (17.6%)	22,228 (82.4%)	15,105 (11.5%)	116,256 (88.5%)	10,825 (9.4%)	104,790 (90.6%)
Non-dependent abuse of drugs (305)	13.8	16.3	11.7	15.4	19.9	25.1	16.2	19.4
Before separating from military service	9.1	9.7	6.4	7.3	13.9	14.4	5.1	4.6
DoD diagnosed	9.0	9.5	6.0	6.7	13.8	14.3	4.5	3.9
VA diagnosed	0.2	0.2	0.8	1.0	0.2	0.2	0.8	1.0
After separating from military service	6.9	8.7	7.9	11.1	10.2	15.5	13.5	17.1
DoD diagnosed	3.1	4.3	4.6	5.7	2.0	3.0	4.4	4.5
VA diagnosed	4.1	4.9	4.3	6.3	8.6	13.1	10.4	13.9
Special symptoms or syndromes, not elsewhere classified (307)	9.8	4.7	6.6	3.8	9.0	5.2	5.5	3.9
Before separating from military service	8.2	3.5	3.7	1.8	7.0	3.2	1.8	1.1
DoD diagnosed	8.1	3.5	3.6	1.8	7.0	3.2	1.7	1.0
VA diagnosed	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.1
After separating from military service	2.1	1.4	3.3	2.2	2.7	2.2	4.0	3.1
DoD diagnosed	1.2	0.8	2.5	1.4	0.8	0.6	1.7	1.1
VA diagnosed	0.9	0.6	0.9	0.9	2.0	1.7	2.4	2.1
Acute reaction to stress (308)	3.2	1.3	2.6	1.2	3.7	2.5	2.8	2.1
Before separating from military service	2.7	1.0	1.6	0.6	2.8	1.8	1.1	0.8
DoD diagnosed	2.7	1.0	1.5	0.6	2.8	1.8	1.0	0.7
VA diagnosed	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.1
After separating from military service	0.5	0.4	1.1	0.6	1.0	0.8	1.8	1.4
DoD diagnosed	0.3	0.2	0.7	0.4	0.2	0.2	0.5	0.4
VA diagnosed	0.2	0.2	0.4	0.2	0.8	0.6	1.3	0.9
Adjustment reaction excluding PTSD (309 excluding 309.81)	19.1	12.1	11.7	8.1	19.6	13.5	17.0	12.5
Before separating from military service	15.6	8.9	6.4	3.6	14.1	7.6	5.3	3.0
DoD diagnosed	15.5	8.8	6.1	3.4	14.0	7.5	4.7	2.6
VA diagnosed	0.2	0.2	0.4	0.3	0.2	0.2	0.7	0.5
After separating from military service	4.7	3.9	6.7	5.2	7.6	7.1	13.1	10.5
DoD diagnosed	2.2	1.8	3.7	2.2	1.5	1.1	2.8	1.9
VA diagnosed	2.6	2.2	3.2	3.2	6.3	6.1	10.7	8.9
PTSD (309.81)	4.9	3.2	4.8	5.2	13.9	17.7	16.4	17.7
Before separating from military service	2.2	0.7	1.0	0.8	3.8	4.2	2.2	1.8
DoD diagnosed	2.1	0.6	0.8	0.6	3.6	4.0	1.6	1.2
VA diagnosed	0.1	0.1	0.3	0.3	0.3	0.3	1.0	0.8
After separating from military service	3.3	2.8	4.2	4.9	12.4	16.5	15.8	17.3
DoD diagnosed	0.6	0.4	1.2	0.9	1.0	1.1	1.9	2.0
VA diagnosed	2.9	2.5	3.5	4.4	12.0	16.1	15.2	16.7
Specific non-psychotic mental disorders due to brain damage (310)	0.5	0.8	0.8	1.1	1.1	2.5	1.3	2.8
Before separating from military service	0.3	0.3	0.3	0.3	0.4	0.7	0.1	0.2
DoD diagnosed	0.3	0.3	0.3	0.2	0.4	0.6	0.1	0.2
VA diagnosed	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0
After separating from military service	0.2	0.5	0.6	0.9	0.8	2.1	1.2	2.6
DoD diagnosed	0.1	0.2	0.3	0.4	0.1	0.2	0.2	0.4
VA diagnosed	0.1	0.3	0.3	0.6	0.7	1.9	1.0	2.3
Depressive disorder, not elsewhere classified (311)	17.4	9.2	14.2	8.1	22.7	14.1	18.9	12.8
Before separating from military service	12.1	5.5	6.9	3.1	12.7	5.2	4.0	1.8
DoD diagnosed	11.9	5.4	6.4	2.6	12.5	5.1	3.2	1.3
VA diagnosed	0.4	0.2	0.8	0.6	0.3	0.2	1.1	0.6
After separating from military service	8.4	4.8	10.0	6.3	15.3	10.8	17.1	12.0
DoD diagnosed	2.3	1.2	3.9	1.5	1.8	0.8	2.5	1.3
VA diagnosed	6.6	3.8	7.0	5.2	14.2	10.2	15.5	11.3
Disturbance of conduct, not elsewhere classified (312)	0.4	0.6	0.2	0.4	0.5	0.8	0.4	0.6
Before separating from military service	0.3	0.4	0.1	0.2	0.3	0.3	0.1	0.1
DoD diagnosed	0.3	0.4	0.1	0.2	0.3	0.3	0.1	0.1
VA diagnosed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
After separating from military service	0.1	0.2	0.1	0.2	0.3	0.5	0.3	0.5
DoD diagnosed	0.1	0.1	0.0	0.1	0.0	0.0	0.1	0.1
VA diagnosed	0.1	0.2	0.1	0.2	0.3	0.5	0.2	0.5

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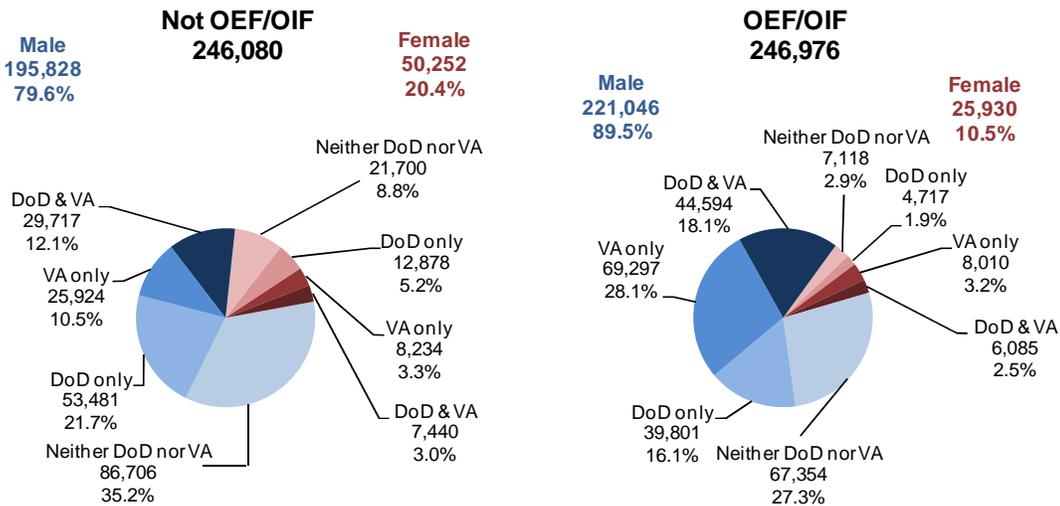
Veterans diagnosed (%)	Not OEF/OIF 246,080 (49.9%)				OEF/OIF 246,976 (50.1%)			
	Active Component 219,112 (89.0%)		Reserve/Guard 26,968 (11.0%)		Active Component 131,361 (53.2%)		Reserve/Guard 115,615 (46.8%)	
	Female	Male	Female	Male	Female	Male	Female	Male
	45,512 (20.8%)	173,600 (79.2%)	4,740 (17.6%)	22,228 (82.4%)	15,105 (11.5%)	116,256 (88.5%)	10,825 (9.4%)	104,790 (90.6%)
Other mental disorder diagnoses ¹	4.4	4.3	3.6	3.5	5.0	5.7	4.2	4.8
Before separating from military service	2.9	2.8	1.5	1.4	2.5	2.2	1.1	0.8
DoD diagnosed	2.8	2.7	1.4	1.3	2.4	2.1	1.0	0.7
VA diagnosed	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.1
After separating from military service	1.9	2.1	2.5	2.5	3.2	4.2	3.5	4.3
DoD diagnosed	0.7	0.7	1.2	0.9	0.5	0.4	0.9	0.7
VA diagnosed	1.3	1.5	1.4	1.8	2.8	3.9	2.9	3.8
TBI (310.2, 800–804, 850–854, and 950)	1.6	2.6	1.9	2.6	3.1	6.6	2.8	5.3
Before separating from military service	1.0	1.4	0.8	1.0	1.4	2.5	0.4	0.7
DoD diagnosed	1.0	1.4	0.7	0.9	1.4	2.5	0.4	0.7
VA diagnosed	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1
After separating from military service	0.6	1.3	1.2	1.8	2.0	4.7	2.5	4.8
DoD diagnosed	0.3	0.6	0.6	0.8	0.2	0.5	0.4	0.8
VA diagnosed	0.4	0.8	0.6	1.1	1.8	4.3	2.2	4.3

¹ Other ICD-9-CM codes for mental disorders (290–319) than those already listed in the exhibit

5. Characteristics of VA Health Care Users and Non-Users

As of March 31, 2010, 40 percent of the study population had transitioned to VA health care (Exhibit 5b). Exhibit 5a indicates that 52 percent OEF/OIF veterans transitioned to VA for health care, including 21 percent who also used DoD care. Additionally, 16 percent males and 2 percent females continued their care at DoD. Fewer non-OEF/OIF veterans (29 percent) transitioned to VA care, including 15 percent who also used DoD care. An additional 27 percent of non-OEF/OIF veterans (22 percent males and 5 percent females) continued their care at DoD only.

Exhibit 5a. Transition Patterns of Veterans to VA Care, as of March 31, 2010, by OEF/OIF Status



Characteristics of female and male veterans at their separation from active military service, separate by VA and non-VA health care users, are contrasted in Exhibit 5b. The gender composition was quite similar for VA users and non-users, with about 15 percent being females. Non-VA users were younger than VA users, and females were younger than males. More female non-VA patients (55 percent) were age 24 or under at their time of separation, compared with 47 percent of male non-VA users and 38 percent of female VA users.

Exhibit 5b. Baseline¹ Characteristics of Female and Male Veterans, by VA and Non-VA Health Care Users

	VA patients 199,301 (40.4%)		Non-VA patients 293,755 (59.6%)	
	Female 29,769 (14.9%)	Male 169,532 (85.1%)	Female 46,413 (15.8%)	Male 247,342 (84.2%)
Age (years)				
mean	30.1	31.4	26.4	28.4
median	27	28	24	25
percentages in age groups:				
17–24	37.8	35.0	55.2	47.0
25–34	33.1	29.4	28.5	28.5
35–44	19.2	23.5	11.6	17.6
45–54	8.6	10.1	4.2	6.0
55–64	1.2	2.0	0.5	0.9
Branch (%)				
Army	57.8	62.1	50.7	48.2
Navy	17.3	12.2	18.3	18.3
Air Force	19.1	11.2	23.3	17.3
Marines	4.7	13.5	5.4	14.1
other	1.1	1.0	2.3	2.1
Character of service (%)				
Honorable/General	92.2	92.0	80.8	83.5
Other than honorable	0.2	0.5	2.4	5.3
Uncharacterized	7.6	7.4	16.8	11.2
Military pay grade (%)				
E1–E4	46.1	44.1	61.5	53.9
E5–E9	42.1	46.1	25.7	33.8
O1–O3	6.0	3.8	7.7	5.5
O4–O10	5.0	4.7	4.6	5.9
other	0.8	1.4	0.4	0.9
OEF/OIF status (%)				
Not OEF/OIF	52.7	32.8	74.5	56.7
OEF/OIF	47.3	67.2	25.5	43.3
Military component (%)				
Active	73.8	62.1	83.3	74.7
Reserve/Guard	26.2	37.9	16.7	25.3
DoD diagnosed mental disorders before separation from active military service (%)	36.6	23.9	28.5	18.6
DoD diagnosed PTSD before separation from active military service (%)	3.5	3.3	1.5	0.6
DoD diagnosed TBI before separation from active military service (%)	1.3	2.1	0.7	1.1
Percent of veterans with service-connected mental disability	19.8	17.7	1.4	0.7
Total disability rating, mean	57.3	59.1	45.6	47.3
Total disability rating, median	60	60	40	40
Percent veterans with service-connected PTSD	5.9	11.6	0.2	0.2
Total disability rating, mean	61.3	60.3	49.3	50.3
Total disability rating, median	60	60	50	50
Percent veterans with service-connected TBI	0.4	1.4	0.0	0.0
Total disability rating, mean	57.1	64.9	38.9	43.6
Total disability rating, median	60	70	30	30
Died as of April 1, 2010 (%)	0.2	0.3	0.4	1.2

¹ At separation from active military service (from July 1, 2005–September 30, 2006)

Regardless of gender, a higher percent of VA users served in the Army than those who were non-VA users. More non-VA users had unknown or uncharacterized character of service. More than half of non-VA users (62 percent for women and 54 percent for men) were in the E1–E4 pay grades at their time of separation. Compared with the veterans who transitioned to VA, more (over 56 percent) non-VA users did not serve in OEF/OIF and fewer (under 26 percent) served in the reserve component.

Before separation from active military service, a higher proportion of VA users (37 percent for females and 24 percent for males) had diagnoses of mental disorders at DoD than non-VA users (29 percent for females and 19 percent for males). Similarly, a higher proportion of VA users were diagnosed at DoD before separation with PTSD and also TBI than their non-VA user counterparts.

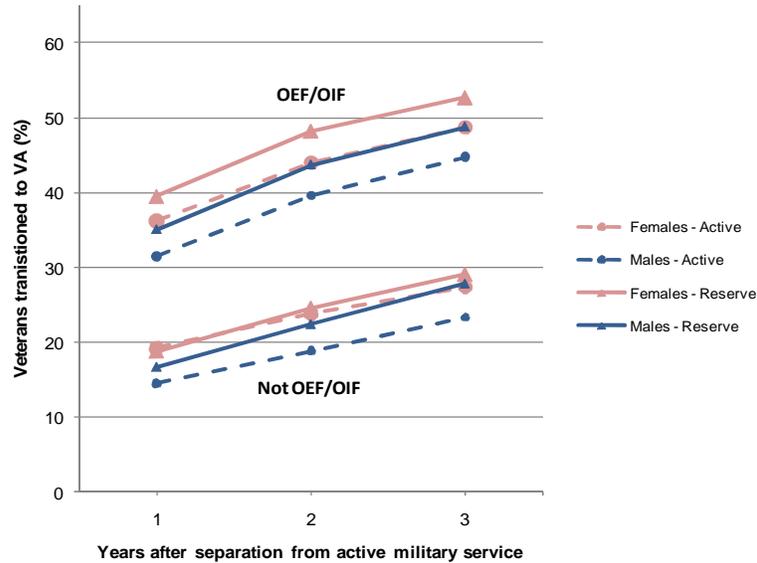
A much higher proportion of VA users received service-connected mental disability compensation than their respective non-VA user counterparts. Among those who were awarded compensation, the median total disability ratings of VA users were higher than those of non-users.

6. Transition Patterns to VA Health Care after Separation from Active Military Service

As of March 31, 2010, 40 percent of veterans in the study population had transitioned to VA health care after separation from active military service (Exhibit 5b). To compare female and male veterans' transition patterns to VA health care, we focused on cumulative percentages of first time use of VA care within the first 3 years after separation from active military service as our measure for transition patterns because the veterans who separated at the end of FY 2006 had less than 4 years to transition to VA.

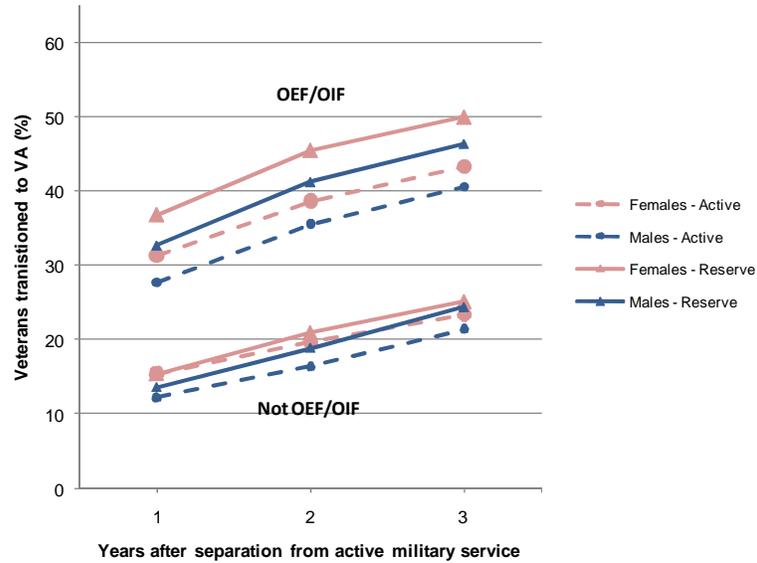
Transition patterns of female and male veterans to VA health care within the first 3 years after their separation from active military service, separated by OEF/OIF status and military component, are depicted in Exhibit 6a. A higher proportion of female veterans transitioned to VA health care within the first year of their separation, regardless of OEF/OIF status or active or reserve component, followed by a steady pace similar to their male counterparts in the second and third years. Across gender and military component, the proportion of OEF/OIF veterans who transitioned to VA care was nearly twice those of their non-OEF/OIF counterparts. For the given OEF/OIF status, a higher proportion of females than males and a higher proportion of veterans in the reserve component than in the active component transitioned to VA within each of the first 3 years, except for the first year in which non-OEF/OIF females and males had a similar transition rate.

Exhibit 6a. Transition Patterns of Female and Male Veterans to VA Health Care within the First 3 Years after Separation from Active Military Service in the Study Population, by OEF/OIF Status and Military Component



To see whether diagnoses of mental disorders (ICD-9-CM diagnostic codes 290–319) before separation influence veterans’ decisions to transition to VA, Exhibit 6b illustrates transition patterns of female and male veterans to VA health care for those who were not diagnosed with any mental disorders at DoD or at VA before their separation. Comparing Exhibit 6a with Exhibit 6b, we found that across all veteran cohorts, veterans who were not diagnosed with any mental disorders were less likely to transition to VA, although with some variations in degree (2–5 percentage points).

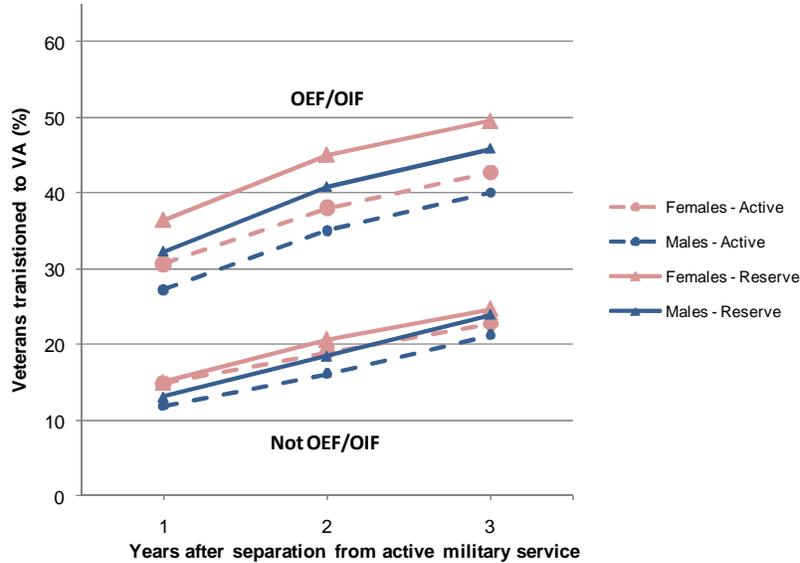
Exhibit 6b. Transition Patterns of Female and Male Veterans to VA Health Care within the First 3 Years after Separation from Active Military Service among 379,400 Veterans Who Had Not Been Diagnosed with Mental Disorders (ICD-9-CM: 290–319) at DoD or VA before Their Separation, by OEF/OIF Status and Military Component



The influence of mental disorders diagnoses on veterans’ decisions to transition to VA was stronger for females than for males. For each year and across military component, the cumulative percentage of transition to VA care for non-OEF/OIF females without mental disorders diagnoses, was 4 percentage points lower than that of all females (regardless of mental disorders diagnoses). For OEF/OIF females, the differences were 5 and 3 percentage points for active and reserve, respectively. For male veterans, the strongest difference was for the cohort of OEF/OIF active component, with the difference of 4 percentage points. The differences were 2 to 3 percentage points for the other male cohorts.

Exhibit 6c displays transition patterns of female and male veterans to VA health care for those who were not diagnosed with any mental disorders or V-codes indicating a psychosocial or behavioral problem at DoD or VA before their separation. The transition patterns were similar (with little decrease in percent) to the ones for veterans who were not diagnosed with any mental disorders (Exhibit 6b).

Exhibit 6c. Transition Patterns of Female and Male Veterans to VA Health Care within the First 3 Years after Separation from Active Military Service among 352,827 Veterans Who Had Not Been Diagnosed with Mental Disorders (ICD-9-CM: 290–319) or V-Codes Indicating a Psychosocial or Behavioral Problem¹ at DoD or VA before Their Separation, by OEF/OIF Status and Military Component



¹V15.40–V15.49, V60.0–V60.2, V60.4, V61.0–V61.22, V61.80–V61.83, V61.90, V62.0, V62.2, V62.5, V62.80–V62.89, V63.0, V63.9, V65.2, V65.5, V69.2–V69.8, V70.1–V70.2, V71.0–V71.1, V71.5, V71.81, and V79.0–V79.1

Because a small proportion of veterans were diagnosed with PTSD (1–4 percentage points) or TBI (less than 3 percentage points) before their separation from active military service (Exhibit 4), the transition patterns of female and male veterans to VA health care for those who were not diagnosed with PTSD (Exhibit 6d) or TBI (Exhibit 6e) at DoD or VA before their separation were almost identical to the transition patterns of all veterans (Exhibit 6a).

Exhibit 6d. Transition Patterns of Female and Male Veterans to VA Health Care within the First 3 Years after Separation from Active Military Service among 483,142 Veterans Who Had Not Been Diagnosed with PTSD (ICD-9-CM: 309.81) at DoD or VA before Their Separation, by OEF/OIF Status and Military Component

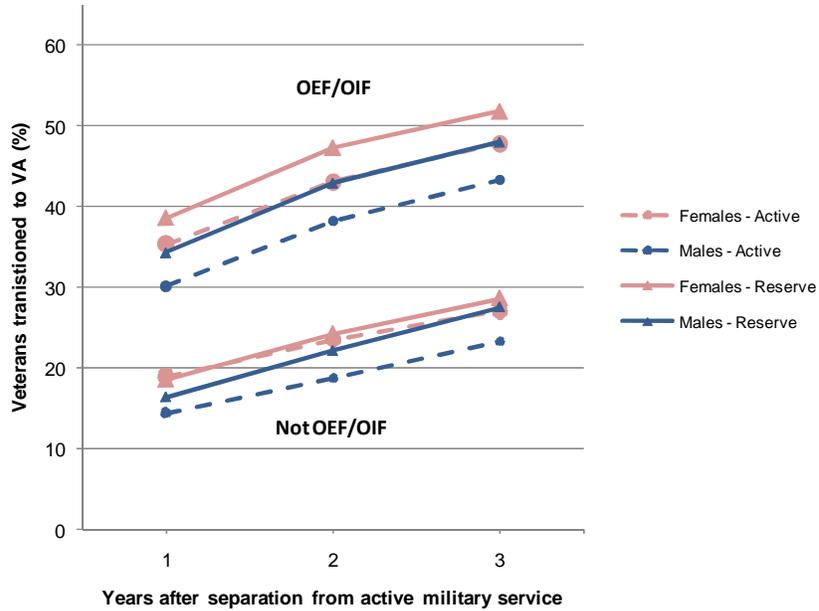
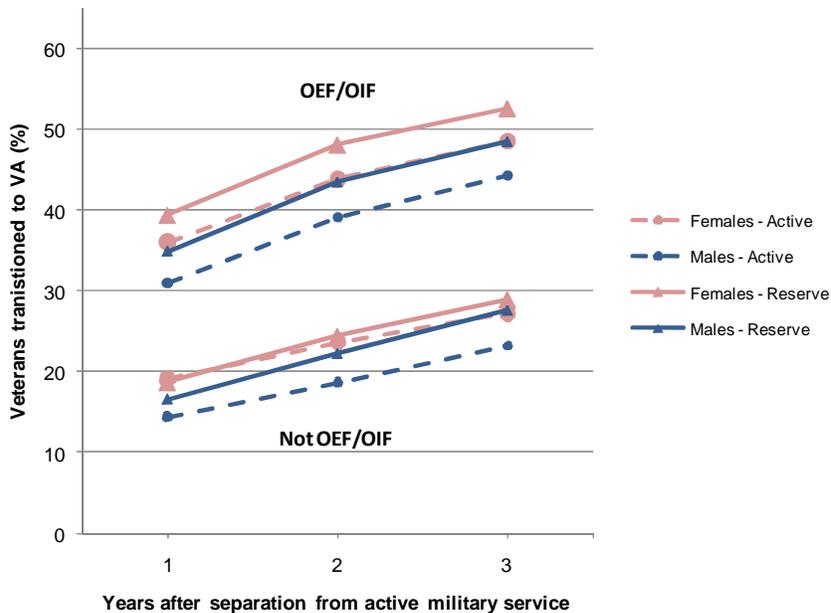


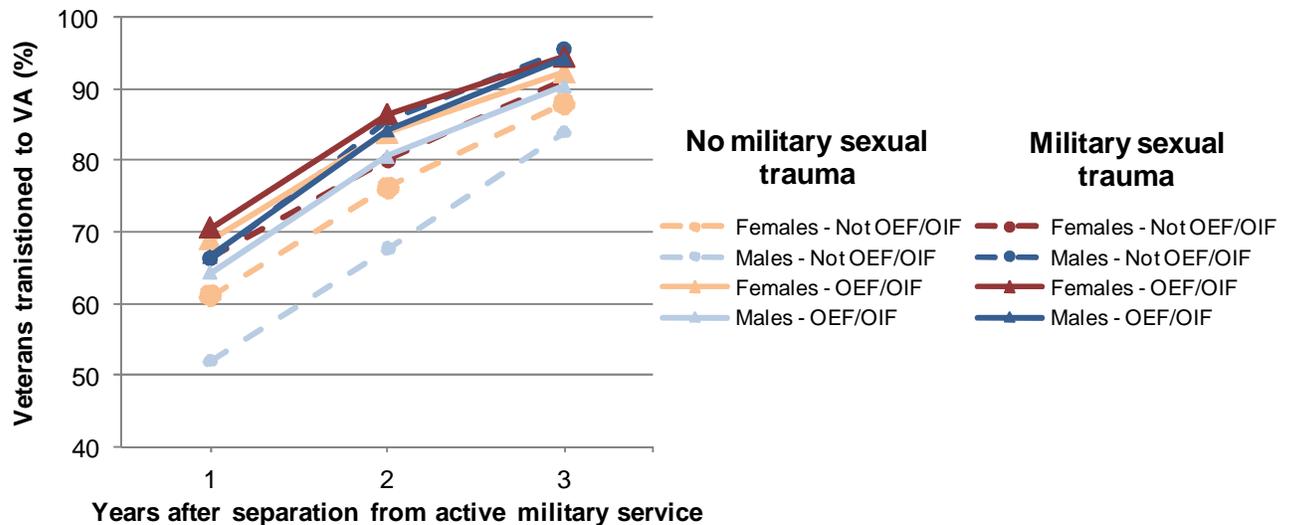
Exhibit 6e. Transition Patterns of Female and Male Veterans to VA Health Care within the First 3 Years after Separation from Active Military Service among 485,928 Veterans Who Had Not Been Diagnosed with Traumatic Brain Injury (ICD-9-CM: 310.2, 800–804, 850–854, and 950) at DoD or VA before Their Separation, by OEF/OIF Status and Military Component



To take into account the fact that only veterans who have chosen to seek VA health care are screened for MST, we limited our study of MST influence on transition patterns to the 199,301 veterans who had transitioned to VA as of March 31, 2010, the last date for which our data have information. We grouped active and reserve components to account for the small number of veterans with MST. Because all these veterans were transitioned to VA, their transition patterns told us only how rapidly their transition occurred.

With variations in degree, veterans with MST transitioned to VA care faster than their non-MST counterparts (Exhibit 6f). The most noticeable differences were for non-OEF/OIF males; the cumulative transitioned percentages of veterans with MST were 15, 18, and 12 percentage points higher than veterans without MST at the first, second, and third year of their separation, respectively. Females transitioned sooner than males, except that non-OEF/OIF males with MST transitioned more rapidly after the first year; they both were 66 percent for the first year.

Exhibit 6f. VA Health Care Transition Patterns for Female and Male Veterans among 199,301 VA Users within the First 3 Years after Separation from Active Military Service, by Military Sexual Trauma¹



¹Only veterans who sought VA health care for treatment related to MST

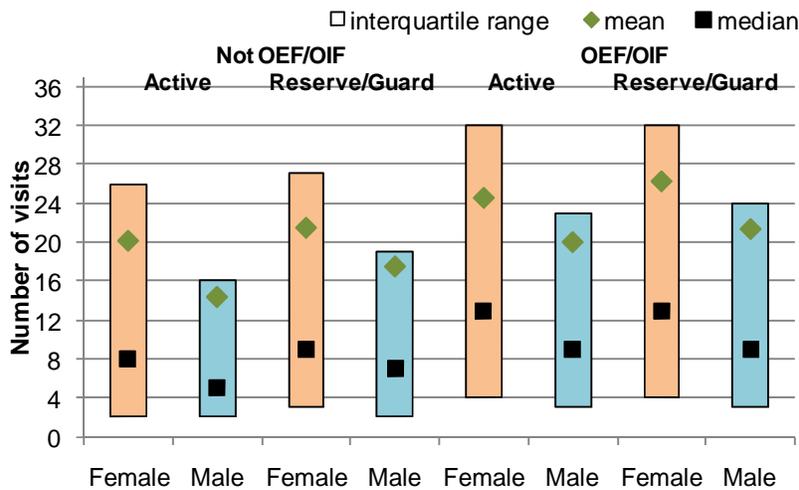
7. Frequency of VA Outpatient Care Utilization of Veterans Transitioned to VA Care

Frequency of VA Outpatient Care Utilization for All Veterans Transitioned to VA Care. Of the 199,301 veterans who transitioned to VA, 198,556 (99.6 percent) utilized VA outpatient health care and were alive as of March 31, 2010. We investigated the frequency of VA outpatient care utilization for mental disorders, TBI, and MST among these 198,556 male and female veterans. We counted a patient’s encounters on the same day as a visit and used the number of visits each patient made during the given time period to measure utilization.

Exhibit 7a charts interquartile ranges, averages, and medians for veterans' individual numbers of VA outpatient visits after separation from active military service by the end of March 2010, separated by OEF/OIF status and military component. The interquartile range (IQR) is the difference between the third and first quartiles and is a measure of variability. The IQR is essentially the range of the middle 50 percent of the data. Because it uses the middle 50 percent, the IQR is not affected by outliers or extreme values.

Across OEF/OIF status and military components, female veterans utilized VA care more frequently than their male counterparts. The median number ranged from 8 to 13 and the upper quartile (75th percentile) from 26 to 32 for women, and the median number ranged from 5 to 9 and the upper quartile from 16 to 24 for men. OEF/OIF veterans used VA care more frequently than their non-OEF/OIF counterparts. Veterans who served in the reserve component made more outpatient visits than their counterparts who served in the active unit.

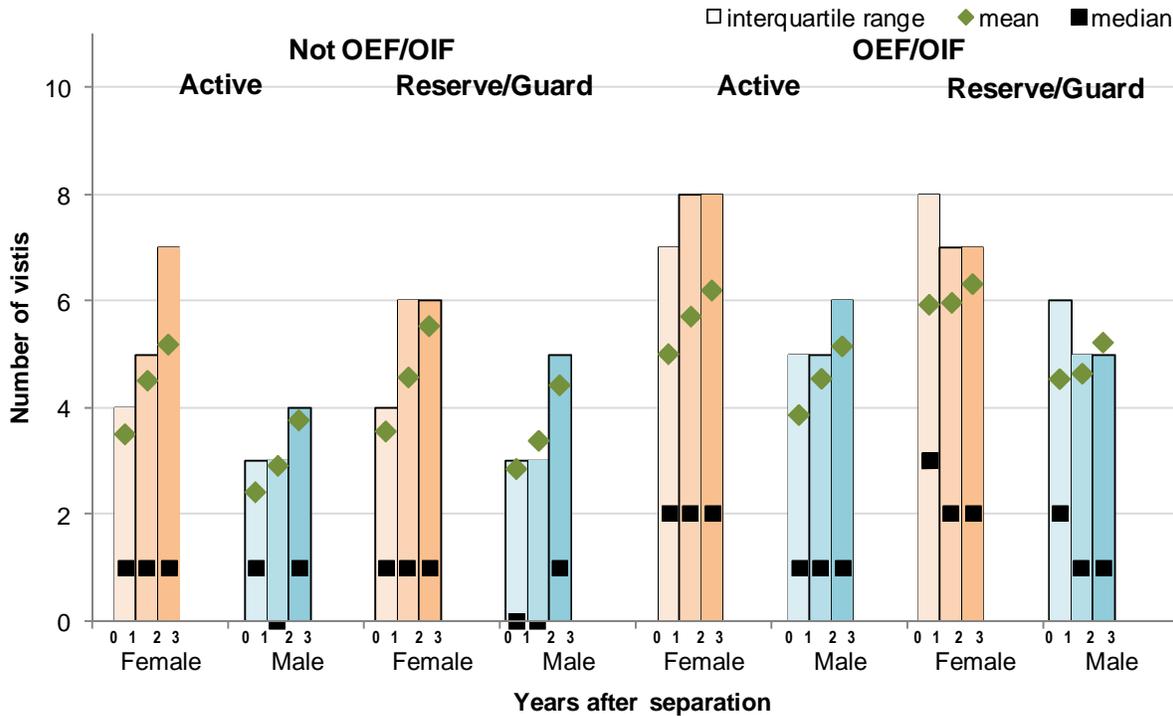
Exhibit 7a. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 198,556 Female and Male Veterans² Transitioned to VA Care after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status and Military Component



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010

To assess whether veterans continued their use of VA health care after they transitioned to VA, we examined the frequency of VA outpatient care utilization by year for the first 3 years after military separation. Year by year, female veterans continued more frequent use of VA care than their male counterparts (Exhibit 7b). OEF/OIF veterans tended to make more visits than their non-OEF/OIF counterparts.

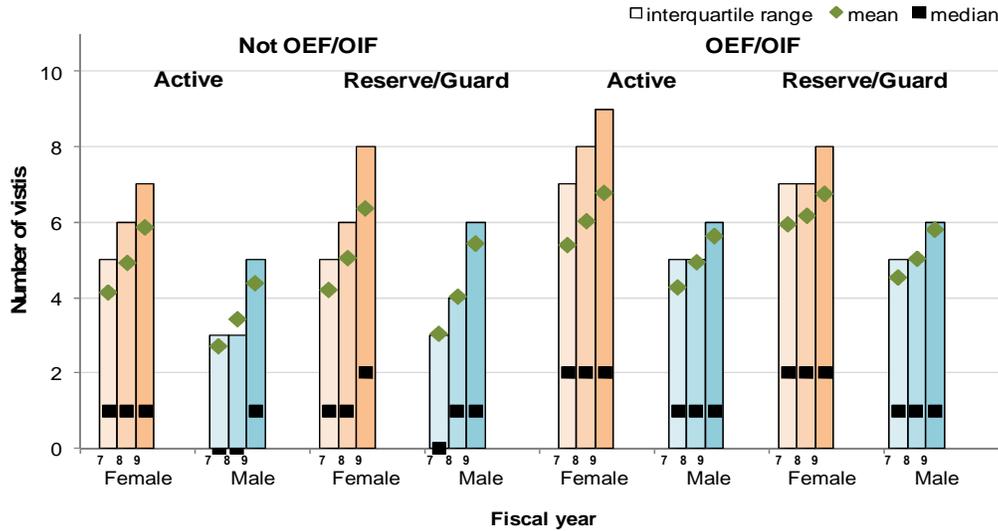
Exhibit 7b. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 198,556 Female and Male Veterans² Transitioned to VA Care after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Years after Separation



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010

We examined the frequency of VA outpatient care utilization by fiscal year to detect whether the patterns of utilization reflected changes in care practice at a certain point in time. With some variation, especially in the upper quartiles, the utilization patterns by fiscal year were comparable to those by year after separation (Exhibit 7c). Changes in care practice, if any, did not differentially influence the care utilization of our veteran cohorts.

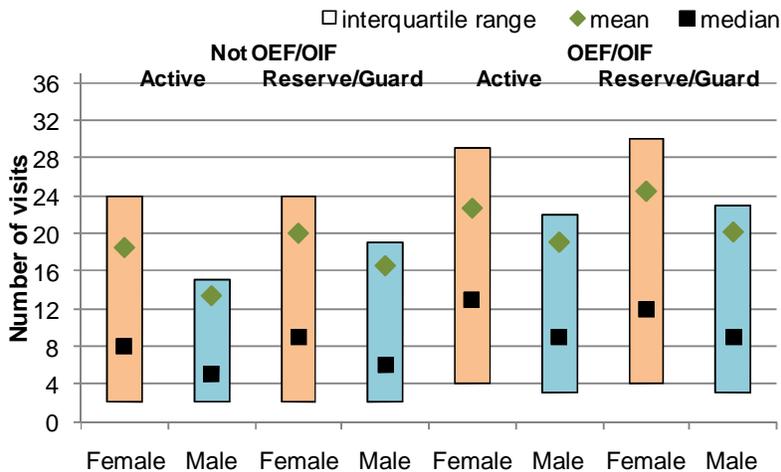
Exhibit 7c. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 198,556 Female and Male Veterans² Transitioned to VA Care after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Fiscal Year



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
 7 - FY2007
 8 - FY2008
 9 - FY2009

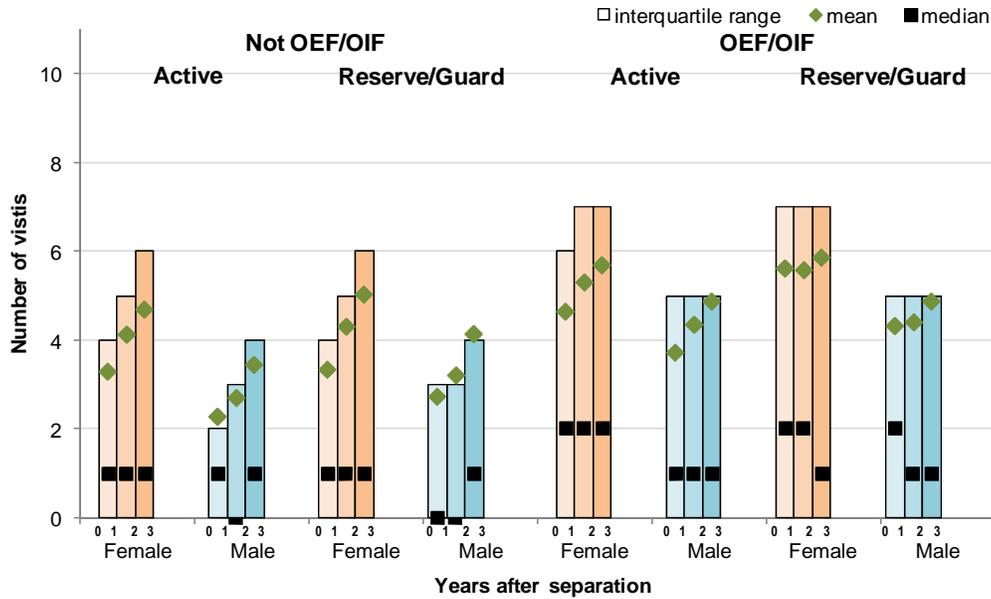
Exhibits 7d–7f represent the VA outpatient care utilization patterns after excluding fee basis care; they are quite similar to those that included fee basis care.

Exhibit 7d. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient (Excluding Fee) Visits¹ among 198,556 Female and Male Veterans² Transitioned to VA Care after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status and Military Component



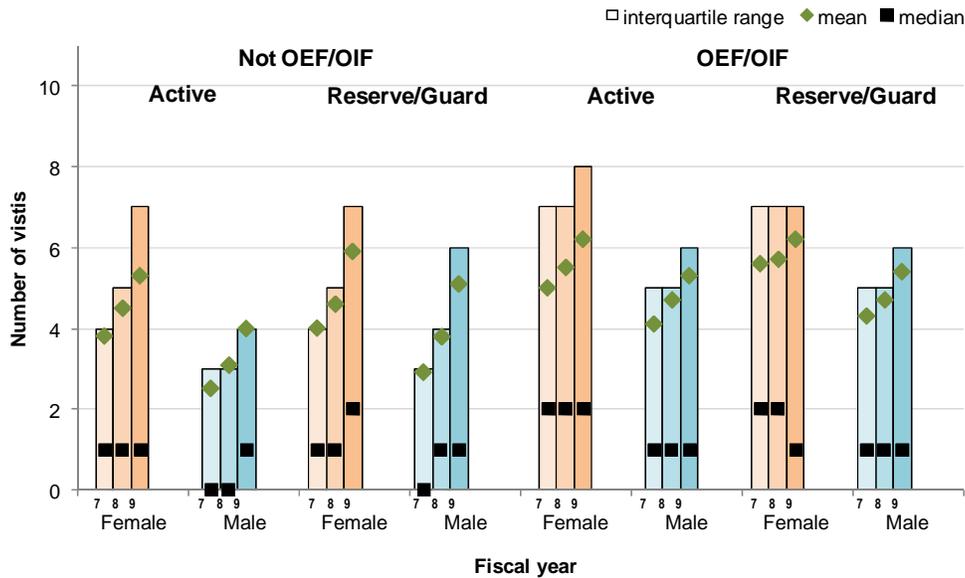
¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010

Exhibit 7e. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient (Excluding Fee) Visits¹ among 198,556 Female and Male Veterans² Transitioned to VA Care after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Years after Separation



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010

Exhibit 7f. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient (Excluding Fee) Visits¹ among 198,556 Female and Male Veterans² Transitioned to VA Care after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Fiscal Year

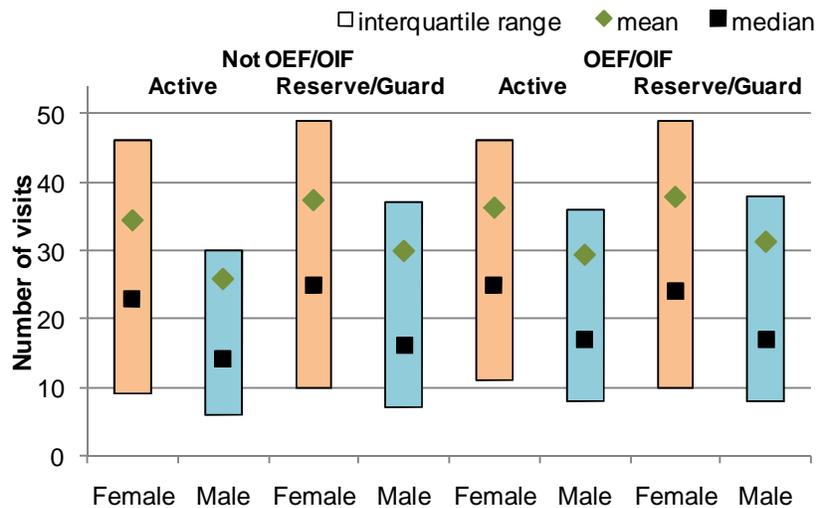


¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
 7 - FY2007
 8 - FY2008
 9 - FY2009

Frequency of VA Outpatient Care Utilization for Veterans Diagnosed with Mental Health Issues. Exhibits 7g–7i display the utilization patterns of VA outpatient care for the 106,490 veterans who were diagnosed with at least one mental disorder or V-code indicating a psychosocial or behavioral problem after separation from active military service. The patterns of these veterans were comparable to those of all veterans (Exhibits 7a–7c), except for the following visible differences:

- Veterans diagnosed with mental health issues had more VA outpatient visits. The median visits ranged from 23 to 25 and the upper quartile visits ranged from 46 to 49 for females, and the median visits ranged from 14 to 17 and the upper quartile visits ranged from 30 to 38 for males (Exhibit 7g).
- For non-OEF/OIF veterans who were diagnosed with mental health issues, utilization tended to increase as years after separation increased, and the trends were more marked for females (Exhibit 7h).
- Utilization of VA outpatient care increased by fiscal year for veterans diagnosed with mental health issues as measured by the medians of visits, except for the stable usage of male OEF/OIF veterans who served in the reserve component (Exhibit 7i).

Exhibit 7g. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 106,490 Female and Male Veterans² Diagnosed with at Least One Mental Disorder³ or V-Code⁴ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status and Military Component



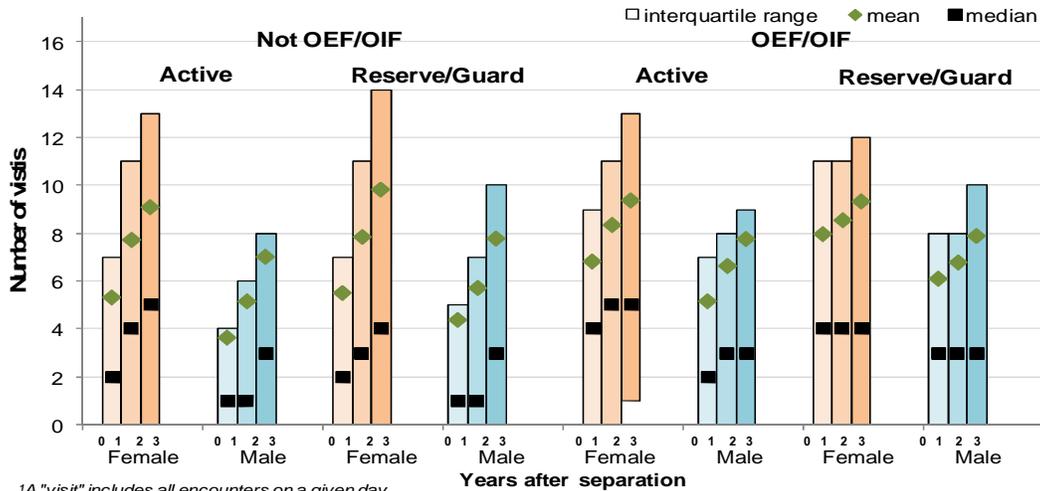
¹A "visit" includes all encounters on a given day

²Excludes veterans who died before April 1, 2010

³CD-9-CM: 290-319

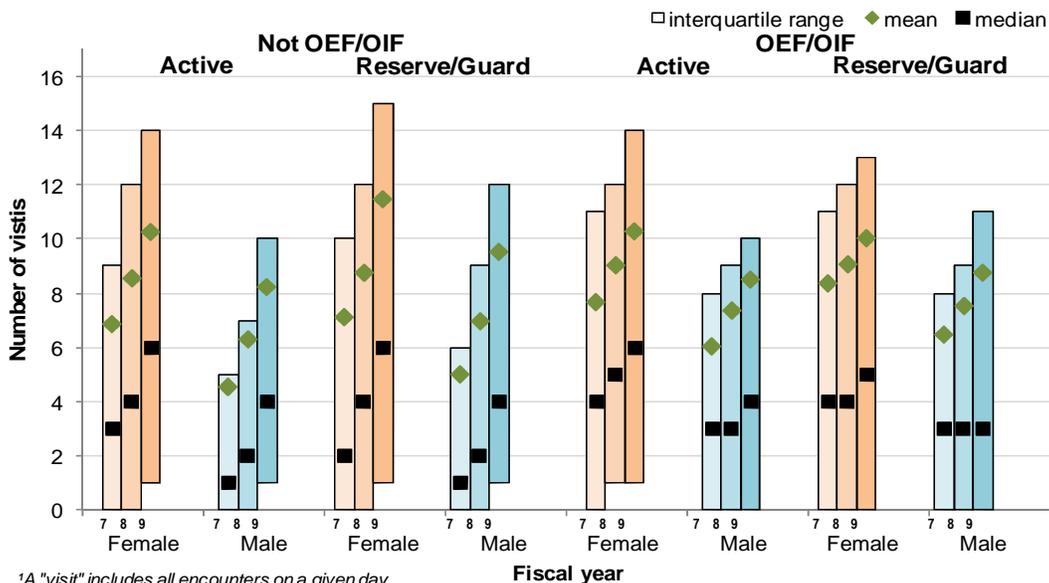
⁴V-codes indicating a psychosocial or behavioral problem: V15.40–V15.49, V60.0–V60.2, V60.4, V61.0–V61.22, V61.80–V61.83, V61.90, V62.0, V62.2, V62.5, V62.80–V62.89, V63.0, V63.9, V65.2, V65.5, V69.2–V69.8, V70.1–V70.2, V71.0–V71.1, V71.5, V71.81, and V79.0–V79.1

Exhibit 7h. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 106,490 Female and Male Veterans² Diagnosed with at Least One Mental Disorder³ or V-Code⁴ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Years after Separation



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 290-319
⁴V-codes indicating a psychosocial or behavioral problem: V15.40 – V15.49, V60.0 – V60.2, V60.4, V61.0 – V61.22, V61.80 – V61.83, V61.90, V62.0, V62.2, V62.5, V62.80 – V62.89, V63.0, V63.9, V65.2, V65.5, V69.2 – V69.8, V70.1 – V70.2, V71.0 – V71.1, V71.5, V71.81, and V79.0 – V79.1

Exhibit 7i. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 106,490 Female and Male Veterans² Diagnosed with at Least One Mental Disorder³ or V-Code⁴ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Fiscal Year

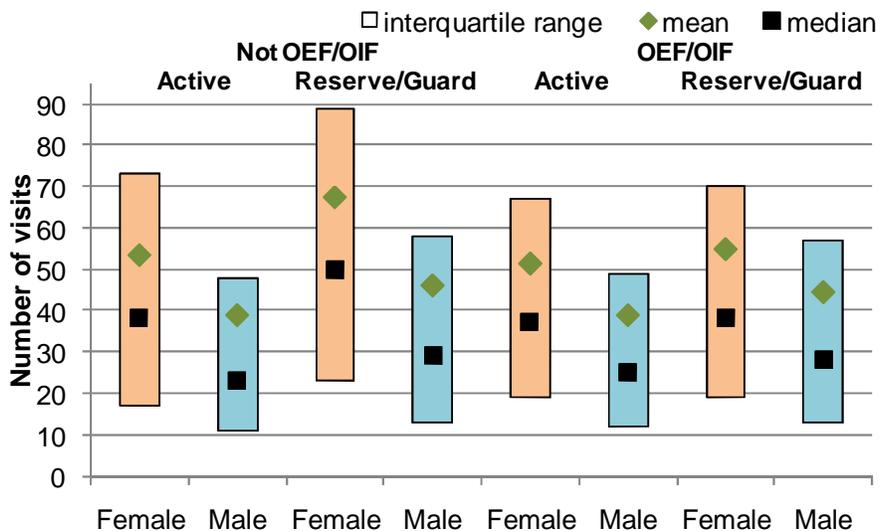


¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 290-319
⁴V-codes indicating a psychosocial or behavioral problem: V15.40 – V15.49, V60.0 – V60.2, V60.4, V61.0 – V61.22, V61.80 – V61.83, V61.90, V62.0, V62.2, V62.5, V62.80 – V62.89, V63.0, V63.9, V65.2, V65.5, V69.2 – V69.8, V70.1 – V70.2, V71.0 – V71.1, V71.5, V71.81, and V79.0 – V79.1
7 - FY2007
8 - FY2008
9 - FY2009

Frequency of VA Outpatient Care Utilization for Veterans Diagnosed with PTSD. PTSD is a specific mental disorder. Among the 106,490 veterans diagnosed with mental health issues, 43 percent had PTSD as one of their diagnoses. The utilization patterns (Exhibits 7j–7l) of these veterans with PTSD were similar to those of all veterans diagnosed with mental health issues (Exhibits 7g–7i), except for the following noticeable differences:

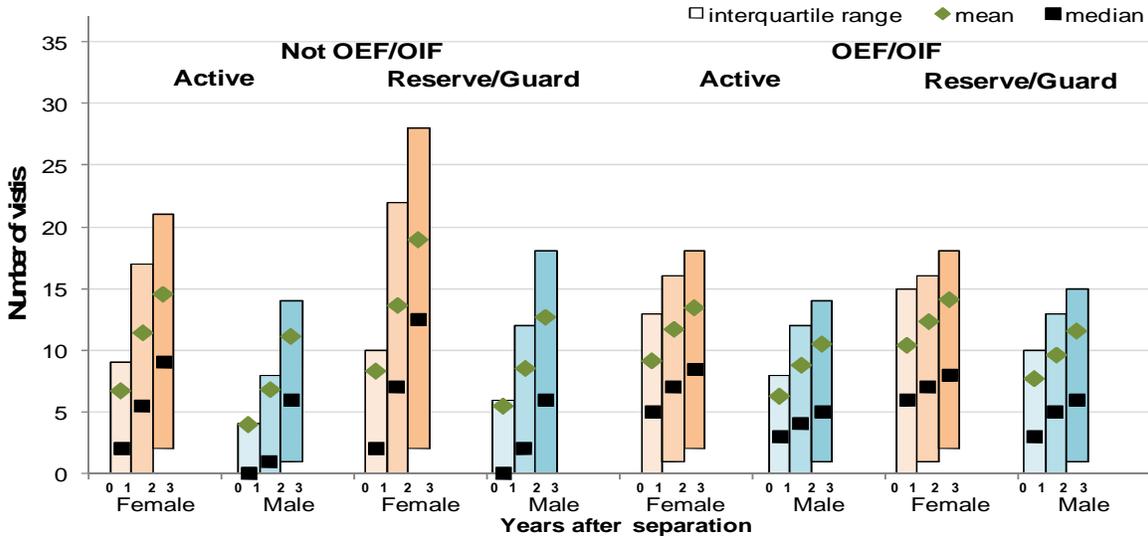
- Veterans diagnosed with PTSD had more VA outpatient visits—the median visits ranged from 37 to 50 and the upper quartile visits ranged from 67 to 89 for females, and the median visits ranged from 23 to 29 and the upper quartile visits ranged from 48 to 58 for males (Exhibit 7j).
- Utilization increased as years after separation increased for veterans diagnosed with PTSD, and the trends were more marked for non-OEF/OIF veterans (Exhibit 7k).
- Utilization of VA outpatient care increased by fiscal year for all veterans diagnosed with PTSD as measured by the medians of visits, and the trends were more marked for non-OEF/OIF veterans (Exhibit 7l).

Exhibit 7j. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 46,125 Female and Male Veterans² Diagnosed with PTSD³ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status and Military Component



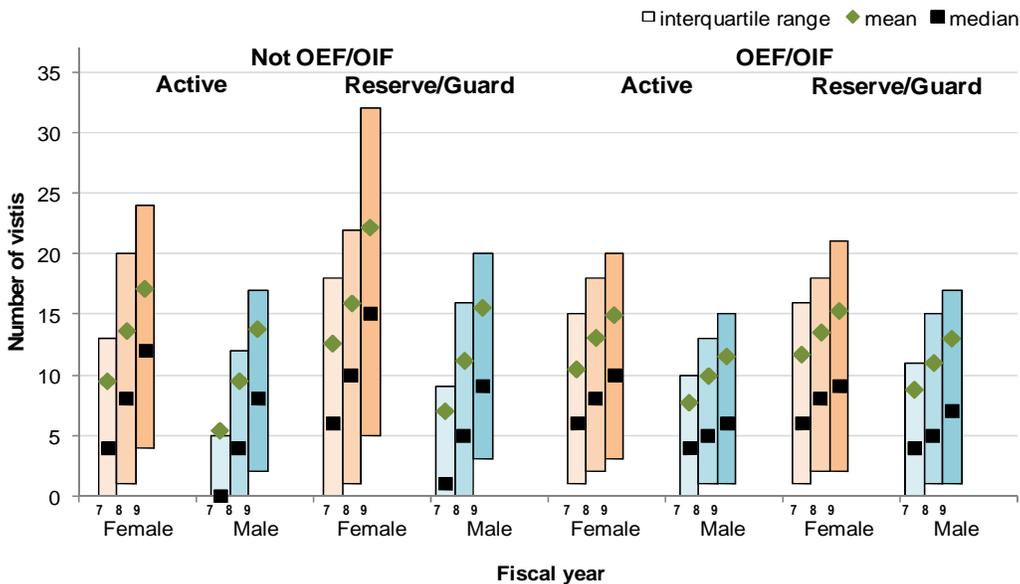
¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 309.81

Exhibit 7k. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 46,125 Female and Male Veterans² Diagnosed with PTSD³ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Years after Separation



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 309.81

Exhibit 7l. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 46,125 Female and Male Veterans² Diagnosed with PTSD³ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status, Military Component, and Fiscal Year



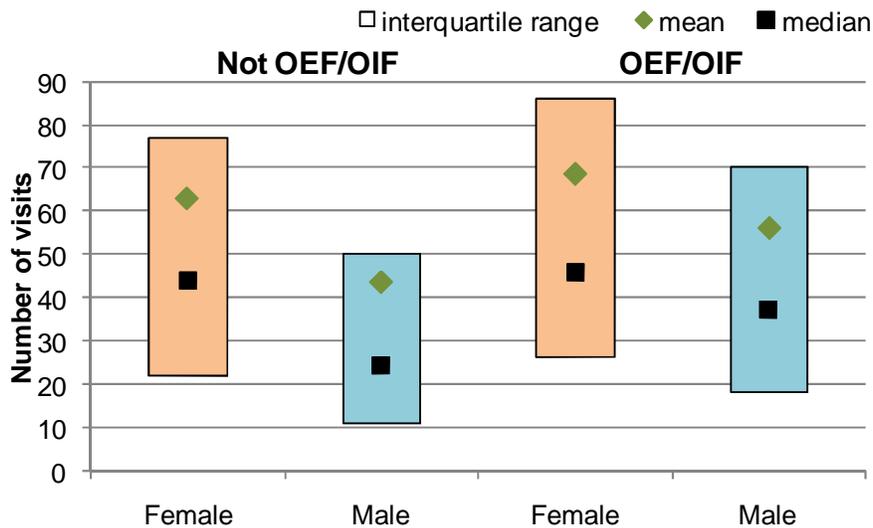
¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 309.81
 7 - FY2007
 8 - FY2008
 9 - FY2009

Frequency of VA Outpatient Care Utilization for Veterans Diagnosed with TBI. We analyzed the intensity of VA outpatient care utilization for veterans diagnosed with TBI without stratifying by military component because of the small size of this subpopulation.

Female veterans diagnosed with TBI made more outpatient visits than their male counterparts, with the medians of 44 for non-OEF/OIF and 46 for OEF/OIF veterans (Exhibit 7m). For males, the medians were 24 for non-OEF/OIF and 37 for OEF/OIF veterans.

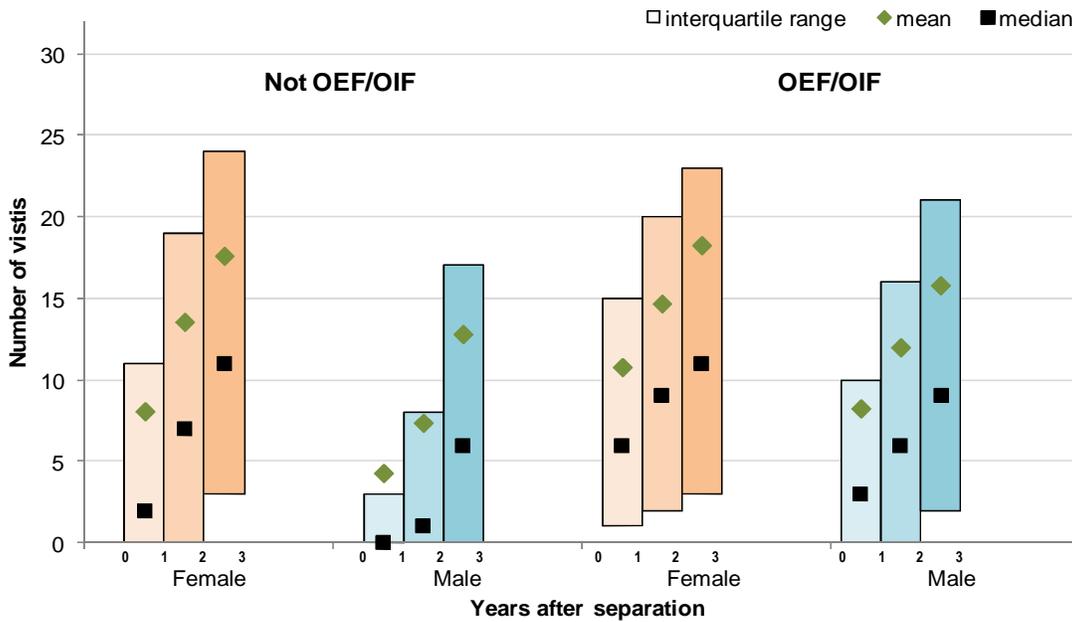
Across gender and OEF/OIF status, veterans diagnosed with TBI increased their utilization of VA outpatient care by years after separation (Exhibit 7n). The increasing trends of utilization were also evident by fiscal year (Exhibit 7o).

Exhibit 7m. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 11,775 Female and Male Veterans² Diagnosed with TBI³ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status



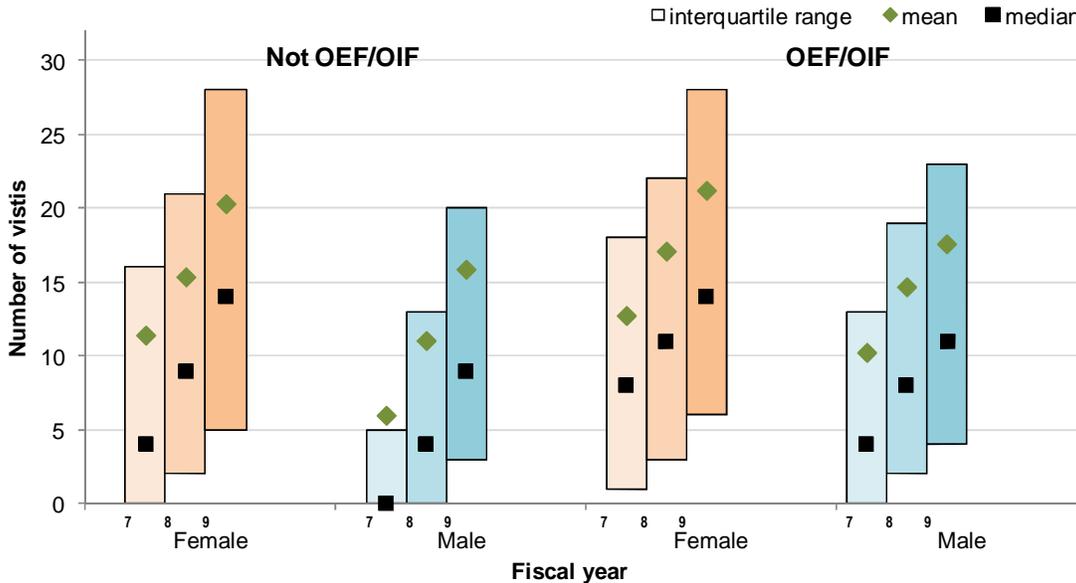
¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 310.2, 800-804, 850-854, and 950

Exhibit 7n. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 11,775 Female and Male Veterans² Diagnosed with TBI³ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status and Years after Separation



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 310.2, 800-804, 850-854, and 950

Exhibit 7o. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 11,775 Female and Male Veterans² Diagnosed with TBI³ after Separation from Active Military Service, as of March 31, 2010, by OEF/OIF Status and Fiscal Year

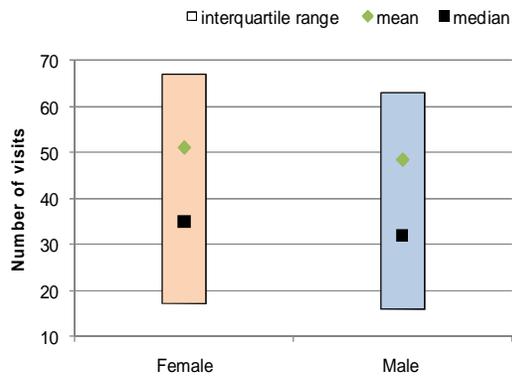


¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³ICD-9-CM: 310.2, 800-804, 850-854, and 950
 7 - FY2007
 8 - FY2008
 9 - FY2009

Frequency of VA Outpatient Care Utilization for Veterans with MST. We analyzed VA outpatient care utilization for veterans with MST without stratifying by OEF/OIF status and military component because of the small size of the subpopulation.

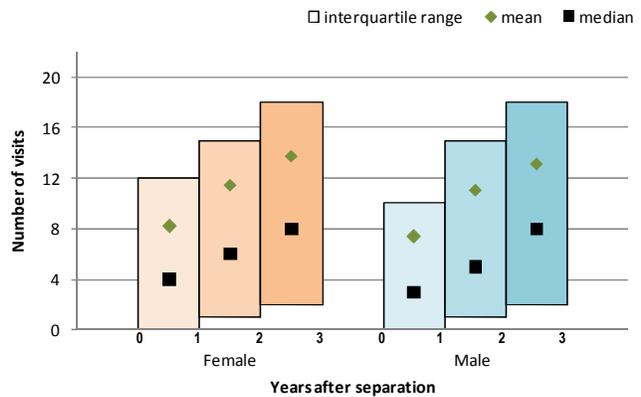
Female veterans with MST made slightly more VA outpatient visits than their male counterparts by the end of March 2010. The median and the upper quartile visits, respectively, were 35 and 67 for females and 32 and 63 for males (Exhibit 7p). Utilization of VA outpatient care by both female and male veterans increased each year after separation (Exhibit 7q). The increasing trends of utilization were also evident by fiscal year (Exhibit 7r).

Exhibit 7p. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 3,798 Female and Male Veterans² with Military Sexual Trauma³ after Separation from Active Military Service, as of March 31, 2010



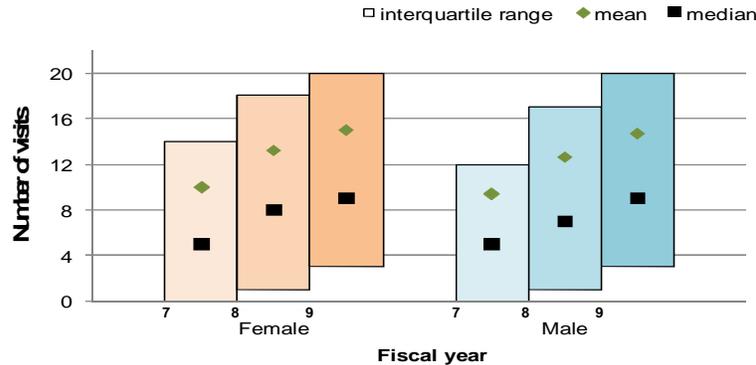
¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³Only veterans who sought VA health care for treatment related to MST

Exhibit 7q. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 3,798 Female and Male Veterans² with Military Sexual Trauma³ after Separation from Active Military Service, as of March 31, 2010, by Years after Separation



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³Only veterans who sought VA health care for treatment related to MST

Exhibit 7r. Interquartile Ranges, Means, and Medians for the Number of VA Outpatient Visits¹ among 3,798 Female and Male Veterans² with Military Sexual Trauma³ after Separation from Active Military Service, as of March 31, 2010, by Fiscal Year



¹A "visit" includes all encounters on a given day
²Excludes veterans who died before April 1, 2010
³Only veterans who sought VA health care for treatment related to MST
 7 - FY2007
 8 - FY2008
 9 - FY2009

8. Service-Connected Disability and Utilization of VA Health Care

As of March 31, 2010, 126,426 (26 percent) veterans in the study population were receiving compensation awards for their service-connected disability (Exhibit 2a). We explored associations between veterans' service-connected disability and their utilization of VA health care during the 2 most current years from our study cutoff date, April 1, 2008–March 31, 2010. VA health care included all inpatient and outpatient services provided at VA facilities and through fee basis.

All Service-Connected Disabilities. Exhibit 8a charts percentages of females and males in the study population who used VA health care during the most current 2 years by their service-connected disability status, separate by their OEF/OIF status and military component. Across service-connected disability status and military component, OEF/OIF females were more likely than their male counterparts to have used VA care. For the non-OEF/OIF veterans, only females with service-connected disabilities and who served in the active component were more likely to have used VA care than their male counterparts. Generally, veterans who served in the reserve/guard component were more likely than those who served in the active component, and also OEF/OIF veterans were more likely than non-OEF/OIF veterans, to have used VA care in the most recent 2 years. For the 126,426 veterans with service-connected disability, Exhibit 8b details percentages of those who used VA health care by their total disability ratings.

Exhibit 8a. Percentages of Female and Male Veterans Who Used VA Health Care from April 1, 2008 to March 31, 2010 in the Study Population, by OEF/OIF Status, Military Component, and Service-Connected Disability Status

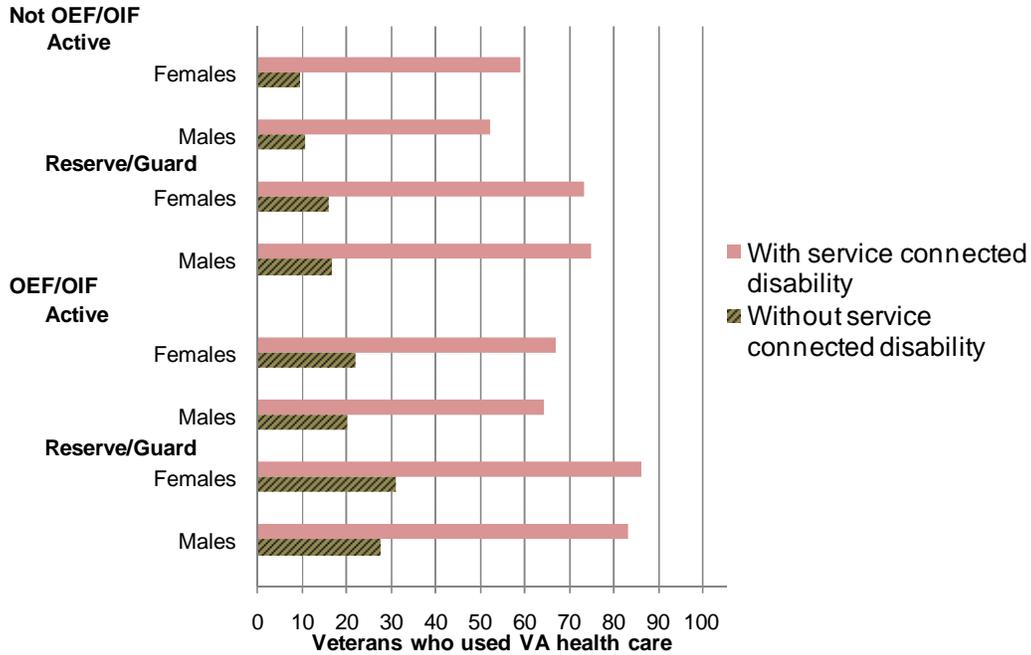
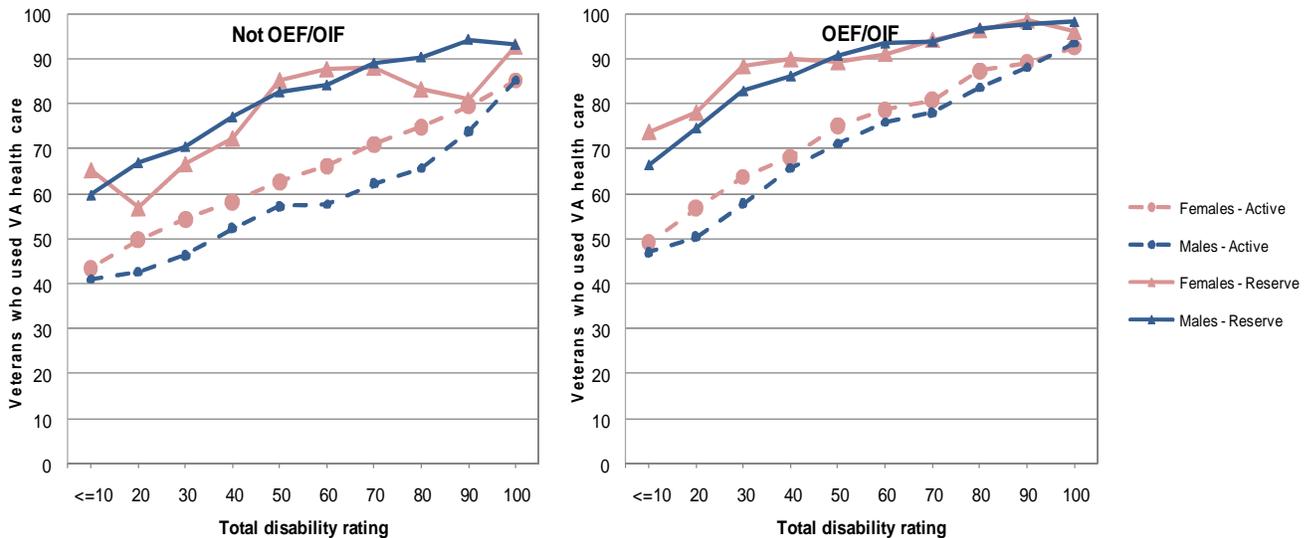


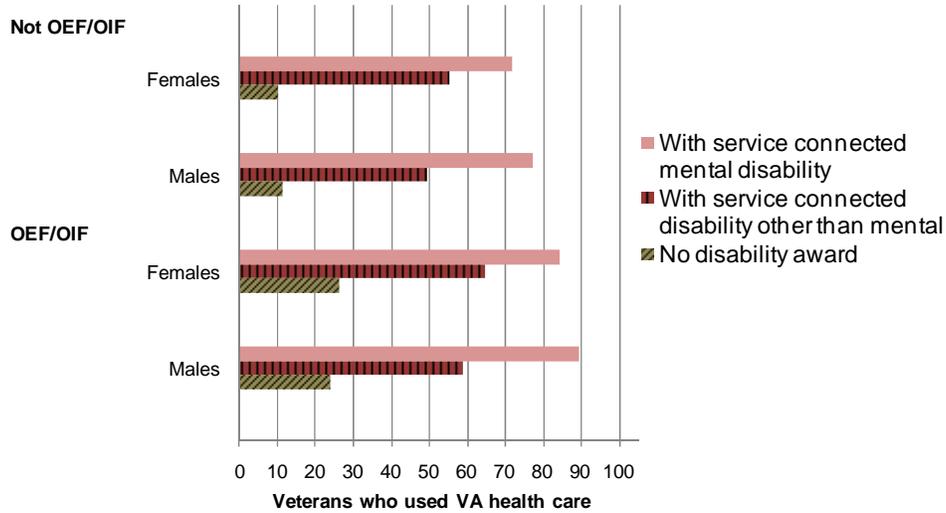
Exhibit 8b. Percentages of Females and Males Who Used VA Health Care from April 1, 2008 to March 31, 2010 among the 126,426 Veterans Who Had Service-Connected Disability, by OEF/OIF Status, Military Component, and Total Service-Connected Disability



Service-Connected Disabilities with a Component for Mental Conditions. Exhibit 8c plots percentages of females and males in the study population who used VA health care during the past 2 years by their status of service-connected disability with a component

for mental conditions, separate by their OEF/OIF status. Over 70 percent (from 72 to 89) of veterans with a disability component for mental conditions sought VA care. This was at least 16 percentage points higher than those of their counterparts who were receiving service-connected disability other than mental conditions.

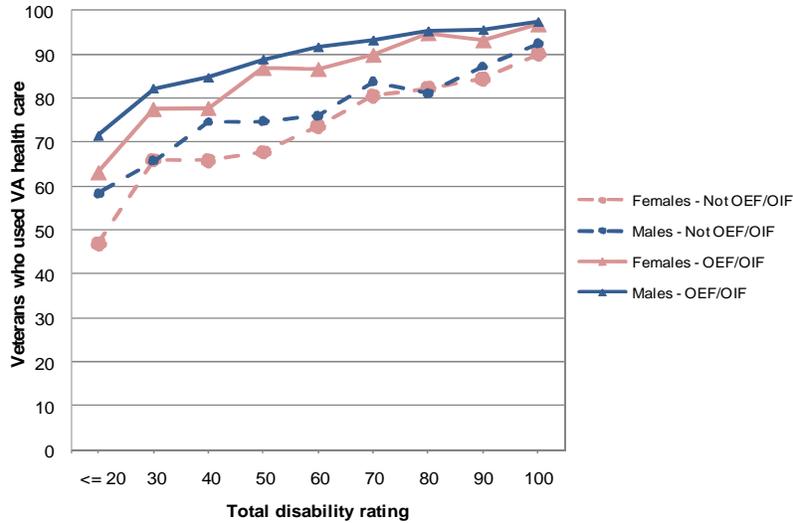
Exhibit 8c. Percentages of Female and Male Veterans Who Used VA Health Care from April 1, 2008 to March 31, 2010 in the Study Population, by OEF/OIF Status and Service-Connected Mental Disability (Disability Condition Codes: 9100–9599) Status



Females with a disability component of mental conditions were less likely (5 percentage points lower, regardless of OEF/OIF status) to seek VA care in the past 2 years than their male counterparts. In contrast, females with service-connected disability other than for mental conditions were more likely (6 percentage points higher, regardless of OEF/OIF status) to seek care than their male counterparts. Regardless of gender, OEF/OIF veterans without awards for service-connected disability were twice as likely to seek VA care as their non-OEF/OIF counterparts.

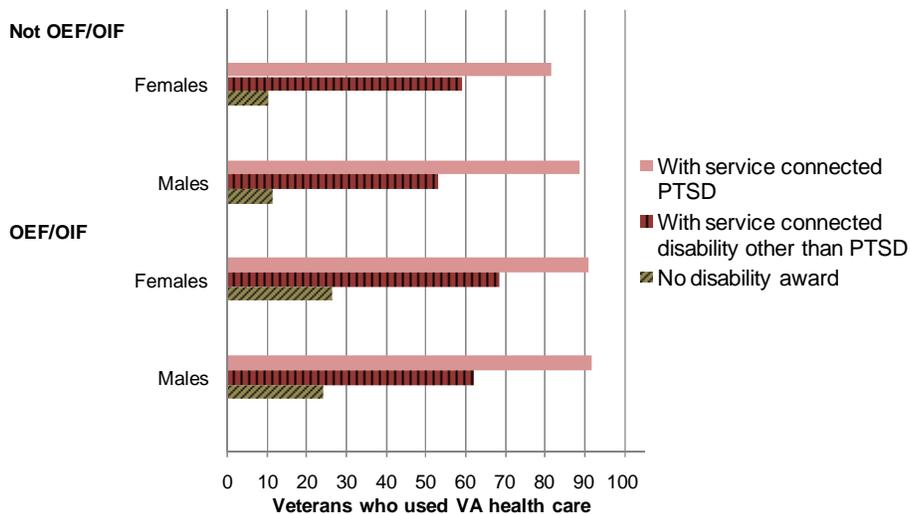
For the 38,368 veterans with a service-connected disability component for mental conditions, Exhibit 8d details percentages of those who used VA health care by their total disability ratings. The likelihood of using VA care in the past 2 years increased as the total disability ratings increased.

Exhibit 8d. Percentages of Females and Males Who Used VA Health Care from April 1, 2008 to March 31, 2010 among the 38,368 Veterans Who Had Service-Connected Mental Disability (Disability Condition Codes: 9100–9599), by OEF/OIF Status and Total Service-Connected Disability



Service-Connected Disabilities with a Component for PTSD. Exhibit 8e plots percentages of females and males in the study population who used VA health care during the past 2 years by their status of service-connected disability with a component for PTSD, separately by OEF/OIF status. Over 80 percent (from 82 to 92) of veterans with a disability component for PTSD sought VA care, which is 23–36 percentage points higher than those of their counterparts with service-connected disability other than PTSD.

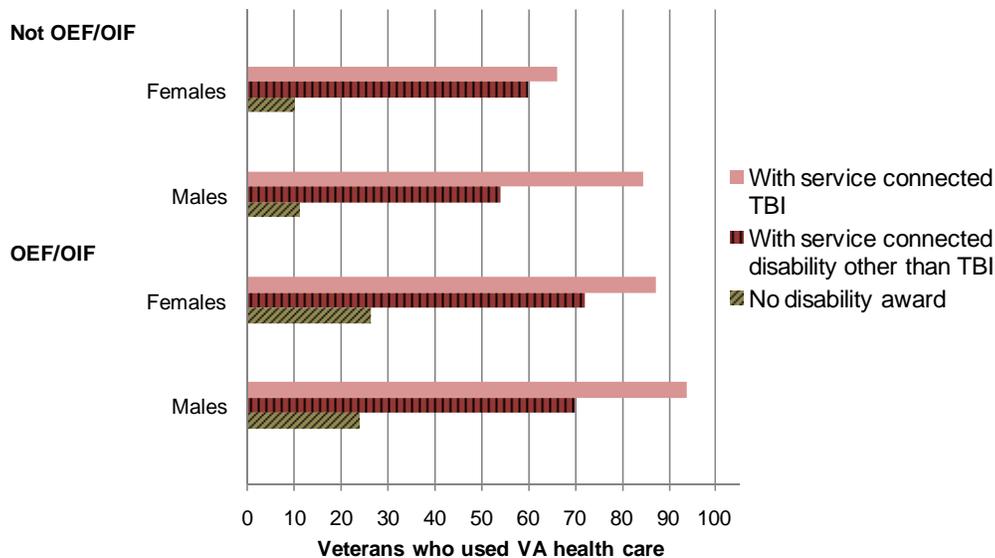
Exhibit 8e. Percentages of Female and Male Veterans Who Used VA Health Care from April 1, 2008 to March 31, 2010 in the Study Population, by OEF/OIF Status and Service-Connected PTSD (Disability Condition Code: 9411) Status



Proportionally fewer (7 percentage points) non-OEF/OIF females with a disability component of PTSD sought VA care in the past 2 years than their male counterparts. In contrast, females with service-connected disability other than for PTSD were more likely (6 percentage points higher for both non-OEF/OIF and OEF/OIF) to seek VA care than their male counterparts. Regardless of gender, OEF/OIF veterans without awards for service-connected disability were over twice as likely to seek VA care than their non-OEF/OIF counterparts. Across gender and awards status, OEF/OIF veterans were more likely to use VA care than non-OEF/OIF veterans.

Service-Connected Disabilities with a Component for TBI. Exhibit 8f displays percentages of females and males in the study population who used VA health care during the past 2 years by their status of service-connected disability with a component for TBI, separate by their OEF/OIF status. Over 65 percent (from 66 to 94) of veterans with a disability component for TBI sought VA care at a higher rate than their counterparts with service-connected disability other than TBI by 6–15 percentage points for females and 24–30 percentage points for males.

Exhibit 8f. Percentages of Female and Male Veterans Who Used VA Health Care from April 1, 2008 to March 31, 2010 in the Study Population, by OEF/OIF Status and Service-Connected TBI (Disability Condition Code: 8045) Status

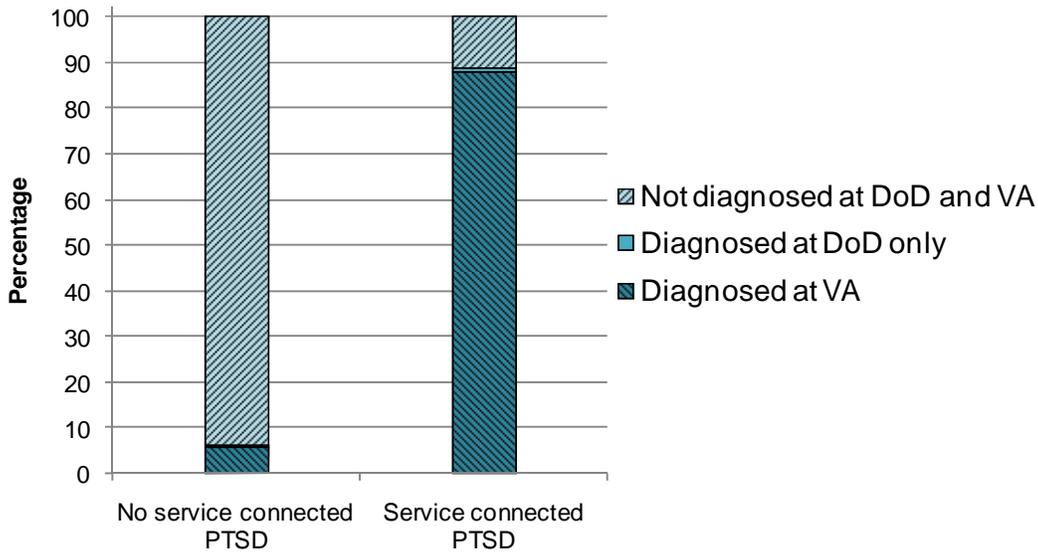


Proportionally fewer (18 percentage points for non-OEF/OIF and 7 for OEF/OIF) females with a disability component of TBI sought VA care in the past 2 years than their male counterparts, although females with service-connected disability other than for TBI were more likely to seek VA care than their male counterparts. Regardless of gender, OEF/OIF veterans without awards for service-connected disability were over twice as likely to seek VA care than their non-OEF/OIF counterparts. Across gender and awards

status, OEF/OIF veterans were more likely to use VA care than non-OEF/OIF veterans in the past 2 years.

Association between PTSD Diagnoses and Total Disability Ratings with a Component for PTSD. We investigated the association between PTSD diagnoses at DoD (from discharge to March 31, 2009) or VA (from discharge to March 31, 2010) after separation from active military service and receiving service-connected disabilities with a component for PTSD as of March 31, 2010. For veterans who did not receive any compensation for PTSD, 94 percent did not have a PTSD diagnosis by VA or DoD after separation from active military service (Exhibit 8g). In contrast, among those who received a compensation component for PTSD, 88 percent were diagnosed with PTSD at VA and an additional 1 percent was diagnosed at DoD. Note that veterans diagnosed only at DoD from April 1, 2009 to March 31, 2010 were not counted as having a diagnosis because of the lack of DoD data during that time period.

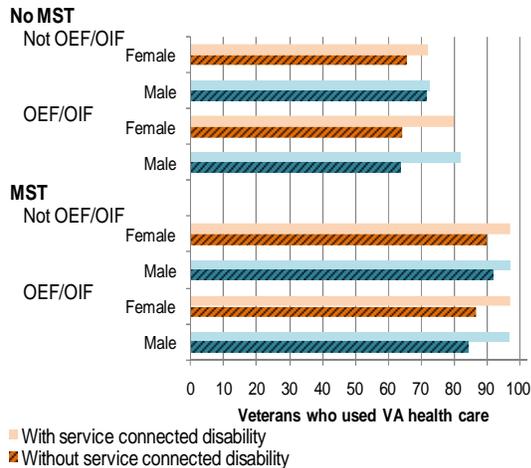
Exhibit 8g. PTSD Diagnoses at DoD (from Discharge to March 31, 2009) or VA (from Discharge to March 31, 2010) after Separation from Active Military Service among Veterans in the Study Population, by PTSD Service-Connected Disability Status as of March 31, 2010



When focusing on PTSD diagnoses at DoD (from discharge to March 31, 2009) or VA (from discharge to March 31, 2010) after separation by total service-connected disability rating, the increasing trend of diagnoses of PTSD with the increase of ratings is noticeable.

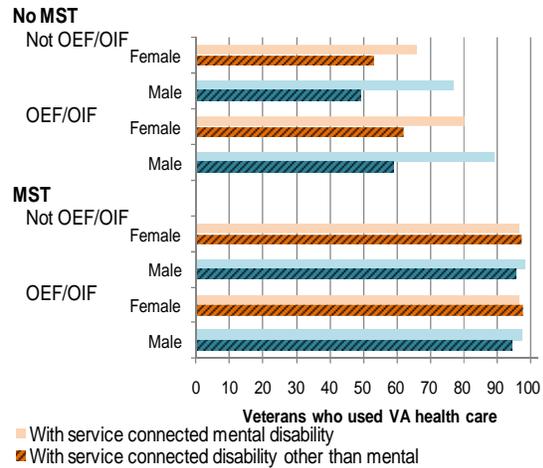
Veterans with MST. Among those who transitioned to VA care, across gender and OEF/OIF status, most (97 percent for those with service-connected disability and 84–92 percent for those without service-connected disability) veterans with MST used VA care in the past 2 years (Exhibit 8i). For veterans without MST, the percentages of VA care utilization dropped to 72–82 percent for those with service-connected disability and to 64–72 percent for those without service-connected disability.

Exhibit 8i. Percentages of Female and Male Veterans Who Used VA Health Care from April 1, 2008 to March 31, 2010 among 199,301 Veterans Who Transitioned to VA Care, by OEF/OIF Status, Military Sexual Trauma,¹ and Service-Connected Disability Status



¹Only veterans who sought VA health care for treatment related to MST

Exhibit 8j. Percentages of Female and Male Veterans Who Used VA Health Care from April 1, 2008 to March 31, 2010 among 126,426 Veterans Who Had Service-Connected Disability, by OEF/OIF Status, Military Sexual Trauma,¹ and Service-Connected Mental Disability Status



When limited to those veterans who received disability compensation, almost all (95–98 percent) MST veterans used VA care in the past 2 years, with or without a disability component for mental disability conditions (Exhibit 8j). For veterans without MST, more veterans who were receiving an award component for mental disability conditions used VA care in the past 2 years than those who were receiving compensation for disabilities other than mental conditions. Within OEF/OIF status, the differences were bigger for males than for females.

Conclusions

Based on the integrated data from both DoD and VA, we characterized the population of nearly half a million veterans discharged from active duty during July 1, 2005 to September 30, 2006 and followed them for their experience transitioning to and using VA health care and benefits through March 31, 2010. We compared female veterans’ characteristics and disease burdens with those of their male counterparts in this veteran population.

Because of the differences in the veterans' baseline characteristics by OEF/OIF status and military component, we conducted our analyses separately by OEF/OIF status and military component, whenever our subgroup population sizes permitted.

By the end of March 2010, 40 percent of veterans in the study population used or transitioned to VA health care, and 23 percent used DoD care (including TriCare) although they did not use VA care. About 22 percent of the study population had mental health diagnoses (combined ICD-9-CM mental disorder codes that include PTSD and V-codes indicating psychosocial or behavioral problems) at VA after their separation from active military service. An additional 7 percent had been diagnosed by DoD. Regardless of their gender and service component, 29 percent or more OEF/OIF veterans had been diagnosed with mental disorders at VA, over twice the percent of their respective non-OEF/OIF counterparts. The percent diagnosed at VA was lower for females (by about 1 percentage point) than for males in the non-OEF/OIF reserve cohort only.

About 3 percent of the veterans had been diagnosed with TBI after their separation from active military duty. The proportion of males diagnosed with TBI was twice as high as females across OEF/OIF status and military unit component.

Although female veterans generally were more likely to be diagnosed with mental health conditions after separation from active military duty, they generally were less likely than their male counterparts to be diagnosed with the specific mental condition of PTSD. The proportion of female OEF/OIF veterans who were diagnosed with PTSD (by VA or DoD) was 12 percent for active component and 16 percent for reserve unit, while the proportion for their male counterparts was about 17 percent for both active and reserve unit.

We examined gender differences in the population to assess:

- Status of receiving VA benefits and total service-connected disability ratings
- Transition to VA care
- Patterns of utilization frequency of VA health care
- Association between disease diagnoses/use of VA health care and receiving VA benefits/total disability ratings

Our results indicate that:

- As of March 31, 2010, a higher proportion of female veterans in the study population were receiving service-connected disability compensation and receiving some compensation for mental disability conditions, except for the OEF/OIF reserve component cohort in which the corresponding proportion of females was about 1 percentage point lower than that of males.

- Although a higher proportion of women in the study population received some compensation for mental disability conditions in general, a lower proportion of females generally were awarded compensation with a component for PTSD, a specific condition of mental disability conditions.
- Among the veterans awarded disability compensation, 30 percent of them were receiving some disability award for mental conditions. For OEF/OIF veterans, PTSD was the most common mental disability award component for both women and men, while major depression was the most prevalent for the non-OEF/OIF veterans. More women veterans received some disability compensation than their male counterparts for each of the five prevailing mental disability award components, except for PTSD.
- Less than 1 percent of the veterans in the study population were receiving disability compensation that included a component for TBI, and fewer females were awarded compensation with a component for TBI than their male counterparts.
- A higher proportion of female veterans in the study cohorts transitioned to VA care after separation from active military service, except for the non-OEF/OIF reserve component cohort in which the proportion of females and males were the same.
- Among those who transitioned to VA health care, female veterans generally were more likely than male veterans to use VA health care, and the utilization by females was higher than that of males including those diagnosed with mental health issues, PTSD, TBI and MST.
- Among those who transitioned to VA health care, patterns of higher utilization intensities by females than those of their male counterparts continued by year after discharge and by fiscal year, including veterans diagnosed with mental health issues, PTSD, TBI, and MST.
- Among those who transitioned to VA health care, increasing trends of utilization was generally observed including veterans diagnosed with mental health issues, PTSD, TBI, and MST.
- Veterans with service-connected disability were more likely to have used VA care in the past 2 years (from April 1, 2008 to March 31, 2010), and higher total disability ratings were associated with higher likelihood of using VA care.

We examined an entire population of veterans recently discharged from military service for their experience transitioning to VA and using VA healthcare and compensation benefits through March 31, 2010. This population-based approach eliminates potential bias of using only veterans who are VA users because differences in characteristics and disease burdens at the time of separation of non-VA users and users may impact their choices of transitioning to VA and of utilizing VA health care in fundamentally different

ways. Because of the lack of population-based veteran data, previous studies on veterans' utilization of VA health care and benefits, including those published in peer-reviewed journals, were largely based solely on VA users. The LC database makes this population-based approach feasible.

Using the unique feature of incorporating DoD treatment data with VA data in the LC database, for the first time we were able to investigate the effect of specific disease diagnoses during military service on patterns of transition to VA care and utilization intensity of VA health care in this report.

We reviewed utilization of VA health care by years after separation from active military service to examine gender difference besides the overall utilization in a given time period used in the published studies. Using this year-by-year interval approach, in addition to looking at overall utilization, provides us broader insights on veterans' decisions to initiate care as well as continue care at VA.

We may not be able to generalize our findings to all U.S. veterans who were discharged from the military during time periods other than July 1, 2005–September 30, 2006. We had no data on these veterans who were not included in the LC database. Studies based on all veterans would allow for better strategic planning and resource decisions, improved targeting of specific veteran groups for outreach, and identification of required legislative and policy changes. VA is working on the establishment of USVETS database, and it will be used to produce 2010 nationwide Veteran population data (VetPop 2010). We are working collaboratively with VA staff on this endeavor.

Issue 2: Gender-Based Biases Not Identified in VBA's Adjudication of Male and Female Disability Claims, but Data Limitations Affect a Full Assessment of Some Outcomes

Summary of Findings

Our analysis of data collected during our review of 752 veterans' claims files showed that gender was not a significant factor in VBA's disability claim decisions for conditions such as TBI, PTSD, or other mental health conditions. VBA's adjudication of male and female veterans' disability claims for these conditions was consistent with medical evidence on record and current policies and procedures. Furthermore, VBA's disability ratings percentages for veterans receiving compensation for TBI, PTSD, or other mental health conditions were also not different for male and female veterans.

VBA has not performed an analysis to quantify the number of veterans who were receiving disability compensation for conditions as a result of MST. Limitations in VBA's data and recent policy changes in how VBA uses some disability codes to capture data on conditions such as TBI affected our ability to fully assess the extent of

differences in how often VBA denied male and female veterans' disability claims and if VBA reversed its denials on appeal more frequently for male or female veterans. VBA's information limitations also made it difficult to fully assess differences in outcomes for veterans filing claims for MST-related disabilities.

Details of Findings

Gender-Based Biases in VBA's Award of PTSD Disability Benefits Not Identified. Our review of veterans' claims files did not identify gender-based biases in adjudicating PTSD claims. However, we found some minor differences in VBA's decisions to grant service-connected PTSD awards for male and female veterans. Specifically, our claims file review supported that VBA granted service connection for a greater proportion of female veterans who filed disability claims for PTSD as a result of MST. VBA granted service connection for PTSD as a result of MST to 9 percent of female veterans who were service-connected for a mental health disorder compared to only 0.1 percent of male veterans. Thirty of the 752 claims files reviewed involved MST-related claims for PTSD or other mental health conditions. During our review of these claims files, we did not identify cases where VBA misapplied its policies and procedures for adjudicating these MST-related claims. Further, we did not find any significant differences in the disability percentage VBA granted to male and female veterans for PTSD as a result of MST. We also did not identify significant gender differences in the disability percentages when we compared veterans receiving compensation for PTSD as a result of MST compared to veterans receiving compensation for PTSD as a result of other experiences such as combat.

In evaluating disability claims for PTSD, VBA guidance allows for the presumption that veterans who have received certain combat decorations engaged in combat, and therefore VBA can concede that a veteran experienced a stressor. More male veterans than female veterans were granted disability compensation for PTSD because VBA conceded—based on the veteran's combat decorations—that the veteran experienced a combat-related stressor. Our claims file review determined that VBA presumed that the veteran experienced a combat-related stressor resulting in PTSD when it granted service connection to 47 percent of the male veterans included in our sample of disability compensation for PTSD, as compared to only 5 percent of female veterans.¹² This difference could potentially be explained by DoD's direct ground combat exclusion policy that requires women be excluded from assignment to units whose primary mission

¹²Maureen Murdoch, James Hodges, Carolyn Hunt, Diane Cowper, Nancy Kressin, and Nancy O'Brien (2003) found that VBA awarded disability compensation for PTSD to more male than female veterans in their review of a random sample of veterans' disability claims. However, once combat exposure is taken into account, male and female veterans are as likely to be compensated for PTSD. In other words, gender is not significant in VBA's PTSD disability compensation decisions for combat-exposed veterans. See Murdoch et.al. "Gender Differences in Service Connection for PTSD." *Medical Care* 71, no. 8 (2003): 950-961.

is to engage in direct ground combat. As a result, more men than women are assigned to combat units where they are more likely to be awarded combat-related decorations.

VBA's new PTSD disability policy, issued in July 2010, allows VBA to presume that veterans assigned to a combat zone experienced conditions that may result in combat-related PTSD even if they did not receive combat decorations. This policy change does not specifically address claims filed for PTSD as a result of MST. VBA officials told us that they expect that this new policy will result in a higher number of PTSD disability awards based on presumed combat exposure for both male and female veterans.

VBA Lacks Historical Data on Denials. VBA does not retain national historical data on denial decisions. VBA captures information on disability decisions made since 2005, both awards and denials, in its Corporate Database, and specifically the RBA 2000 data system. However, we found that VBA overwrites some data on claims denials. VBA officials told us that RBA 2000 is not programmed to retain data on denied decisions for conditions that are subsequently awarded.

VBA's data on denied decisions does not capture information on denial decisions that were eventually awarded either because a veteran appealed VBA's decision or filed a new claim for the same condition. As a result, we were not able to fully assess if there are differences in VBA's reversal of its denial decisions for male and female veterans. We were also not able to assess if there were differences among male and female veterans in how often they appeal VBA's decisions or how often they file new claims for the same condition. In the absence of more complete data on denial decisions, VBA management cannot fully assess the workload associated with processing appealed decisions or re-filed claims. VBA officials told us they are in the process of modernizing the RBA 2000 data system and it is possible to improve the capability to the system to capture longitudinal data on veterans' claims activity, including denial decisions.

Minor Differences in VBA's Denial Rates for Veterans' Claims for Mental Health Conditions Were Detected. We examined VBA's RBA 2000 data from December 2005 through March 2010 to determine at what rate male and female veterans were denied disabilities for PTSD or other mental health conditions. When we found evidence that VBA had later granted a veteran a disability award for the same condition, we excluded those denial decisions from our analysis.

We found differences in VBA's denial rates among male and female veterans' claims for PTSD or for other mental health conditions. Specifically, VBA denied female veterans at a higher rate than male veterans for PTSD. We estimate that VBA denied 49.8 percent of female veterans and 37.7 percent of male veterans who applied for PTSD disability compensation. (See Exhibit 9.) During our claims file review, we examined reasons VBA cited for denying veterans' PTSD disability compensation claims. We found little difference in the reasons why VBA denied male and female veterans' claims for PTSD

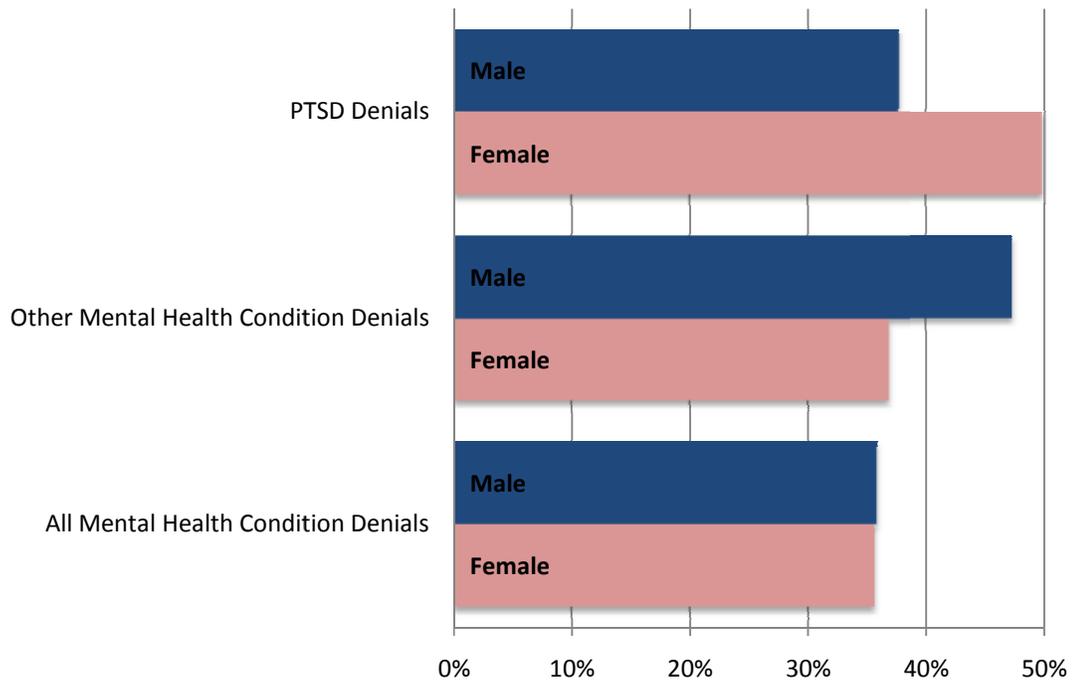
disability compensation. During our claims file review, we determined that denial decisions were in accordance with medical evidence and VBA's current policies and procedures.

VBA denied male veterans at a higher rate than female veterans who filed for disability compensation for other mental health conditions such as major depressive disorder or panic disorder. We estimate that VBA denied 47.2 percent of male veterans who filed a claim for a mental health condition other than PTSD, compared to 36.9 percent of female veterans. (See Exhibit 9.) We found little difference in VBA's reasons—detailed in veterans' claims files—for denying veterans' claims for disability compensation for a mental health condition.

Some veterans, while denied for PTSD, received disability awards for different mental health conditions. For example, a veteran who applied for PTSD disability compensation may be diagnosed with a different disabling mental health condition (such as anxiety disorder) during a C&P examination, which VBA may grant instead of the original claim for PTSD. VBA's disability payments are based on a veteran's total disability rating, not on the specific types of disabling conditions. For example, a veteran with a total disability compensation rating of 30 percent for PTSD receives the same monthly payment as a veteran with a total disability compensation rating of 30 percent for major depressive disorder.

Because veterans who apply for PTSD may actually receive disability compensation for another mental health condition, we combined data on veterans who applied for PTSD disability compensation with data on veterans who applied for disability compensation for other mental health conditions. We found minor differences in VBA's denial rates. Specifically, we estimate that VBA denied 35.6 percent of female veterans and 35.9 percent of male veterans who applied for either PTSD or another mental health condition. (See Exhibit 9.)

Exhibit 9. VBA Denial Rates for PTSD and Other Mental Health Conditions



Source: OIG analysis of VBA data

Changes in VBA’s Policy Affect Assessment of VBA’s Denial Rates for TBI. We were unable to reliably measure VBA’s denial rates for veterans who filed for disability compensation for TBI. VBA revised its policy in October 2008 to change what medical conditions were captured under the disability code 8045 (VBA Fast Letter 08-36)—the code VBA now uses to track claims awarded or denied for TBI. Prior to October 2008, VBA used this code to capture claim denials and awards for conditions defined as “brain disease due to trauma,” which could include claims for TBI, but also included a number of other possible conditions. From our review of claims veterans filed for medical conditions coded as 8045, we found no evidence that VBA misapplied its policies and procedures.

VBA Captures Limited Data on MST-Related Disability Awards, and This Data May Not Be Accurate. We were not able to quantify any differences between male and female veterans’ disability outcomes for PTSD as a result of MST because VBA’s data on MST disability awards is limited. VBA currently captures information on awards and denials for conditions as a result of MST. Specifically, VBA captures information in its Corporate Database on PTSD claims if the claim is related to a personal assault, sexual assault, or sexual trauma. However, data currently captured on PTSD as a result of MST could under-represent the actual number of claims filed and granted for conditions as a result of MST.

Since 2009, VBA has required its regional offices to track veterans' claims for PTSD as a result of MST as a special issue in its Modern Award Processing Database (MAP-D), which is part of its Corporate Database. However, at the time of this review, VBA's data system lacked the capability to track other conditions that veterans may claim as a result of MST, such as other mental health disorders or physical conditions. Until recently, only one special issue designation existed—PTSD as a result of personal trauma or MST. In July 2010, VBA directed regional offices to use this special issue designation to capture information on all claims related to MST, not just claims for PTSD.

VBA officials told us that they do not generate national reports on the number of claims pending for PTSD as a result of MST. Reports are available to regional office managers to help them track their workload for claims filed for PTSD as a result of MST. However, none of the managers at regional offices we visited routinely generated and analyzed available reports to track their office's MST-related pending claims workload and could not quantify their office's MST-related claims workload.

VBA recently developed additional special issue indicators for MAP-D to capture more specific information on MST-related claims, such as claims filed as a result of sexual harassment, physical assault, and non-physical personal trauma. These new special issue indicators were made available in late September 2010 and VBA issued guidance to regional offices. We were not able to assess whether regional offices are fully complying with VBA's guidance to use these additional indicators to more accurately capture information on MST-related claims, because these indicators were just recently made available to regional offices.

Prior to the implementation of the additional MAP-D special issue indicators, an auto-populating feature in MAP-D may have caused veterans' claims for MST-related PTSD to be erroneously captured as only PTSD claims. We observed at three of the four regional offices we visited that MAP-D automatically selected PTSD, rather than PTSD-Personal Trauma (which includes MST), as the special issue designation. Claims processors at these three regional offices told us that they were unaware that MAP-D erroneously auto-populated the special issue data field. We tested the accuracy of MAP-D special issue data against an internal tracking system maintained by a Women Veterans Coordinator at one regional office. For selected veterans, we found that 55 percent of claims filed for PTSD as result of MST were captured only as PTSD in MAP-D. Revisions to MAP-D appear to have corrected the auto-populating issue; however, VBA's data on pending claims related to PTSD as a result of MST will not be accurate until these claim decisions captured before the MAP-D special issue designation was reconfigured to capture this information are finalized.

Veterans May Be Unaware of Available Assistance Because Few Regional Offices Post Signs Detailing Women Veterans Coordinator Services. Most regional offices do not post signs informing veterans about services available through the Women Veterans Coordinator, such as assistance with filing a claim, and female veterans may be unaware of available services. Only 15 percent of Women Veterans Coordinators reported that signs describing available assistance are posted in public areas in their regional offices. Only one of the four regional offices we visited had signs posted in public waiting areas making veterans aware of Women Veterans Coordinator services.

Conclusions

Based on our review of about 750 veterans' claims files, we determined that gender was not a significant factor in veterans' disability claims outcomes for TBI, PTSD, or other mental health conditions. VBA adjudicated male and female veterans claims for these conditions consistently and in accordance with medical evidence on record and current policies and procedures. Generally, VBA awarded service-connection disability for PTSD at a higher frequency for males than females. Conversely, VBA awarded service-connection disability for other mental health conditions at a higher frequency for females than males. Limitations in VBA's data prevented us from fully assessing whether gender was a significant factor in VBA's claims denials. Currently, VBA does not retain historical data on denial decisions nationally because some data is overwritten if the denied condition is subsequently awarded. Without complete and accurate information on denied conditions, we could not accurately assess whether gender played a role in VBA's denial of veterans' disability claims. VBA also has not fully assessed to what extent MST-related cases affect its current workload or if there are differences in rate of awards or denials for MST-related claims. VBA officials told us they are in the process of modernizing the RBA 2000 data system and it is possible to improve the system's capacity to capture longitudinal data.

Lastly, the majority of Women Veterans Coordinators reported that signs were not posted in their regional office to inform veterans of services available through the Women Veterans Coordinator. VBA should increase its efforts to make veterans aware of services available to them through the Women Veterans Coordinators.

Recommendations

1. We recommended the Acting Under Secretary for Benefits, in on-going efforts to modernize the Rating Board Automation data system, develop reporting capabilities to capture longitudinal data on veterans' claims activity.
2. We recommended the Acting Under Secretary for Benefits require regional offices to post signs making veterans aware of services and assistance provided by Women Veterans Coordinators.

Comments

The Acting Under Secretary for Benefits concurred with our findings and recommendations. VBA will include enhancements to its rating application modernization project to capture longitudinal data on ratings that are produced in the modernized rating application. VBA will also provide signs to regional offices that detail services and assistance available through the Women Veterans Coordinator. We consider the planned actions acceptable and will follow up on their implementation.

Issue 3: VBA Has Guidance and Training for Evaluating MST Claims, but Sensitivity Training is Needed for Claims Processors and Women Veterans Coordinators

Summary of Findings

VBA included guidance in its claims processor manual in 2009 on the types of evidence that can be considered in evaluating a veteran's disability claim for PTSD as a result of MST. VBA's M21-1MR (Part III, Subpart iv, Chapter 4, Section H, Topic 30) provides specific examples of the types of evidence that can be considered in evaluating a PTSD claim as a result of MST. Evidence that can be considered includes visits to a counseling center without a specific diagnosis or ailment, tests for sexually transmitted diseases, or a sudden request for a change in occupational series or duty assignment. All claims processors and supervisors that we interviewed during our site visits to four regional offices stated that they were familiar with VBA's MST-related guidance on PTSD.

Details of Findings

Information on MST is Included in PTSD Training. VBA does not provide training specifically about processing MST-related claims. Rather, information on processing MST-related claims is included in some of VBA's training on PTSD claims processing. For example, "VBA's FY 2011 Challenge Training Program"—which all newly hired claims processors are required to attend—includes a module on MST in the course on PTSD claims processing. Similarly, we examined the VBA-required training for claims processors at the entry, intermediate, and advanced career levels. We found that VBA includes MST topics in its "PTSD and Other Psychological Conditions" training course that claims adjudicators are required to complete. We also examined the PTSD claims development training available to all claims processors on VA's electronic Learning Management System and found that it included learning topics on MST as well. VBA officials told us that a new training lesson on MST will be available as part of its training curriculum in November 2010.

VBA training officials told us that regional offices were required to provide claims processors training on PTSD in FYs 2009 and 2010. Claims processors from the regional offices we visited reported attending PTSD training that included some discussion on MST within the last 2 years. At each regional office, the training was provided locally by training coordinators or senior claims processors. At one regional office, the Women Veterans Coordinator arranged for clinicians and social workers from the local VA medical facility to provide training specifically related to MST for regional office staff. All of the 16 claims processors we interviewed told us that they felt that VBA's training on MST-related PTSD claims was adequate.

VBA Has Taken Steps To Standardize its Process for Collecting Evidence for MST Claims. Officials at each of the regional offices visited told us that one of the greatest challenges experienced in adjudicating MST-related claims is the lack of evidence documenting the event, such as formal police reports. VBA issued guidance (VBA Fast Letter 10-25) to regional offices in July 2010 standardizing its process for collecting evidence to support veterans' claims for PTSD as a result of MST. According to VBA's guidance, regional office Women Veterans Coordinators should contact each veteran—both male and female—filing a claim for PTSD as a result of MST to obtain information on reports that the veteran may have filed while in service documenting an MST event. We visited two regional offices after VBA issued this guidance. At the time of our visits, regional office managers were aware of this new process and were working with Women Veterans Coordinators to implement this process. We were not able to fully assess the implementation and effectiveness of this new process because VBA issued the policy so recently.

Most Women Veterans Coordinators are assigned to this position on a collateral basis, and over half must meet VBA's claims processor production requirements. Seventy-six percent of Women Veterans Coordinators reported that they spent less than 9 hours per week working on their coordinator duties during the last year. In response to a recent report issued by VA's Advisory Committee on Women Veterans, *Women Veterans—A Proud Tradition of Service*, VBA is creating full-time Women Veterans Coordinator positions at regional offices that serve veteran populations of at least 40,000 women. VBA is also developing a job description to standardize Women Veterans Coordinator duties across all regional offices. VBA officials told us that they expect to finalize the full-time Women Veterans Coordinator job description by December 2010 but were unsure when these full-time positions would be implemented by regional offices.

MST Sensitivity Training Needed for Claims Processors and Women Veterans Coordinators. Some Women Veterans Coordinators and claims processors we interviewed told us they felt unprepared to effectively communicate with veterans who may be distressed or emotional during interactions regarding their MST-related disability claim. Women Veterans Coordinators told us that VBA did not provide them with sensitivity training on how to best interact with veterans who report experiencing MST.

Specifically, they noted that VBA should provide training to help sensitize claims processors to the emotional issues unique to veterans who have experienced MST.

At one regional office, the Women Veterans Coordinator is participating in a state-provided training program for victim advocates because VBA has not provided her with any training. This Women Veterans Coordinator told us that she has experienced difficulty in effectively managing conversations with veterans who were very distressed by their MST experience.

VBA’s Reference Materials Could Be Made More Accessible to Claims Processors.

VBA’s reference materials on TBI, PTSD, other mental health conditions, and MST could be made more accessible, according to many of the claims processors we interviewed during our site visits. Claims processors and regional office managers told us that it can be difficult to quickly find VBA reference materials. At one regional office, we observed a reference toolbox that provided claims processors with a central web page that included quick references to relevant VBA guidance and references. VBA reported that they are in the process of improving the accessibility of reference materials. Specifically, VBA reported that a new website is being developed which will allow claims processors to locate reference materials more efficiently through a search tool and topic-driven hyperlinks. VBA officials told us that they expect these updates to be available to claims processors sometime during FY 2011.

Conclusions

VBA has issued guidance on MST-related claims. However, some claims processors and Women Veterans Coordinators told us that they believe they need more training because they felt unprepared to effectively communicate with veterans who may be distressed or emotional during interactions regarding their MST-related disability claim. As VBA increases its direct interaction with veterans who file MST-related claims by requiring Women Veterans Coordinators to call each of these veterans, it should increase the preparedness of its claims processor workforce—including Women Veterans Coordinators—to best communicate with veterans who may be distressed. To better assist claims processors, VBA should continue to take steps to improve the accessibility of reference materials pertaining to TBI, PTSD, other mental health conditions, and MST. This would allow all claims processors to have access to the same information resources. VBA officials told us they are in the process of improving on-line reference materials for claims processors and expect these improvements to be completed sometime in FY 2011.

Recommendations

3. We recommended the Acting Under Secretary for Benefits provide claims processors and Women Veterans Coordinators military sexual trauma sensitivity training.

Comments

The Acting Under Secretary for Benefits concurred with our findings and recommendation. In addition to VBA's current required annual course on PTSD that includes a module on sensitivity in processing MST claims, VBA will also develop training specifically on MST for claims processors and will provide sensitivity training to all Women Veterans Coordinators. We consider the planned actions acceptable and will follow up on their implementation.

Issue 4: VBA Has Not Assessed the Feasibility of Requiring MST-Specific Training and Testing

Summary of Findings

VBA has not assessed the feasibility of requiring MST-specific training and testing as part of its proficiency certification for claims processors because it has not analyzed available data on its MST-related claims workload and outcomes. Without analysis of available data on MST-related claims workload and the consistency of how these claims are adjudicated, VBA cannot identify any disparities in how these claims are processed. As a result, VBA is not well-positioned with the information needed to determine whether additional MST-specific training and testing is needed. Some regional offices process specific types of claims through specialized claims processor workgroups. However, none of the regional offices we visited processed MST-related claims through one of these workgroups.

Details of Findings

VBA Has Not Assessed the Feasibility of Requiring MST-specific Training and Testing. VBA officials reported that they collect data on pending and completed claims related to MST. However, VBA does not routinely generate national reports to analyze the volume of MST-related claims, compared to the overall volume of disability claims. Additionally, VBA uses trends identified during Systematic Technical Accuracy Reviews to determine additional training material needed by claims processors. These reviews do not focus on specific types of claims, such as those related to MST. Therefore, we determined that VBA is not well-positioned with the information needed to determine whether additional MST-specific training and testing is needed.

Some MST-Related Questions on PTSD May Be Included on VBA's Certification Examination. Claims processors must pass VBA's certification examination in order to be eligible for promotion to the GS-11 level. VBA training officials told us that VBA's certification exam is designed to test a claims processor's competence in processing a disability claim—regardless of the type of disability claim. To that end, VBA's certification examinations include at least one question related to specialized conditions

such as Agent Orange or PTSD. VBA does not have a requirement to include a certain number of questions on the examination specifically related to MST, nor is there a requirement that claims processors must answer questions related to specialized conditions accurately in order to pass the examination.

Some Types of Claims Are Processed Through Specialized Claims Processor Workgroups. While most claims processing work is not assigned based on the type of disability the veteran is claiming, some regional offices have created specialized claims processor workgroups to process initial claims filed by certain groups of veterans. For example, there are workgroups that specialize in the processing of claims filed by former prisoners of war, homeless veterans, or Agent Orange-exposed veterans. The purpose of these workgroups is to ensure that initial claims filed by these special populations of veterans are expeditiously processed. Claims processors working in these workgroups do not have additional certifications. These claims processors may also work on any claims assigned to them through VBA's digit-based claims assignment process. None of the regional offices we visited had specialized workgroups dedicated to processing MST-related claims.

Conclusions

VBA has not assessed the feasibility of implementing MST-specific training and testing for claims processors who work on MST-related claims because it has not analyzed available data on its MST-related workload and how consistently these claims are adjudicated. Without a complete assessment of its MST workload and outcomes, VBA cannot determine if additional MST-specific training and testing in addition to its current requirements for MST is necessary. VBA's current claims processor proficiency certification examination does not always include questions on MST as related to PTSD claims.

Recommendation

4. We recommended the Acting Under Secretary for Benefits perform an analysis of military sexual trauma claims volume, assess the consistency of how these claims are adjudicated, and determine whether additional training and testing on processing these claims is needed.

Comments

The Acting Under Secretary for Benefits concurred with our findings and recommendation. VBA will review existing information and data related to MST claims to determine whether additional training and testing on processing these claims is needed. We consider the planned actions acceptable and will follow up on their implementation.

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 7, 2010

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft report. Your efforts to provide this comprehensive data analysis are impressive. These analyses provide valuable insights to clinicians throughout the Veterans Health Administration (VHA) as we strive to become a more Veteran-centric health care system. Because we must make every effort to provide the highest quality of health care to Veterans who experience combat stress, it is important to have independent reviews to obtain objective viewpoints about how our system treats both male and female Veterans as they return from combat. Your report provides the type of information that we can use to improve care.
2. Also, I expect this assessment and data about Veterans' use of VA's health care services for mental health conditions such as traumatic brain injury, post-traumatic stress disorder, and military sexual trauma, will inform future research, policy and program development, and management. Communications between our staffs have already begun. Your efforts and willingness to discuss the data, data collection, the basis for conclusions in the report, and possible directions for future studies are very much appreciated. These discussions have helped us to understand the data, conclusions, as well as what additional research and study may be needed.
3. Although this review concentrates on the experience of female Veterans, it is important that we continue to study and review how

services and benefits are provided to both male and female Veterans, and understand why differences exist. While the findings in this review are important, it is crucial that VHA continues to review our processes, and study the data to ensure that we continue to provide care that meets the unique needs of men and women. Again, thank you for your efforts and for providing the valuable information in this report that will help us in the process.

4. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)

Robert A. Petzel, M.D.

Acting Under Secretary for Benefits Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 7, 2010

From: Acting Under Secretary for Benefits (20)

Subj: OIG Draft Report—Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits [Project No. 2010-01640-R1-0258]—VAIQ 7055640

To: Assistant Inspector General for Audits and Evaluations (52)
Assistant Inspector General for Healthcare Inspections (54)

1. Attached is VBA's response to the OIG's Draft Report: Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits.
2. Questions may be referred to Catherine Milano, Program Analyst, at 461-9216.

(original signed by:)
Michael Walcoff

Attachment

**Veterans Benefits Administration (VBA)
Comments on OIG Draft Report
Review of Combat Stress in Women Veterans
Receiving VA Health Care and Disability Benefits**

VBA concurs with OIG's findings and submits the following comments in response to the recommendations in the OIG draft report:

Recommendation 1: We recommend the Acting Under Secretary for Benefits, in ongoing efforts to modernize the Rating Board Automation data system, develop reporting capabilities to capture longitudinal data on veterans' claims activity.

VBA Response: VBA concurs. These enhancements were identified as part of the rating application modernization project that is scheduled for completion by November 2011. This will provide longitudinal reporting capabilities for ratings produced in the modernized rating application.

Target Completion Date: December 31, 2011

Recommendation 2: We recommend the Acting Under Secretary for Benefits require regional offices to post signs making veterans aware of services and assistance provided by Women Veterans Coordinators.

VBA Response: VBA concurs. VBA will provide signs to regional offices that indicate available services and assistance provided by Women Veterans Coordinators.

Target Completion Date: March 31, 2011

Recommendation 3: We recommend the Acting Under Secretary for Benefits provide claims processors and Women Veterans Coordinators military sexual trauma sensitivity training.

VBA Response: VBA concurs. The Training and Performance Support System (TPSS) module for Rating Veterans Service Representatives (RVSRs) on the topic of post-traumatic stress disorder (PTSD) contains information regarding sensitivity in processing military sexual trauma (MST) claims. This training course is required as part of the mandated annual Core Technical Training Requirements. C&P Service is also developing a training lesson on MST for claims processors that is scheduled for deployment in January 2011. Sensitivity training will be provided to all VBA Women Veterans Coordinators. This training will be offered through the Learning Management System by September 2011.

Target Completion Date: September 30, 2011

Recommendation 4: We recommend the Acting Under Secretary for Benefits perform an analysis of military sexual trauma claims volume, assess the consistency of how these claims are adjudicated, and determine whether additional training and testing on processing these claims are needed.

VBA Response: VBA concurs. VBA will review existing information and data related to MST claims to determine whether additional training and testing on processing these claims are needed.

Target Completion Date: April 1, 2011

OIG Contact and Staff Acknowledgments

OIG Contact	Limin Clegg Nick Dahl
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