Statement of
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Department of Veterans Affairs
on the
Status of Womens Health Care Programs
before the
House Veterans Affairs Committee
Subcommittee on Health

October 2, 2002

Mr. Chairman and Members of the subcommittee, I am pleased to be here today to report on the status of the National Women Veterans Health Program in the Department of Veterans Affairs (VA). I was appointed as the Director of the VA Women's Health Program (WVHP) and have served in that capacity since 1999. I have responsibility for ensuring that the VA policies regarding the provision of health care to women are administered at every VA facility and community outpatient clinic. I speak to you today not only from my position as Director of the WVHP, but also as a Vietnam-era Air Force veteran, an advanced practice nurse, and a 15-year veteran user of the VA health care services.

VHA responded to a 1983 General Accounting Office report entitled, "Actions Needed to Ensure that Female Veterans have Equal Access to VA Benefits" by designing innovative health care systems and investing resources to address the deficiencies identified in that report.

As a result of the focus on women veterans, many improvements have been made, and innovative strategies were instituted and are now in place to provide high quality health care to women in VHA. The Program operates through a network of field-based Deputy Field Directors who provide needed regional leadership, guidance, and support to network and medical center leaders and facility-based Women Veterans Coordinators. Women Veterans Coordinators (WVCs) were appointed in all VHA facilities as early as 1985 to be advocates for women seeking VA care. These Coordinators are instrumental to the development, management, and coordination of women's health services at not only their individual VA medical centers, but also the entire array of

community-based outpatient clinics, which aim to enhance veteran access to VA health services. They also typically have significant clinical caseloads in addition to providing local clinical expertise to other providers and health care managers.

As VHA reorganized from hospital-based to an outpatient preventive medicine health care delivery model in the mid-1990's, leadership was decentralized into 22 (now 21) Veterans Integrated Service Networks (VISNs). In keeping with these changes, Lead, or liaison, WVCs have been appointed, one in each VISN. These VISN WVCs have been recently appointed as the official field advisory committee to the WVHP office to identify needed improvements and overcome gaps in services. Given the magnitude of their role in supporting local women's health care delivery, newly appointed WVCs may obtain further training through a mini-residency offered in Tampa, Florida. To date, 77 new WVCs have been oriented in this program. The Women Veterans Program Office was established within the Office of Public Health and Environmental Hazards and the first full-time Director of the Program was appointed in 1997. Two VACO staff support the Program Director and Deputy Field Directors.

As Dr. Roswell mentioned, the ability to expand and organize women veterans' health care services was significantly enhanced by the Veterans Health Care Act of 1992, which provided authority for an array of gender-specific services and programs to care for women veterans. As a result, eight Comprehensive Women's Health Centers (CWHCs) and four Stress Disorder Treatment Centers were established. The CWHCs serve as the VHA's state-of-the art, best practice models for delivering women veterans' health care.

The CWHCs are comprised of interdisciplinary teams of health care providers delivering "one-stop-shopping" comprehensive health care to women veterans. Services include gender-specific preventive care (Pap smears and mammography) and primary general medical care, basic gynecologic services, mental health screening for MST, care for substance abuse and Major Depressive Disorders, general reproductive services, social support and case management (homelessness and domestic violence), and nutritional and pharmacological services. Patient and provider education and clinical research

are also major components of these programs. Over half of VA medical centers (VAMCs) have a separate women's health clinic, two-thirds of which were established since 1995. While the remainder often provide care in general primary care settings, women veterans are typically referred to a specialized women's health clinic for preventive screenings or gender-specific care. Over 40 percent of VAMCs have one or more designated women's health providers in outpatient mental health clinics to accommodate their special needs, and 11 percent have developed specialized women's mental health clinics.

VHA has made considerable strides in providing Military Sexual Trauma (MST) Counseling to both female and male veterans. Readjustment Counseling Service in collaboration with Mental Health and Behavioral Sciences and the WVHP offices have designed systems and programs to ensure all veterans are screened for MST, and receive appropriate counseling and treatment when indicated. The collaborative efforts of these programs ensure that veterans receive timely, sensitive, and comprehensive MST treatment at all VA health care access points.

The WVHP office collaborates with the Patient Care and Pharmacy Services to ensure these program offices remain current and informed relative to unique and changing needs of the women veterans' population.

The delivery of health care services to a diverse population of women veterans ranging in age from 20 – 100 years (894 women were 94 year old or older in FY 2001) has been an ongoing challenge for VA. The number of women veterans seeking VA health care is increasing every year. As the Under Secretary has mentioned, in 2000, approximately 150,000 women veterans were seen as outpatients and 13,000 as inpatients. In 2001, these numbers rose to 166,000 outpatients and nearly 14,000 inpatients. In fact, women are the fastest growing segment of the veteran population. In anticipation of increased numbers of women, the next challenge for VA will be to evaluate which health care delivery model demonstrates the best clinical outcomes and are most cost effective in providing care to women. One possibility is to develop a scorecard to

measure the efficiency and effectiveness of various models of delivering health care to women.

The WVHP has faced many challenges and instituted strategies that have markedly improved the way health care is provided to women. However, there will be more challenges in the future. Quality improvement is a dynamic process. In 2022, our women veterans health care delivery model will undoubtedly look very different than it does today. The WVHP and the Lead Women Veterans Coordinators, who comprise the Field Advisory Committee, are currently developing performance measures to facilitate this inquiry process and to position ourselves to be responsive to the growing number of women veterans and their changing health care needs. This is a challenge that my office and the dedicated group of Women Veterans Coordinators readily accept.

Mr. Chairman, thank you for this opportunity to provide a report on the status of the National Women Veterans Health Program. I would now be pleased to answer any questions that you or other members of the Subcommittee might have.