Statement of
Mary Antoinette (Toni) Lawrie RN, WVPM
Bay Pines VAMC, FL and VISN 8 Lead WVPM
Department of Veterans Affairs

Before the
House Veterans Affairs Committee
Subcommittee on Health
October 2, 2002

Mr. Chairman and Members of the Subcommittee, I am Toni Lawrie, a registered nurse currently working as the Women Veterans Program Manager (WVPM) at the Bay Pines VAMC on the west-central coast of Florida, and Lead WVPM for VISN 8. I am pleased to be here today to report on the status of women veterans health care at Bay Pines in particular, and VISN 8 in general. Almost 10 years ago, in March of 1994, I provided a statement to the House Subcommittee on Oversight and Investigations in regard to "VA actions to improve the provision of health care to women veterans and related issues". In reviewing that testimony I was reminded that I called for VA to open primary care clinics for women regardless of service connected status, for VA to identify several centers of excellence to show the way in women's health care, and for VA to eliminate physical and psychological barriers for women seeking health care from the VA. To my delight and surprise, VA has done just that. I can only hope I am as on target with my suggestions now as I was then. The Bay Pines Women's Program was recognized in 2002 as a VA Clinical Program of Excellence.

Florida is home to 107,000 women veterans, and Puerto Rico has 6000, so VISN 8 has about 113,000 women veterans according to the 2000 census figures. This is and increase of some16,000 from the 1990 census, which showed the VISN 8 women veteran total as 97,200. VISN 8 has the largest workload of women veterans in the nation. In FY 2000, three of our VA facilities were ranked in the top 10 VAs in the nation treating unique numbers of women (Tampa # 1, NF/SG #3, and Bay Pines #9). In FY 02, we treated in excess of 21,000 (a 19% market share) unique women across the Network.

VISN 8 has a Women Veterans Workgroup which reports to the Director through the Clinical Council. This work group developed a 5 Year Strategic Plan to expand and improve the care of women veterans. Three of the main goals in the plan speak to both our "best practices" and our vulnerabilities. Those goals are:

- Improve the quality and availability of services to women by reducing privacy deficiencies and creating a uniform package of services available to them, particularly in CBOCs.
- Increase market penetration for women to 25% of the population across the network by 2007, and

- Offer "full service" Primary Care clinics at VAMCs especially for women, with as many disciplines as practical (primary, mental health, gynecologic, breast care, nutrition, pharmacy, and social work services), providing on site service to exceed patient expectations.

Privacy deficiencies in the hospitals have been largely overcome in the past several years, however, with the rapid proliferation of Community Based Outpatient Clinics (CBOC) in the system and the conversion of in-patent space to out-patient space, the deficiencies are back. Each WVPM in VISN 8 surveyed the CBOCs, finding a lack of privacy curtains, restrooms unequipped for women's needs, misplaced exam tables without stirrups, exam rooms on public corridors which could be easily accessed by other patients, a lack of acoustical privacy at check in, and only a few that offered gender specific examinations for women. Reclaimed space in hospital facilities generally exist on easily accessed public corridors and few rooms have enhanced privacy provided by draw curtains.

The overall VISN 8 goal was to raise market penetration of the veteran population to 25%, so the goal for women was raised from 20 to 25%.

And the 3rd goal of offering "full service" settings for women to receive care is driven by current practice in VISN 8, and by findings from satisfaction surveys of users. All of the facilities in VISN 8 have dedicated space in the hospitals where "women's services" are offered. They vary in the mix of services, some offering more than others. However, we have identified the more comprehensive mix of services as one of our Best Practices in the care of women. It is preferred not only by our patients, but also by our providers. Hallway or "curbside" consultations between a matrix of primary and specialty care providers saves time, money, and the potential for clinical error. We know our patients want this kind of service. In a recent (9/2002) survey of 243 outpatient women across the VISN we asked, "If you had the option of choosing where you receive health care within the VA system, which of the following would you choose? Primary care, not separated from male patients, Primary care, separated from male patients, or in a Women' Health clinic?". Only 7% of respondents chose Primary care, not separated, while 86% chose Womens Clinics and 6% chose Primary Care, separated. A second question, "If you are seen in the Women's Clinic, does it offer you…less privacy (0%), same privacy (16%), more privacy (82%)". I do not think that each VA facility in the nation needs to develop a separate womens clinic. Some in our more rural areas would not have the population of women veterans to support it. In these situations, women veterans should be seen by providers who are willing and trained to provide gender specific care for women in a primary care practice. However, where larger populations of women veterans reside, I would urge VA to continue to support women's clinics rather than "mainstreaming" women into mixed gender primary care clinics. Some study of the costs of this multi-specialty care approach versus "traditional" primary care will have to be made in the future to reassure our leaders that the goodwill of patients is worth a few pennies more.

Another aspect of the Women Veterans Health Program that needs some attention is the decline in time that the WVPMs have to devote to their role in outreach, administration, problem solving, and program planning. While VA suggests that the WVPM have a background in nursing or social work, increasingly "technicians" (health techs, pharmacy techs, program assistants, etc) are being placed in the role. These are well intentioned women, but quite often, they do not hold a place in the facility hierarchy to champion the cause of women veterans effectively. On the other hand, when a nurse or social worker (or other professional such as psychologist) is brought on, they are more likely to be nurse practitioners, clinical specialists, or clinical social workers who have advanced practice skills and are expected to practice clinically for a large segment of their work day. Several full time WVPM positions have essentially been reduced to part-time by the requirement that the practitioners carry a clinical caseload. This has happened even in some of the 8 Women Veterans Comprehensive Health Centers established by Congress in 1993. I know this because I facilitate an orientation week for newly appointed WVPMs to help them get up to speed in their new role more quickly. The womens program cannot survive if only 5 hours a week is allocated to the duties of WVPM. I know this because I had the title as an "additional duty" for 6 years before being assigned to the full time pursuit of managing the program. As a full time WVPM, I have been able to devote much of my time to improving and expanding the services available to women veterans at Bay Pines, and in VISN 8. At Bay Pines, we have become a Clinical Program of Excellence. We have a market penetration in our county population of about 35%. We have been able to develop tools/instruments to better help us communicate with and serve women. We have developed training programs for WVPMs and mental health clinicians who work with sexual trauma victims. We have developed a unique residential day treatment program for women who are suffering from PTSD as a result of military sexual trauma. This program was funded in FY 2000 by a grant from HSR&D's "innovative initiatives" RFP. The program has been highly successful in treating women for whom out-patient therapy alone was insufficient in the treatment of sexual trauma. Pre and post testing of 75 women clients who have been through the 4-week residential program provides statistically significant evidence that the program works, and works WELL. Preliminary data analysis indicates significant improvement of symptoms including anxiety, depression, intrusive thoughts, sleep disturbance, and sexual functioning as a result of the treatment intervention. The patients are also very satisfied with the care that they receive in the Sexual Trauma Day Treatment Program (STDTP); 99% indicate that they would return for additional treatment if needed, and 100% would recommend the program to a fellow veteran who needed treatment because of sexual trauma. Research associated with this program continues and holds promise of important findings. These types of things would not have happened if I only had 5 hours or 20 hours a week to put to the program. We are currently using the STDTP as a model to develop a treatment program for male victims of military sexual trauma at Bay Pines. We are also asking for funding to train two post-doctoral year

psychologists in these special programs yearly, to begin a pool of highly trained mental health clinicians from which VA can draw.

The VISN 8 Women Veterans Workgroup, advisory to the Director has created several work products that are helpful to the overall effort, especially in the creation of instruments that survey the satisfaction of women with their care. We also developed policies on Maternity Care, Treatment of Infertility, and Gender Reassignment, for review and approval of the VISN 8 Clinical Council. VISN 8 is a "benchmark" network in the care of women veterans. We have seen that systems which work well for women, also improve the care of men.

Women veterans no longer enjoy the designation of a "special emphasis" category of patients in VA care. We do not know why.

I thank the Chairman and the Committee members for requesting my statement. It is heartening to those of us in the field to know that our thoughts, ideas and opinions are valued by the men and women in Congress who make the laws.