STATEMENT BY

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ADVISORY COMMITTEE ON WOMEN VETERANS

BEFORE THE U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS AFFAIRS,

SUBCOMMITTEE ON HEALTH

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Mr. Chairman, members of the Subcommittee, I thank you for the opportunity to address the Subcommittee on its interest and concerns related to women veterans' health within the Department of Veterans Affairs (VA).

I was appointed as a member of the VA Advisory Committee on Women Veterans on March 1, 2001, and will remain on the committee until July 2004. In August of this year, was appointed Chair of this Advisory Committee by the Secretary of Veterans Affairs. You have heard, in earlier testimony, the mission of the committee, its meeting schedules, and our reporting process.

Women veterans are a rapidly increasing population for the VA. Women comprise nearly 20% of the active force and will in the near future find themselves among our ranks, placing an even greater need and demand within the VA to provide women veterans health programs.

I would like to address a few specific points in this testimony that touch on the following topics: the Advisory Committee biennial reports; VA Women Veterans Health

Clinics; VA Women Veteran Coordinators; the VA Women Veteran Health Program Office; Homeless Women Veterans Pilot Programs.

The Biennial Report of the VA Advisory Committee on Women Veterans

During the two years prior to the biennial submission of a report the committee reviews previously submitted biennial reports. The committee members are placed on one of two subcommittees: health care or benefits. Briefings are requested from appropriate offices or departments within the VA and annually the committee conducts a VA site visit in the field. Our most recent site visit was to the VA Tampa and Bay Pines Florida campuses to include the Vet Center and Regional Office, and two Community Based Outpatient Clinics. The compilation of the information utilized for the coordination of the recommendations presented in the biennial report is an ongoing evolution.

Others may speak with greater understanding, however, before the 2002 Report, some past committee members have expressed their concern that the VA response process was done on an uncoordinated, independent and/or individual office/department approach and that the answers were at times somewhat ambiguous. However, the purpose and the level of importance placed on the contribution of the advisory committee come into question when responses are not interpreted as significant.

Considering the time spent on briefings, site visits, and presentations, not to mention the writing of the report, it is truly unfortunate that the 2000 Report was lost to Congress for a time due to a sunset provision in the original legislation. The requirement for submission was reinstated in Public Law (PL) 106-419. It is the Committees hope that this doesn't occur in the future with any of the reports that congress feels strongly enough to request in legislative action.

The VA Chief of Staff, in a briefing earlier this year, assured the committee that the response to each of the committees' recommendations in the 2002 biennial report, would be addressed in timely manner with a coordinated approach process. Additionally, that the Chief of Staff would oversee this process. The Advisory Committee submitted its Report to the Office of the Secretary before July 1, 2002 as requested. It was a finalized document in less than sixty (60) days. Having read the 2002 Report responses, it appears that authority was given by VA leadership to those responsible for responding to the recommendations, allowing for specific comment and committing to up-dates on subject matter.

WOMEN VETERAN HEALTH CLINCS

Presently, the VA has eight (8) designated Comprehensive Women Health Centers, four of which were given this designation nearly twenty years ago. Perhaps, it is time to re-assess them and ensure there is adherence to the criteria of care that sets them aside as Comprehensive Centers. Leadership must be held accountable for the standards of care delivered as determined by the outcomes acquired through and evaluation of performance measures.

Every two years, in a competitive process, the VA selects Centers of Excellence in women health care. In 2002, six were selected. They include The Comprehensive Health Care Program of Durham VA Medical Center, along with the Women Veterans Health Care Programs of Alexandria VA Medical Center, Boston VA Medical Center of VA New England Health Care System, Bay Pines VA Medical Center, VA Pittsburgh Medical Center, South Texas VA Veterans Health Care System. The VA Advisory Committee on Women Veterans applauds these programs for the accomplishments, energy, effort and effective programs they have instituted in the delivery of service and care for women

veterans. They meet the highest standards of clinical outcomes, patient satisfaction, and productivity. Is it possible that some of these Centers of Excellence should be designated as Comprehensive Women's Health Centers?

In addition to the Comprehensive Centers, approximately eighty-five or fifty percent (50%) of the VA Medical Centers have women veterans' health clinics. Of this number, two-thirds (2/3) or 57 clinics, have come on line since 1995. The remaining VA Medical Centers deliver care to women veterans in the general primary care setting with referral to clinics. Gender specific care is done in a GYN clinic or by contracting into the community.

In today's health care delivery market, women's health is a fast growing, widely recognized, and professionally accepted specialty. The female body process, its hormone system with its inter-relationship to other aspects of health considerations, pharmacology, the issues related to sexual trauma, domestic violence, and its therapeutic delivery setting, culturally sensitive education programs, research opportunities, …these are only a few focus points that substantiate the need for women's health clinics and its inter-disciplinary approach. The movement towards Women's Health Clinics in the community is obvious and the thrust is also apparent in the acceleration of the approach taken in medical school curriculum and the fellowships offered.

In a report to Congress, of the results from a national survey of medical schools and recommendations for a core women's health curriculum in medical education, a major leap forward has been taken to advance medical education. Through the Office of Women's Health (OWH) collaboration with representatives of the Health Resources and Services Administration, the NIH-Office of Research on Women's Health, (ORWH), the Association

of American Medical Colleges (AAMC), and the American Medical Women's Association, significant steps were taken towards the design and implementation of a model curriculum to help medical schools achieve an innovative, multi-disciplinary, lifespan approach to women's health.

The diversity of services offered in the VA Women Veterans Health Clinics varies widely. But the ability to address the health care issues of the women veterans should not be compromised. Again, performance measures are vital.

Outcomes are the golden key. They will unlock the door that restrains the growth opportunities of innovative programs, services, and delivery systems. This is what you seek. You need outcomes…measurable evaluations of programs. These outcomes justify the dollars spent, the staff assigned, and the contracts formed or expanded. Without outcomes how can we come to you seeking more … Asking you to expand programs for women veterans, even asking you to help retain what we all have labored so hard to obtain? If we, on either side of this table, as advocates, don't have the information necessary to carry on…we have all lost…but most particularly, the women veterans of America. The Advisory Committee stresses the valuable importance of the VA to work toward the continued and expanding process of collecting and reporting outcomes. Outcomes define quality and justify investment. If outcomes are significant, however, we need to know that all this work in data gathering is not a futile exercise. Will VA budget dollars follow?

This leads me to my next topic of discussion.

VA Women Veteran Coordinators

Women Veteran Coordinators are truly vested in their job. They work endless hours, many, far beyond the limits of their official FTEE, in order to get the job done. Their innovative approach to duty has driven the efforts of the women veteran programs. The issue of FTEE allocation for WVC, at both the local and VISN level is a listed recommendation in the Advisory Committee's Report 2002. We seek no less than .5 FTEE for local WVC and full time at the VISN level. Here, once more, the Advisory Committee appreciates the need for outcomes. However, we also appreciate the level of responsibility placed upon the WVC. The level of FTEE for WVCs varies widely within the local level structure of medical centers. Some report a mere four hours of FTEE validation. Another concern of the Advisory Committee is the fact that the language creating the position of WVC merely states the medical centers must "designate" a Woman Veterans Coordinator. It does not mandate that they be given any FTEE nor are funds earmarked for their positions.

In many instances, WVCs, at the local level, not only visit the in-patient women veterans on the hospital units, but also assist, represent, advocate, and intervene on behalf of the women veterans seen in all the clinics areas, plan and participate in outreach activities, coordinate local women veterans advisory meetings, monitor clinic utilization, assist with women veterans issues presented by homeless veteran outreach team members, serve as a resource for community partners serving women veterans, assist with the WVC strategic plans, work with the VISN WVC and contribute to the coordinated VISN WVC programs and the regularly scheduled conference calls and the WVC is often the first Point Of Contact for women veterans at the local VA Medical Center. Now we add on the

necessity for the WVC to track performance measures in the quest of outcome numbers. …. If we asked the WVCs, I'm sure the list would go on and most likely include the ever-expanding situation of women veterans in the Community Based Outpatient Clinics (CBOC's).

Many VISN WVCs are also local medical center WVCs. So to the list above place upon their shoulders the responsibility of VISN oversight and advocacy…and outcomes. According to the VHA Handbook 1330.1 Guide to the Women Veterans Health Services, there is reference to the involvement of the VISN WVC at the VISN level on the Strategic Planning, Space, Environment of Care, and Pharmacy committees. We would also recommend this consideration for the VWVC at the local medical center lever. This would also assist with the correction of privacy issues and/or eliminate its occurrence when new construction or rehab of facilities is considered. And privacy issues still remain an issue for many veterans.

<u>Women Veteran Health Program Office (WVHPO)</u>

With PL 102-585, the Veterans Health Care Act of 1992, four (4) Regional Women Veteran Coordinator positions were mandated. Later they became known as Deputy Field Directors.

The WVHPO is not mandated but operates at the pleasure of the VA Under Secretary of Health. Its first Director was appointed in 1997. It is the program office under which women's health care is coordinated for the entire VA. The Advisory Committee asks that you legitimize the resources for the Women Veterans Health Programs by enabling legislation to mandate its existence.

Homeless Women Veterans Pilot Programs

The Advisory Committee has requested an up-date on these pilot programs. We have been concerned about the continued funding of these programs after the first year of designated funding. We were given to understand that the VISN directors and local medical centers understood that if additional funding was not designated in the budget for the second and third year of the pilot programs that they would commit to the continued funding for the programs at the designated level of the first year. It is unclear if this is, in fact, the case and if all affected Department Chiefs are aware of this arrangement. It was our concern from the beginning that if the money for these special programs, set up as three year pilots, was not set-aside protected dollars, as was the intent of Congress, that the money would be lost in the big VA pool of need. We ask Congress to consider this when providing funding for any special projects in the future.

This concludes my testimony. Thank you, again, for allowing me this opportunity. I am available for questions.

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Served in the Army Nurse Corps (1968 – 1970) with assignments at Fort Campbell, KY and the 18th Surgical Hospital (Camp Evans & Quang-Tri) in the Republic of South Vietnam.

In 1993, initiated Philadelphia Stand Down for homeless veterans and served as its Executive Director and President through 1998. Worked in nursing until 1996, when the position of Program Director for Homeless Veteran Services at The Philadelphia Veterans Multi-Service & Education Center was accepted. Responsibilities include a ninety-five-bed Transitional Residence (LZ II) and a Homeless Veteran Day Service Center (The Perimeter).

Is an active member of Vietnam Veterans of America (VVA) since 1987. Presently, is a Director-at-Large on their National Board of Directors (1999 to Present), Chair of VVA National Women Veterans Committee, and member of VVA's Veterans Health Care Committee, Government Affairs Committee and Homeless Veteran Task Force.

Serves as a member of the VA Advisory Committee on Women Veterans with an August 2002 appointment as Chair and is an Ex-Officio Liaison to the VA Homeless Veterans Advisory Committee.