



 Department of Veterans Affairs

Advisory Committee On Women Veterans 2002 Report

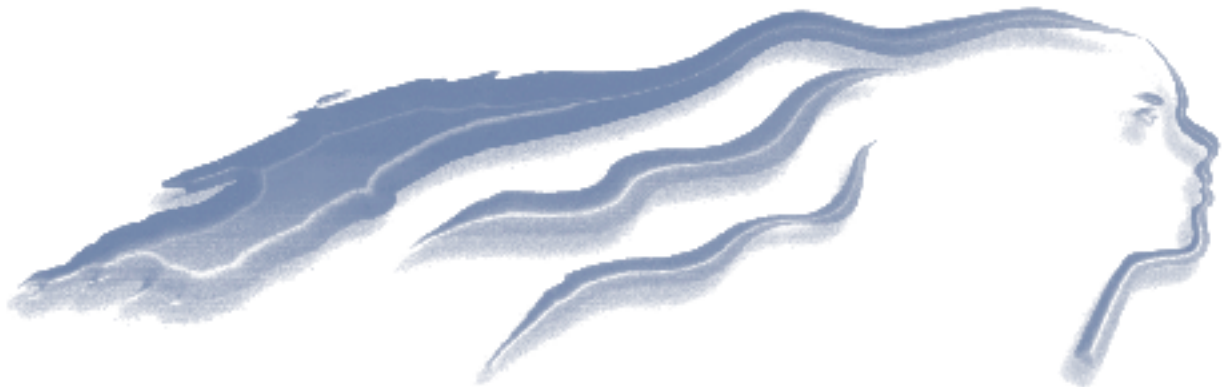


*Women Veterans...
Forging the Future for Those
Who Follow*

April 2003

Department of Veterans Affairs

Advisory Committee On Women Veterans 2002 Report



The Department of Veterans Affairs Advisory Committee on Women Veterans is required to submit a report of activities in Compliance with the provisions of Public Law 98-160.

TABLE OF CONTENTS



LETTER FROM THE CHAIR	1
PART I	3
Executive Summary	3
PART II	5
Summary of Recommendations	5
PART III	9
Recommendations and Rationale.....	9
A. Outreach	9
B. Sexual Trauma Counseling and Care	10
C. Women Veterans Coordinators.....	10
D. Health Care	11
E. Staff Education.....	12
F. Employment of Women Veterans in the Federal Government.....	12
G. Strategic Planning	13
H. Women Veterans Who Are Homeless	14
PART IV	17
VA Response to Recommendations.....	17
A. Outreach	17
B. Sexual Trauma Counseling and Care	21
C. Women Veterans Coordinators.....	22
D. Health Care	25

Table of Contents (continued)

E. Staff Education.....	28
F. Employment of Women Veterans in the Federal Government.....	28
G. Strategic Planning	30
H. Women Veterans Who Are Homeless	31
PART V	35
Future Considerations	35
APPENDICES	
Appendix A	39
Historical Perspective.....	39
Appendix B	43
Advisory Committee Site Visits – A Cumulative Record	43
Appendix C	45
Past Chairs of the Advisory Committee on Women Veterans.....	45
Appendix D	47
VA Advisory Committee on Women Veterans Membership Profile.....	47
Appendix E	53
Center for Women Veterans Mission and Goals.....	53



The 2002 report that follows represents the 10th biennial report of the Advisory Committee on Women Veterans. The Committee was established in 1983 by Public Law 98-160 with a charge to:

- ❑ Assess the needs of women veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the Department of Veterans Affairs (VA);
- ❑ Review the programs and activities of VA that are designed to meet these needs;
- ❑ Make recommendations for appropriate action, and;
- ❑ Follow-up on these recommendations.

During the reporting period of 2000 - 2002, the Committee has pursued its mandate through visiting facilities off-site within the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA); briefings by VA officials; interfacing with veterans service organizations (VSO); participating in women veterans forums, town hall meetings and similar events; and reviewing and analyzing pertinent VA reports and publications.

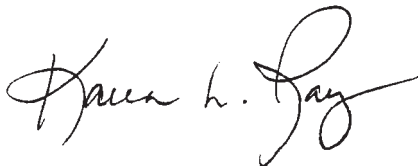
The Committee has seen continued progress in VA's approach to addressing the needs of women veterans. Recent examples include the introduction of newborn services, and release of the first nationally representative study assessing the quality of life for women veterans. Another major example involves the efforts of the Women Veterans National Strategic Work Group to evaluate women's health care and provide preliminary recommendations for strategic planning for women's health.

However, there continue to be areas of need with respect to ensuring that women veterans receive the care and services they've earned, and that such care is provided with the dignity and respect they deserve. This report builds on those of the past in continuing to define vital issues that impact women veterans' receipt of their benefits and recommending VA actions that can improve the quality of services. Issues such as female inpatient psychiatric units, continued availability of sexual trauma counseling, assistance for

women veterans who are homeless and their children, and attention to minority women veterans in outreach, hiring and research are among the concerns that are presented in the report.

As the number of women in the military continue to climb (estimates indicate women comprise approximately 25 percent of new recruits), and the nation pursues the war brought on by the attack of September 11, 2001, military women share in the new challenge of defending against terrorism. They honor our country through their service. It is our honor to represent them on this Committee and to help VA stand ready to serve their needs.

Respectfully Submitted,

A handwritten signature in cursive script that reads "Karen L. Ray".

Karen L. Ray, RN, MPH, MA
Colonel, Army Nurse Corps (Retired)
Chair



Executive Summary

The 2002 Report of the Advisory Committee on Women Veterans provides recommendations that address the following issues:

- ❑ Outreach
- ❑ Sexual Trauma Counseling and Care
- ❑ Women Veteran Coordinators
- ❑ Health Care
- ❑ Staff Education
- ❑ Employment of Women Veterans in the Federal Government
- ❑ Strategic Planning
- ❑ Women Veterans Who Are Homeless

The report of the Advisory Committee on Women Veterans is submitted biennially by the Committee, which is comprised of women veterans and women veterans' advocates appointed by the Secretary of Veterans Affairs. Current Committee membership includes representation by veterans from the Air Force, Navy, Army and Marine Corps, as well as the Reserve and National Guard. Members represent a variety of military career fields and possess extensive military experience, to include service in Vietnam and the Persian Gulf Wars.

A total of twenty-four recommendations with supporting rationale are provided in this report. Recommendations stem from data and information gathered in exchange with the Department of Veterans Affairs (VA) officials, women veterans, researchers, veterans service organizations (VSO), internal VA reports, and site visits to Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) facilities.

Highlights

- Recommendations to address the need to create or modify services to provide specifically for the needs of women. An example is the request for each of the 22 Veterans Integrated System Networks (VISN) to develop an inpatient psychiatric unit exclusively for women veterans, and to establish a domiciliary for women veterans who are homeless.
- Concerns to improve the care for women veterans by addressing staffing levels for women veterans coordinators (WVC) positions, permanently removing eligibility restrictions for sexual trauma counseling, and ensuring a standardized new employee orientation that includes information concerning the specific needs of women veterans.

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- Monitor and analyze the more recent services introduced by VA, such as obstetrical care and pilot programs for women veterans who are homeless, to help ensure that provision of services meet potential increases in demand. Guidelines for case management of women veterans who are homeless should be developed and disseminated based on analysis of pilot projects deemed successful.
 - Emphasis on the need for research to determine the success of health and benefit programs in meeting the needs of women veterans, as VA conducts strategic planning to design future care and services.
 - Research to assess the impact of the increasing number of women in the military and their changing military roles on the design and delivery of VA services. The rising proportion of minority women heightens the need for meaningful data regarding women veterans of all racial/ethnic groups.

In addition to the recommendations of the 2002 report, the Committee identified future concerns for its ongoing oversight and monitoring. These include:

- ◆ The collection of military service information via the National Census forms.
- ◆ The VA-DOD task force studying the need for sexual trauma services by members of the Selective Reserve and National Guard.
- ◆ Policies related to all military personnel, including Selective Reserve Forces and members of the National Guard receiving basic VA benefit information.
- ◆ The Community Based Outpatient Clinics (CBOC), Veterans Equitable Resource Allocation (VERA), and Capital Asset Realignment for Enhanced Services (CARES).



Summary of Recommendations

1. Foster partnerships with community-based service providers to increase outreach to women veterans, in particular minority women and those isolated from the mainstream. Outreach to women veterans should include information related to VA entry points, health care, benefits, employment services and opportunities.
2. Develop a VISN-wide strategic plan, with outreach goals, coordinated by the VISN WVC with consideration of cultural and regional issues/influences affecting women veterans. Further, local evaluation of outreach programs should be monitored for effectiveness and incorporated into the VISN strategic plan.
3. Request that the VISN directors consider specific funding for outreach to women veterans within their jurisdiction.
4. Continue annual briefings from the Director, Women Veterans Health Programs (WVHP) and the WVC from VBA, to include the status of the implementation of sexual trauma/sensitivity training to all employees, with an update on how this activity is verified or tracked in personnel files.
5. Seek to permanently remove the eligibility requirement for access to sexual trauma counseling.
6. Seek to establish a designated full-time VISN WVC, without collateral duties.
7. Establish and maintain a minimum of twenty hours per week (.5 FTEE) for WVCs.
8. Request that VHA/VBA directors provide the WVCs with appropriate space to perform their duties, necessary office equipment, and administrative support as indicated by workload.
9. Recommend that all VA medical centers establish women veterans advisory committees with a minimum of one non-VA woman veteran consumer employee, and meet on a regular basis. Further, recommend that the committee meeting minutes be submitted to the VISN WVC. It would be beneficial to conduct an annual town meeting for local women veterans, which includes the WVC from VBA, if possible.
10. Recommend increased communication between VA health care providers and community contract care providers for an enhanced case management approach ensuring a coordinated continuity of care.
11. Request updates on the VHA plan to provide diagnostic, therapeutic and support services for the increased obstetrical and gynecological needs of women veterans.

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12. Recommend that each VISN develop an inpatient psychiatric unit dedicated exclusively to the treatment of women veterans.
 13. Recommend continued women veteran's health research with sufficient funding. Further, attention should be given to study design and data gathering which includes all women veterans' subgroups within the women veteran population (Black, Hispanic, Asian, and American Indian).
 14. Ensure that a system-wide standardized training module be utilized for all new employee orientation, which includes the specific needs of women veterans as contributed by the WVC.
 15. Recommend increased recruitment and hiring of qualified women veterans, with attention to minority women veterans in Federal service positions within VA, also addressing senior executive service positions and appointed political positions within the Department. Further, request the Office of Personnel Management (OPM) to encourage other Federal agencies to recruit and hire qualified women veterans. This includes the Department of Labor (DOL), Veterans Employment and Training Service (VETS) in positions of the Disabled Veterans Outreach Program (DVOP) and as Local Veterans Employment Representatives (LVERs).
 16. Recommend that women veterans be appointed to all VA advisory committees to address those concerns and issues specific to women veterans.
 17. Recommend an examination of the data gathered in support of recent studies conducted by VA, such as the *5th National Survey of Veterans* and the *1999 Large Survey of Veterans*. This would determine if either study provides sufficient samples of women veterans by age, race/ethnicity, era of service, and non-users of VA health services to conduct regression analyses on the success of VA health and benefits programs in meeting the needs of women veterans. If an existing data set can be found, make it available to appropriate researchers who wish to study women veterans. If it does not exist, the Committee recommends that the Secretary of Veterans Affairs work with Congress to identify funding to collect such data.
 18. Request that the strategic planning process at national, regional/VISN, and local VA levels recognize and address issues arising from the growing numbers of active duty women and their changing military roles. These findings could impact future women veterans' benefits and care.
 19. Provide printed materials on women's health issues and benefits in Spanish as well as in English. This material should be made available at all VA facilities and included in all outreach programs.
 20. Recommend each VISN establish a domiciliary unit exclusively for women veterans who are homeless.

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- 21.** The Committee recommends that the Secretary of Veterans Affairs work with the Secretary of Housing and Urban Development (HUD) to review the “Sense of Congress” found in Public Law 103-446 and to encourage grant proposals giving priority to veterans who are homeless under the McKinney Notice of Funding Availability (NOFA).
 - 22.** Request a briefing on the outcome of each of the 11 homeless pilot projects and plans for continuing those projects that were deemed successful. Further, after project analyses, develop guidelines for program case management for promulgation throughout VA and with community partners for women veterans who are homeless.
 - 23.** Request that the VA Advisory Committee on Homeless Veterans address the issue of the definition of homelessness as defined by the McKinney-Vento Act. The Committee is particularly interested in those women veterans who are homeless stating they reside with family or friends, as they are presently excluded. The Committee additionally requests that the Secretary of Veterans Affairs include this as an item of discussion for the President’s Interagency Council on the Homeless.
 - 24.** Encourage the VISNs to work with community-based service providers to obtain services for the children of women veterans who are homeless and seeking assistance within VA.



Recommendations and Rationale

A. Outreach

1. **Foster partnerships with community-based service providers to increase outreach to women veterans, in particular minority women and those isolated from the mainstream. Outreach to women veterans should include information related to VA entry points, health care, benefits, employment services and opportunities.**

Rationale: *Reaching minority women veterans poses additional problems requiring specific attention in the arena of outreach. The understanding of, and sensitivity to, cultural issues and the structure of cultural groups is needed in order to impact outreach efforts to the minority population. American Indian women veterans living on reservations serve as an example.*

2. **Develop a VISN-wide strategic plan, with outreach goals, coordinated by the VISN WVC with consideration of cultural and regional issues/influences affecting women veterans. Further, local evaluation of outreach programs should be monitored for effectiveness and incorporated into the VISN strategic plan.**

Rationale: *The development of a strategic plan assists in the coordination of goals, outlining recognized agendas, and defining the approach for attainment of the goals. The VISN strategic plan for women veterans brings focus to the identified issues of the WVC and women veterans. It consolidates an approach for a course of action. It assists in oversight of programs and action plans.*

By recognizing the successes of the local WVCs, the VISN is able to draw upon their individual strength and incorporate local successful approaches that could be utilized by all WVCs, thereby, benefiting all women veterans of the VISN.

3. **Request that the VISN directors consider specific funding for outreach to women veterans within their jurisdiction.**

Rationale: *There is an expense related to successful outreach programs. If outreach is an important tool then it seems an investment is needed. Outreach information directly impacts VA on many levels: the budgetary requirements; the time allotted to WVCs; the increased need for gender-specific training, personnel requirements, and the type of providers, procedures and benefits needed. A consideration for outreach may include enclosing VA information in letters from Congressional delegations to their constituents. Other possibilities for increased awareness would include Post Office fliers, advertisement in public transportation terminals, on buses and regional rail lines/trolleys, within laundromats, grocery store chains and libraries, to name a few. (See 38 U.S.C § 7722)*

B. Sexual Trauma Counseling and Care

4. **Continue annual briefings from the Director, Women Veterans Health Programs (WVHP) and the WVC from VBA, to include the status of the implementation of sexual trauma/sensitivity training to all employees, with an update on how this activity is verified or tracked in personnel files.**

***Rationale:** Women veterans who suffer from sexual trauma often have difficulty in settings that place them in an environment that they interpret as threatening. There is concern that although VA is working to incorporate sexual trauma/sensitivity training, indications are that it has not been fully implemented with all staff at all VA facilities.*

5. **Seek to permanently remove the eligibility requirement for access to sexual trauma counseling.**

***Rationale:** A final report by Katherine M. Skinner, PhD, "Quality of Life by the Year 2010," indicated that women veterans are expected to increase in VA system from the present 5.5 percent to 7.2 percent. In a companion report, "Women Veterans using VA Ambulatory Care," Dr. Skinner finds that 55 percent of the sample women in the study reported sexual harassment and nearly one quarter (23 percent) reported sexual assault while they were in the military. This information indicates the problem is not disappearing. Utilization outcomes will provide additional documentation for this legislative action.*

C. Women Veterans Coordinators (WVC)

6. **Seek to establish a designated full-time VISN WVC, without collateral duties.**

***Rationale:** At the VISN level, the Committee believes a full-time WVC is important as an effective coordinator of services, programs, outreach, training, and oversight. This position also provides support, assistance and guidance for the WVC in the medical centers of the VISN.*

7. **Establish and maintain a minimum of twenty hours per week (.5 FTEE) for WVCs.**

***Rationale:** Existing positions should not be decreased to meet this level of FTEE. The workload of WVCs is ever expanding, especially in light of the increased number of community-based outpatient clinics (CBOC). There is also the projected increase in the number of women veterans, ultimately leading to an increase of women veterans accessing VA health care system.*

8. **Request that VHA/VBA directors provide the WVC with appropriate space to perform their duties, necessary office equipment, and administrative support as indicated by workload.**

Rationale: As reported by Katherine M. Skinner, PhD, at the One VA Women Veterans Coordinators Conference, on April 23, 2002, 72 percent of the WVCs indicated that the most difficult part of their job was limited time available and lack of clerical support.

- 9. Recommend that all VA medical centers establish women veterans advisory committees with a minimum of one non-VA woman veteran consumer employee, and meet on a regular basis. Further, recommend that the committee meeting minutes be submitted to the VISN WVC. It would be beneficial to conduct an annual town meeting for local women veterans, which includes the WVC from VBA, if possible.**

Rationale: This process could increase outreach and communication, identify outstanding issues, bring oversight to local services, and measure customer satisfaction.

D. Health Care

- 10. Recommend increased communication between VA health care providers and community contract care providers for an enhanced case management approach ensuring a coordinated continuity of care.**

Rationale: Coordinated case management would ensure that the care and treatment of women veterans are consolidated and accessible by all health care providers for a positive holistic approach to the delivery of service.

- 11. Request updates on the VHA plan to provide diagnostic, therapeutic and support services for the increased obstetrical and gynecological needs of women veterans.**

Rationale: In light of the age of women veterans utilizing VA (FY99 outpatients by age), 49.5 percent are between the ages of 25 to 44. As the percentage of women veterans who use VA rises, so too will the demand for increased obstetrical and gynecological care.

- 12. Recommend that each VISN develop an inpatient psychiatric unit dedicated exclusively to the treatment of women veterans.**

Rationale: Inpatient psychiatric care for women veterans remains a concern. This issue closely relates to the issue of designated units for women veterans who are homeless and those with a history of sexual trauma. Women often find themselves the only female on a psychiatric unit and are intimidated by the presence and remarks of male veteran patients. They may also lack a sense of security and safety. Often times they are unable to fully participate in group therapeutic settings. The rising number of women veterans will most likely create an increased demand for mental health services and projections need to be established to keep up with this demand for care. If the study on sexual trauma experience of the National Guard and Reserve women results in this group accessing mental health care in the VA system, this will prove yet another source of increased demand.

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- 13. Recommend continued women veteran’s health research with sufficient funding. Further, attention should be given to study design and data gathering which includes all women veterans’ subgroups within the women veterans population (Black, Hispanic, Asian, and American Indian).**

***Rationale:** Dr. John G. Demakis, Director of Health Services Research & Development Service, reported to the Committee that it continues to be difficult to understand or identify the specific needs and issues of subgroups within the women veterans population. The increasing population of minority women within the active duty ranks heightens the imperative for VA to design and fund health research that will profile their needs.*

E. Staff Education

- 14. Ensure that a system-wide standardized training module be utilized for all new employee orientation, which includes the specific needs of women veterans as contributed by the WVC.**

***Rationale:** Katherine M. Skinner, Ph.D., on April 23, 2002, at the One VA Women Veterans Coordinator’s Conference, indicated that over 25 percent of the WVCs employed by VA medical centers had never been included in providing information for new employee orientation.*

F. Employment of Women Veterans in the Federal Government

- 15. Recommend increased recruitment and hiring of qualified women veterans, with attention to minority women veterans in Federal service positions within VA, also addressing senior executive service positions and appointed political positions within the Department. Further, request the Office of Personnel Management (OPM) to encourage other Federal agencies to recruit and hire qualified women veterans. This includes the Department of Labor (DOL), Veterans Employment and Training Service (VETS) in positions of the Disabled Veterans Outreach Program (DVOP) and as Local Veterans Employment Representatives (LVERs).**

***Rationale:** The Committee recognizes that VA has a continuously improving record in the hiring of women. This recommendation specifically addresses the hiring of women veterans.*

- 16. Recommend that women veterans be appointed to all VA advisory committees to address those concerns and issues specific to women veterans.**

***Rationale:** Women veterans have unique needs and as veterans, it is imperative that they are present on all VA advisory committees to assure that they have an active voice in the committees’ decision-making.*

G. Strategic Planning

- 17. Recommend an examination of the data gathered in support of recent studies conducted by VA, such as the *5th National Survey of Veterans* and the *1999 Large Survey of Veterans*. This would determine if either study provides sufficient samples of women veterans by age, race/ethnicity, era of service, and non-users of VA health services to conduct regression analyses on the success of VA health and benefits programs in meeting the needs of women veterans. If an existing data set can be found, make it available to appropriate researchers who wish to study women veterans. If it does not exist, the Committee recommends that the Secretary of Veterans Affairs work with Congress to identify funding to collect such data.**

Rationale: *The veteran population has been declining over the past 20 years. Today, women comprise about 5.5 percent of that population. Over the next years, the veteran population will continue to shrink but the number and the percentage of women veterans will grow. According to the Defense Data Management Center, women comprise about 15 percent of today's total active duty population and this percentage will likely increase because almost 20 percent of all personnel who entered active duty over the past 5 years were women. Additionally, today's women veterans are younger than their male counterparts (61.2 percent vs. 19.9 percent are under 45) and more apt to belong to a minority group. These differences can affect the utility and effectiveness of VA programs designed to help veterans. The "model vet" around whom VA programs are designed can no longer be assumed to be male. Programs must be designed with the needs of all veterans in mind. Data is available to model the needs of male veterans by age, race/ethnicity, era of service, etc. Such data is not available on women veterans.*

- 18. Request that the strategic planning process at national, regional/VISN, and local VA levels recognize and address issues arising from the growing numbers of active duty women and their changing military roles. These findings could impact future women veterans' benefits and care.**

Rationale: *According to the Defense Manpower Data Center, there were fewer than 1000 active duty women deployed in support of military operations during the 1980s. During the 1990s, over 40,000 women deployed for the Gulf War. Today, more than 12,000 women serve aboard Navy ships. Over 20,000 have served as Peacekeepers in Bosnia and Kosovo and many hundreds are already involved in operations in and around Afghanistan. VA strategic planning at all levels must accommodate this new reality—that active duty women now face the same risks as men. As veterans, more of them could require services previously viewed as needed only by men. In planning facilities, services, and research, VA must keep pace with these changes.*

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- 19. Provide printed materials on women’s health issues and benefits in Spanish as well as in English. This material should be made available at all VA facilities and included in all outreach programs.**

***Rationale:** The Hispanic women veterans population has increased approximately 200 percent since 1980. Many of these veterans were raised speaking Spanish as their primary language. They understand and prefer reading Spanish material rather than English.*

In some instances, when a veteran becomes disabled, the family members are often the ones seeking information on benefits. Many of the family members do not speak or read English. Written materials available in Spanish, makes it easier for their families to access services for the disabled veteran.

H. Women Veterans Who Are Homeless

- 20. Recommend each VISN establish a domiciliary unit exclusively for women veterans who are homeless.**

***Rationale:** We base this consideration upon the tenuous situation faced by women veterans in the present domiciliary system, which is primarily male. Women veterans who are homeless have a higher rate of sexual abuse/trauma. Some have difficulty dealing with males in an appropriate manner conducive to a therapeutic setting. Separate domiciliary facilities for women veterans could incorporate substance abuse and PTSD treatment.*

- 21. The Committee recommends that the Secretary of Veterans Affairs work with the Secretary of Housing and Urban Development (HUD) to review the “Sense of Congress” found in Public Law 103-446 and to encourage grant proposals giving priority to veterans who are homeless under the McKinney Notice of Funding Availability (NOFA).**

***Rationale:** Presently, HUD is discouraging NOFA funding for transitional housing programs with the request of a 30 percent set aside of the grant dollars going for permanent housing only. In competing for the NOFA McKinney funding, many cities are requesting proposals for only permanent housing. This situation effects those needing funding for transitional housing thereby eliminating a potential match for VA Homeless Grant and Per Diem grant proposals. VA will lose a financially effective and efficient resource for providing assistance to veterans who are homeless if non-profit agencies lose the ability to obtain HUD McKinney grants for transitional programs. These successful non-profits agencies have reduced recidivism, shortened the length of VA inpatient stay, hence reducing the cost of treatment programs. We would encourage the Secretary and the VA Homeless Veterans Advisory Committee to investigate a joint venture, creating cooperation, between VA and HUD in allowing a portion of HUD McKinney NOFA dollars to be set aside and accessible for linkage to VA Homeless Grant & Per Diem requests for the creation of transitional housing for veterans who are homeless.*

Additionally, in 1994, “The Sense of Congress” was stated in Section 1005 of Public Law 103-446. It addresses the need for attention to veterans who are homeless in the homeless grant funding dollars of Federal agencies. After 1996, the attention to veterans who are homeless as a priority in the HUD funding cycle for McKinney grants was minimized. Today, at the local level, homeless veteran-specific programs are rarely, if ever, given much consideration.

- 22. Request a briefing on the outcome of each of the 11 homeless pilot projects and plans for continuing those projects deemed successful. Further, after project analyses, develop guidelines for program case management for promulgation throughout VA and with community partners for women veterans who are homeless.**

Rationale: *The rising number of women in the military has the potential for an increase in the number of women veterans who are homeless. Women veterans who are homeless must be recognized as having unique needs, such as privacy, childcare, prenatal and pregnancy care, and treatment for physical and sexual trauma. With the special attention and investment made to these gender-specific pilot programs, successful approaches could well be utilized across the system for increased positive outcomes.*

- 23. Request that the VA Advisory Committee on Homeless Veterans address the issue of the definition of homelessness as defined by the McKinney-Vento Act. The Committee is particularly interested in those women veterans who are homeless stating they reside with family or friends, as they are presently excluded. The Committee additionally requests that the Secretary of Veterans Affairs include this as an item of discussion for the President’s Interagency Council on the Homeless.**

Rationale: *Many women veterans, including those with children, resort to living on a temporary short-term basis from house to house in an attempt to avoid the streets and in some cases, the shelter system, which poses its own issues of security. We encourage the Secretary and the VA Homeless Veterans Advisory Committee to address this concern and seek resolution to the situation, which will, in fact, assist all veterans who are homeless.*

- 24. Encourage the VISNs to work with community-based service providers to obtain services for the children of women veterans who are homeless and seeking assistance within VA.**

Rationale: *In light of the increased number of women on active duty eventually becoming veterans, it is anticipated that the number of women veterans who are homeless will also rise. Many women veterans who are homeless have dependents. Many of these women have little, if any, family support. They have great difficulty finding a suitable place for their children while they obtain care in VA residential programs. Sometimes their only option is to relinquish custody of their children. In many cases they simply refuse VA care and treatment*

because of this issue. If each medical center were to partner with a community provider as a resource for assistance with the children, many more women veterans could find their way “home.” And, so too then, would their children.



VA Response to Recommendations

A. Outreach

1. **Foster partnerships with community-based service providers to increase outreach to women veterans, in particular minority women and those isolated from the mainstream. Outreach to women veterans should include information related to VA entry points, health care, benefits, employment services and opportunities.**

VA Response: The Women Veterans Health Program (WVHP) office will develop a Women Veterans Health Internet site linked to the Office of Public Health and Environmental Hazards Web site for the purpose of communicating programs, services and updates to enhance VA's outreach efforts to women veterans and their families with the completion targeted for the fourth quarter of Fiscal Year (FY) 2003. Veterans Benefits Administration (VBA) recently expanded the Veterans Services and Outreach Internet pages to include a separate women veterans' page with links to the Center for Women Veterans, Veterans Health Administration (VHA) and other Federal agencies highlighting the special needs of women veterans. The Web site may be conveniently accessed by going to www.vba.va.gov/bln/21/Topics/Women/index.htm.

In addition, during FY 2003, VA plans to:

- Undertake collaborative action with the Women's Research & Education Institute (WREI) to collect data on active-duty minority women in order to determine minority demographic status of women in the military.
- Compare active duty women with women veterans to project minority women veterans' demographic trends. VA will utilize the findings to conduct comprehensive minority women veterans' market analysis of local communities and facility catchment areas.
- Based on findings, initiate targeted local outreach efforts to increase outreach to appropriate minority veterans, and to increase market penetration.
- Develop WVHP patient video/DVD/internet infomercial and distribute to all VHA and VBA Women Veterans Coordinators (WVC), veterans service organization stakeholders, Center for Women Veterans and Advisory Committee on Women Veterans to be utilized for outreach and staff education purposes.

During FY 2004, VA will:

- Establish VA performance measures to ensure that cultural training is conducted for appropriate VA staff. Evidence of this training shall be documented in employee training records upon completion.
- Establish mechanisms for evaluating the effectiveness of current outreach efforts in various geographical and demographic segments.
- Identify all VA literature and outreach methods targeting women veterans and ensure that information contains both VBA benefits and VHA services that are unique to women veterans. Ensure that all printed literature is published in Spanish as well as English and explore the need for Braille formats.

VA currently fosters outreach in many ways. WVCs continue to seek opportunities for providing information about health care and benefits to women veterans.

The Readjustment Counseling Center (Vet Center) programs provide outreach and community-based service functions as part of its mission. Vet Center employees are knowledgeable about the local veteran population and the community so they can locate, contact and inform women veterans of services related to military-related traumas. Collaboration between VHA, VBA and Vet Centers has allowed a continuum of outreach and in-reach activities to occur. Partnerships have been developed with local, State, and Federal governmental agencies, university affiliates, women's health stakeholders and the Women In Military Service for America Memorial to foster VA's women veterans outreach efforts.

The Department of Defense (DoD) estimates that, on average, 226,000 service members separate from active duty each year. VA provides pre-separation (Transition Assistance Program [TAP], Disabled Transition Assistance Program [DTAP], retirement, etc.) briefings to service members at military installations worldwide. In FY 2001, VA presented TAP/DTAP or other briefings to an estimated 84 percent of all separated or retired service members. In FY 2002, to date, approximately 74 percent of those leaving the service received VA benefits briefings.

VBA has oversight responsibility for the TAP and DTAP programs and has developed a PowerPoint presentation to support Military Service Coordinators in preparing their briefings. The presentation includes information on benefits and health care including a series of four slides on specific issues relating to women veterans, including military sexual trauma (MST) services. Both local and Central Office management personnel make periodic visits to transition sites to evaluate the quality of the TAP presentations. In addition, a Military Services Coordinator's page on the VBA Intranet offers training materials and other information to assist the coordinators.

VA implemented the Benefits Delivery at Discharge (BDD) program in 1998 as an extension of TAP and DTAP. BDD processes claims for service-connected compensation before

discharge. Compensation payment is authorized as soon as VA receives the veteran's military discharge certificate (DD-214). Currently, 133 military installations worldwide participate in this program, and in FY 2001 almost 23,000 BDD claims were finalized.

Through the Veterans Assistance Discharge System (VADS), VA mails benefits and health care information to each service member upon release from active duty. Veterans receive a follow-up packet approximately 6 months later. The general VADS packet contains both telephonic and Internet contact information for each benefit line in addition to a Welcome Home Letter and a Veterans Benefits Timetable. Women veterans' issues are one of the areas highlighted by the VADS program.

2. Develop a VISN-wide strategic plan, with outreach goals, coordinated by the VISN WVC with consideration of cultural and regional issues/influences affecting women veterans. Further, local evaluation of outreach programs should be monitored for effectiveness and incorporated into the VISN strategic plan.

VA Response: One of the areas for improvement of VA's strategic planning process is alignment, which is a systematic way of ensuring that critical organizational goals and objectives are met by aligning people, technology and budget with those goals and objectives. An effective strategic alignment system integrates strategic planning, operational planning, individual and team planning along with performance measurement and accountability. By improving alignment, VA will achieve greater progress in accomplishing critical goals, improved service to veterans, increased productivity, and greater employee satisfaction.

VA's overall approach to achieve improved alignment is for each Administration to develop its own Strategic Plan and for each Staff Office to develop an Integrated Business Plan. These plans will be designed so that the goals and the objectives in the VA Strategic Plan cascade throughout the organization. These documents will be directly aligned with the goals and objectives in the VA Strategic Plan and will provide significantly more information regarding implementing strategies and performance measurement on women veterans' issues. In addition, it is anticipated that the VHA Veterans Integrated Services Networks (VISN), VBA Area Offices, and NCA Memorial Service Networks will develop detailed Implementation Plans/Operating Plans that define how each network will implement strategies and allocate resources to achieve the goals, objectives, and performance targets in the VA and Administrations' strategic plans. These implementation plans should provide more detailed information regarding regional activities associated with women veterans' issues.

VA will publish WVHP 5-year National Strategic Plan and related VACO directives and guidance relative to VISN-level women's health strategic planning activities. VHA will monitor implementation of VHA Handbook 1330.1, dated May 2, 2001, VHA Services for Women Veterans. In addition, the WVHP will conduct site visits to ensure that the Department, VHA and WVHP strategic plans are integrated and translated into local and VISN operating and business plans and report a summary of findings to local, VISN, Chief Network Office (CNO) and Deputy Under Secretary for Health.

The National WVHP Strategic Plan Goal #2 states: “Ensure the provision of the full spectrum of services to women veterans as outlined in VHA Handbook 1330.1.” Objective 2.1 states, “Each facility will develop a written Women Veterans Health Program Plan of Care to submit to CNO by FY 2003.”

In 1999, VISN WVC roles were established to assist VISNs in developing policy and processes that would allow standardization of health care delivery to women veterans. The VISN WVCs assist the WVHP in developing and implementing strategic goals and plans. At the VISN level, the WVCs collaborate to share best practice models, develop standardized approaches, problem-solve and provide guidance and policy to VISN and local VHA administrators.

At the One VA WVC Training Conference held in April 2002, sessions were conducted for WVCs on improving their knowledge of the strategic planning process and developing sensitivity to the needs of women veterans, particularly in the area of sexual trauma.

VBA Compensation and Pension Service personnel conduct at least 12 regional office site visits annually. During these site visits, outreach programs (including the Women Veterans Program) are reviewed and recommendations for improvement are made as necessary. VBA’s annual report on outreach also includes a summary of activities nationwide on each of the targeted populations.

VBA is reviewing the feasibility of having a separate strategic plan for each of its four areas.

3. Request that the VISN directors consider specific funding for outreach to women veterans within their jurisdiction.

VA Response: VHA will revise VHA Handbook 1330.1, dated May 2, 2001, VHA Services for Women Veterans, to incorporate guidance to ensure women veterans’ outreach is included in VISN budget allocation.

VA will develop performance outcome measures to ensure that successful outreach to women veterans is accomplished within local jurisdictions.

VA will monitor facility compliance with established timeliness, access to care, travel and wait time benchmarks for women veterans.

Funding for a variety of outreach comes from the medical center budget. Other activities are funded by the medical center in conjunction with other organizations. Where necessary, WVCs seek funding for events through veteran service organizations, volunteer groups, other agencies or local facility funds. At the One VA Training Conference held in April 2002, workshops were offered to provide training on preparing successful business plans and how to seek funding for programs and services through collaboration and creativity. This type of training, in conjunction with other successful outreach efforts, assists WVCs in the identification of local funding sources, opportunities and creative funding alternatives.

B. Sexual Trauma Counseling and Care

4. **Continue annual briefings from the Director, Women Veterans Health Programs (WVHP) and the WVC from VBA, to include the status of the implementation of sexual trauma/sensitivity training to all employees, with an update on how this activity is verified or tracked in personnel files.**

VA Response: VA has and will continue to provide such briefings. The WVHP will oversee the development of a Veterans Health Initiative (VHI) self-study educational module on sexual trauma. The VHI modules are designed to focus attention on the connection between significant events that occurred during military service and later health conditions experienced by the veteran. The capability will exist to track employees' completion of the sexual trauma module. The targeted completion date of this module is FY 2003. Employee sexual trauma/sensitivity training is provided to VHA employees on an elective basis.

VHA released a software package in 1999 to VHA facilities that automatically tracks MST screening performed. The package now includes a screening question template for computerized entry of a veteran's MST status, tracking of MST services provided by non-VA providers and national reporting mechanisms. This software also allows the veterans to be excluded from billing for any counseling or medical treatment related to MST. Staff training for implementation of screening all enrolled veterans includes:

- VHA directives providing guidance and establishment of MST Coordinators and Implementation Support Teams at every VA Medical Center.
- Web-based training site for implementation of the software and screening of veterans.
- National conference calls with MST Coordinators to discuss issues related to providing counseling and treatment to veterans who experienced MST.
- VISN-level training programs including Web-based training to ensure that VA staff receives MST training and that it is recorded.

VHA Directive 99-039, Military Sexual Trauma Software Mandate, directs facilities to implement the MST software for purposes of tracking, counseling and treatment to victims of MST and the appointment of a multidisciplinary Implementation Support Team (IST).

VHA Directive 2000-009, Sexual Trauma Counseling Section of the Veterans Millennium Health Care Act, Public Law 106-117, directs VHA facilities to implement the requirements of PL 106-117.

Sensitivity and confidentiality are two main focuses of sexual trauma training initiatives for VA staff. In 2001, a National Military Sexual Trauma Work Group was established.

The work group is comprised of representatives from various programs including VHA, VBA, Readjustment Counseling Services and DoD. Since June 2001, the group has implemented

a structure of VISN-level Points-of-Contact to aid in communication, resolution of MST-related screening, treatment issues and development of staff training. The work group has also collaborated with VISN 4 on production of a videotape for each facility to use for training staff on sensitivity issues related to veterans who experienced MST and supported the establishment of a Web-based MST Community of Practice clinical discussion “chat room.”

A sensitivity workshop was included in the third One VA WVC Training Conference, conducted in April 2002, covering sensitivity in both verbal and written communications with victims of military sexual trauma.

5. Seek to permanently remove the eligibility requirement for access to sexual trauma counseling.

VA Response: This would be accomplished by legislation currently pending before Congress. The legislation would make permanent VA’s authority to provide special counseling and treatment for victims of sexual trauma.

The Veterans Millennium Health Care and Benefits Act, PL 106-117, Section 115(e) (November 30, 1999), mandated a research investigation entitled, Military Sexual Trauma Among the Reserve Components of the Armed Forces (Principal Investigator: Amy Street, Ph.D.). VA and DoD have collaborated in the design of a study that will determine:

- The extent to which former members of the reserve components of the Armed Forces experienced physical assault of a sexual nature or battery of a sexual nature while serving on active duty for training.
- The extent to which such former members have sought counseling from VA relating to those incidents.
- The additional resources that, in the judgment of the Secretary, would be required to meet the projected need of those former members for such counseling.

In a letter dated April 18, 2001, VA advised the House and Senate Committees on Veterans’ Affairs of the challenges faced in obtaining a representative sample of participants for the study. Due to the complexity of the data collection, the anticipated completion date for the study is projected to be March 2003.

C. Women Veterans Coordinators (WVC)

- 6. Seek to establish a designated full-time VISN WVC, without collateral duties.**
- 7. Establish and maintain a minimum of twenty hours per week (.5 FTEE) for WVCs.**
- 8. Request that VHA/VBA directors provide the WVC with appropriate space to perform their duties, necessary office equipment, and administrative support as indicated by workload.**

VA Response: (Recommendations 6-8) As VHA refines and redefines the role, there will be increasing emphasis on the expected outcomes in terms of quality medical care for women veterans. As specific goals are established, those who are held accountable at the facility and VISN level will need to take the appropriate steps to accomplish the goals. Prior to the establishment of specific outcomes, measures and accountability, it would be premature to designate specific positions in the VISN.

The National WVHP Strategic Plan Goal #6 states: “Establish a performance standard to support the Women Veterans Program Manager (WVPM) position.” Objective 1.1 says to “Revise HRML (Human Resource Management Letter) 05-94-16 regarding the WVPM.”

The WVHP contracted with Partners In Change, a private consulting firm specializing in human resource management, to develop a Performance Model for the Women Veterans Coordinator position. As a first important step, for the purposes of the pilot, the WVC position was renamed Women Veterans Program Manager (WVPM), emphasizing their program management responsibilities.

VHA is committed to high quality health care for women veterans seeking care in VA facilities. WVCs have played an important role in fulfilling that commitment in the past. They were particularly well utilized in what was basically an inpatient health care delivery system with very few female patients. There the personal attention of a single individual, working with individual patients and with the system to improve services, could have a tremendous impact. However, as health care has changed to a largely outpatient system with many more women veterans receiving care, the role of the WVC has changed from a general purpose administrative role to a primarily clinical role within a culture of improvement of clinical outcomes. The proper balance between clinical and administrative responsibilities will need to be determined as quality outcome goals are established. Designating specific numbers of hours for one individual may not accomplish the specific goals established. This may require the skills of a number of individuals under the direction of the leader who is held accountable for the outcomes. As VHA works toward establishing outcome measures, officials would be happy to provide briefings to the Committee and receive their input on important outcomes.

VA needs to clearly establish performance standards, resource support and technical needs, and monitor for compliance. The appropriate allocation of protected time is critical for the WVC to successfully and effectively carry out their programmatic responsibilities. Most VHA WVCs are clinicians (nurses, physicians, social workers, or psychologists) who are expected to perform clinical duties in addition to their women veterans’ programmatic responsibilities. Experience has proven that the experience, skills, knowledge and abilities of clinical professionals are critical attributes to their success as WVCs. It is important to ensure that health services and administrative aspects of the local women veterans’ health programs are balanced with the coordinators’ clinical duties.

In March 2000, VBA issued an all-station directive reinforcing its commitment to outreach to women veterans. It emphasized the importance of the WVC position and provided basic language to be used as an addendum to the assigned coordinator’s position description.

The directive provided Core-Operating Standards for the WVC program including a sample Memorandum of Understanding (MOU) that requires regional office management to quantify the amount of time and resources that can and will be devoted to WVC functions. Geographic and population differences between regional offices make mandating a minimum .5 FTEE impractical. Regional office management is encouraged to use the provided Core-Operating Standards and MOU to determine the appropriate staffing level for their situation. VBA plans to conduct a regional office WVC survey in FY 2003 to judge the effectiveness of these MOUs.

Appropriate space, equipment and clerical support are important elements in supporting the role of the WVC. The National Strategic Work Group Preliminary Report supports the availability of these elements.

- 9. Recommend that all VA medical centers establish women veterans advisory committees with a minimum of one non-VA woman veteran consumer employee, and meet on a regular basis. Further, recommend that the committee meeting minutes be submitted to the VISN WVC. It would be beneficial to conduct an annual town meeting for local women veterans, which includes the WVC from VBA, if possible.**

VA Response: VA concurs with this recommendation and, in fact, this guideline is stated in VHA Handbook 1330.1, which provides guidance for delivery of health care to women veterans. Guidance regarding establishment, membership, and functions of a Women Veterans Advisory Committee are included. The handbook will be revised to include guidance for local facilities to conduct annual town hall meetings. WVCs are encouraged to disseminate minutes to local, VISN and WVHP leaders. This level of communication is essential for obtaining support for the delivery of services that are responsive to the needs and preferences of their women veteran customers. In addition, VISN-level women veterans' health committees are being utilized to ensure women veterans' health needs and outcomes are achieved, tracked and expanded.

VHA will establish VA women veterans' performance measures to ensure that the findings, recommendations and actions taken are regularly communicated to internal and external stakeholders, and to local, VISN, and VACO leaders.

VBA WVCs participate in VHA and VISN Advisory Committees where feasible. In some areas, the VBA coordinators have multiple VAMCs and VISNs in their catchment area making it impractical for them to attend all advisory meetings.

D. Health Care

10. Recommend increased communication between VA health care providers and community contract care providers for an enhanced case management approach ensuring a coordinated continuity of care.

VA Response: The National WVHP Strategic Plan Goal #3 states as follows: “Ensure VA data systems include specific, easily retrievable information on women veterans and the services they receive.” Objective 3.2 states that, “All fee-basis and contract care provided will be included in VA data base and ensure that data are retrievable by gender, types of services and cost.” The target completion date is FY 2005.

Coordinated case management and increased communication between VA health care providers and contract providers improve care for all veterans. This issue is a systems problem and is not specific to women veterans’ health care. It will require a systems approach and VHA is working on this. As technological advances are made in computerized record management and sharing capabilities between VA and contract systems, communication will be enhanced. WVCs are often clinical health care providers and provide case management for complex and high-risk women veterans seen in their program. WVCs are also involved in the development of processes that enhance sharing of information such as radiology and laboratory reporting systems for providers.

11. Request updates on the VHA plan to provide diagnostic, therapeutic and support services for the increased obstetrical and gynecological needs of women veterans.

VA Response: VHA will be happy to provide the requested updates and welcomes the opportunity to collaborate with the Advisory Committee to define measurable performance outcome measures to evaluate the provision of diagnostic, therapeutic and support services for the increasing gender-specific needs of women veterans.

VHA will assume responsibility to monitor local compliance with established performance measures and regularly report findings to the Under Secretary, through appropriate channels, and provide annual briefings to the Advisory Committee on Women Veterans on the progress.

The Center for Women Veterans is working with officials from the HHS Office of Women’s Health to develop a MOU, which will address this issue as well.

12. Recommend that each VISN develop an inpatient psychiatric unit dedicated exclusively to the treatment of women veterans.

VA Response: VA will conduct an analysis of women inpatient psychiatric admissions to determine utilization trends and to administer customer satisfaction surveys to determine women veterans’ satisfaction relative to safety, privacy and confidentiality during their inpatient stay.

Inpatient psychiatric care of women veterans is a major concern. The impact of the environment is a critical factor in providing inpatient mental health services and treatment of women veterans. Physical buildings that are often in need of updating and modernization further complicate security, safety and privacy. As more women veterans utilize VA programs, and more women are screened for mental health needs such as MST, the demand for women's inpatient treatment will most likely increase.

The overall number of medical and psychiatric hospital admissions as well as the average lengths of stay have decreased considerably, given the shift in focus from acute tertiary care to preventive health and outpatient health care delivery model over the past 10 years. Alternative inpatient settings are considered when small numbers of patients do not support sustaining a local unit exclusively for women veterans.

This issue has been raised a number of times over the years because of the relatively low percentage of women seeking care from VHA. In FY 2002, of 43,717 women veterans who used VA mental health services, 19.4 percent were service-connected. The numbers of women veterans by VISN ranged from 1,125 in the smallest VISN to 4,017 in the largest VISN. Approximately 6.8 percent of veterans discharged from mental health bed sections in FY 2001 were women and the proportion of women appears to be increasing.

However, this issue is a complicated one. Decades ago, when hospital treatment was synonymous with any treatment, women's units existed in a number of settings, but most of these units have been closed even in the private sector. While all VA psychiatric units currently are required to have women's beds and provide adequate privacy for women, the shrinking size of inpatient populations often result in only one or two women on a unit with 20 or more men. VA recognizes that it is often difficult to provide groups to those women who need to deal with special issues related to sexual trauma.

Transferring women veterans to a geographically remote inpatient setting, away from their children and family support systems, can contribute to a non-therapeutic milieu and create secondary challenges integrating them back into their communities.

One major drawback in providing VISN-wide inpatient psychiatric units dedicated exclusively to the treatment of women veterans is the decreased inpatient length of stay, currently averaging 6-8 days. These admissions usually deal with stabilizing patients so that they can return to outpatient treatment. Thus, traveling long distances from home to a women's psychiatric facility is markedly inconvenient and tends to break any attempt at continuity of care. The WVHP officials would like to work with the Women Veterans Advisory Committee to explore opportunities to better address the mental health treatment needs of women veterans.

- 13. Recommend continued women veterans' health research with sufficient funding. Further, attention should be given to study design and data gathering which includes all women veterans' subgroups within the women veteran population (Black, Hispanic, Asian, and American Indian).**

VA Response: VHA has established policy requiring VA-sponsored research to specifically address women and minority women veterans' health issues. It is included in the following publications:

- VHA Handbook 1200.9, Women and Minorities in Research
- VHA Handbook 1204.01, Office of Research and Development Policy Documents for Health Services Research and Development

In FY 2000, funding for women's health research at VA totaled \$24.2 million for 305 studies. VA was a major source of support for women's health research, providing about \$5.8 million in funding for 61 studies. VA investigators active in research affecting women's health research received approximately 24 percent of their study funding from VA. The remainder was from a multitude of agencies and organizations (predominantly NIH, as well as pharmaceutical and private entities, foundations and voluntary agencies, other Federal agencies such as the Department of Defense, universities affiliated with VA, and other government and academic entities). In FY 2000, a total of 109 new studies were funded, with VA providing about one-fourth of the funding for new projects (\$1.4 million). There were 12 new VA-funded studies.

The FY 2001 Women's Health Research Summary Report is in the process of being prepared. Preliminary analysis (the final numbers have not been fully verified) indicates that total funding was about \$28.7 million; with VA support totaling \$6 million (for 57 projects) or about 21 percent of overall funding to VA investigators for women's health research. New VA funding totaled \$1.6 million for 13 projects. This includes studies by Dr. Katherine Skinner and Dr. Elizabeth Yano evaluating VA's women's health programs.

In FY 2002, The Office of Health Services Research and Development (HSR&D) funded a Career Development Award to Dr. Donna Washington, whose area of research is in women's health. It is noteworthy that she was recently appointed to HHS' Office on Women's Health Minority Women's Health Panel of Experts. In addition, Dr. Washington is Principal Investigator on another HSR&D project funded in FY 2002, "Women Veterans' Ambulatory Care Use: Patterns, Barriers and Influences." This study will examine race and ethnicity among a number of other gender and military-related factors that may impact ambulatory care use. In previous research on male veterans, military and race-related experiences were shown to affect perceptions about, and use of, the VA health care system.

The FY 2002 HSR&D revised solicitation for research on women's health care and identifies numerous possible areas for future research, including: "analysis of the needs of special populations of women veterans (e.g., minority and homeless women)."

Other studies that examine subgroups of women veterans -- A VA Cooperative Study by Marian Butterfield (Durham, NC, Project No. 0706D) on HIV Seroprevalence and Risks in Veterans with Severe Mental Illness is examining the effects of race, gender and veteran status on HIV risk behaviors.

E. Staff Education

- 14. Ensure that a system-wide standardized training module be utilized for all new employee orientation, which includes the specific needs of women veterans as contributed by the WVC.**

VA Response: The WVHP, in collaboration with the Employee Education System (EES) and VBA, is currently producing a professional video infomercial with a targeted completion in FY 2003 or early 2004. This infomercial will be utilized for outreach purposes and as a standardized orientation tool for VHA facility staff and will highlight the VA women veterans' benefits and services. VBA collaborated with VHA to produce a series of satellite video training conferences concerning MST, sensitivity, and gynecological rating issues. VBA has provided copies of the videotapes to the VBA regional offices, VHA management, and the Center for Women Veterans. Regional offices use the tapes for both initial and refresher training for new Veterans Services Representatives (VSR), Rating-VSR (RVSR), and public contact personnel.

A sensitivity workshop was included in the third One VA WVC training conference, conducted in April 2002, covering sensitivity in both verbal and written communications with victims of MST.

F. Employment of Women Veterans in the Federal Government

- 15. Recommend increased recruitment and hiring of qualified women veterans, with attention to minority women veterans in Federal service positions within VA, also addressing senior executive service positions and appointed political positions within the Department. Further, request the Office of Personnel Management (OPM) to encourage other Federal agencies to recruit and hire qualified women veterans. This includes the Department of Labor (DOL), Veterans Employment and Training Service (VETS) in positions of the Disabled Veterans Outreach Program (DVOP) and as Local Veterans Employment Representatives (LVERs).**

VA Response: The Secretary of Veterans Affairs sent a letter dated June 24, 2002, to the Secretary of Labor requesting the Secretary of Labor's cooperation in encouraging the recruitment and hiring of women veterans for DVOP and LVERS positions. The Honorable Elaine Chao, Secretary of Labor, replied in a letter dated August 16, 2002, that she shared the Advisory Committee's interest in providing women veterans full and equal opportunities to be employed as LVERS and DVOP specialists. She advised that she had asked the Assistant Secretary for Veterans' Employment and Training, Mr. Fred Juarbe, Jr., to review the matter and determine what may be done to better address this issue.

In a letter to the Secretary of Veterans Affairs dated August 23, 2002, Mr. Juarbe noted that LVER and DVOP personnel are State employees and are not hired by DOL. The positions, however, are funded under Federal law. Each State has its own personnel system, including

recruitment and hiring policies and procedures. He pledged to encourage the States, through the DOL network of Directors and Assistant Directors assigned to each State, to increase their efforts to identify, recruit and hire more women veterans into the LVERS and DVOP positions. He also offered to work with VA's Vocational Rehabilitation and Employment Service to establish contacts with the State Administrators of the Labor Exchange system in each State to help identify potential candidates for these jobs.

VA will contact the Office of Personnel Management about encouraging Federal agencies to recruit and hire qualified women veterans.

16. Recommend that women veterans be appointed to all VA advisory committees to address those concerns and issues specific to women veterans.

VA Response: VA is committed to appointing women veterans to all of its advisory committees. Candidate referral sources – from veterans service organizations to professional associations to the White House – are regularly contacted by VA committee managers to produce the names of women veterans who would be qualified for committee membership. For each committee vacancy, the pool of candidates is screened carefully to determine whether a woman veteran is available.

Of the 15 VA advisory committees created by Congress, which are currently operational (excluding the Advisory Committee on Women Veterans), 9 have members who are women veterans. All 15 have female members, and VA expects that some of those women have simply not identified themselves as veterans. At this point, 61 women serve on the 15 committees described above, and 14 of those women are veterans. When including the Advisory Committee on Women Veterans, the totals are 74 women and 27 women veterans.

It must also be understood that at least half of the VA advisory committees created by Congress are highly specialized panels requiring expertise in such professions as environmental medicine, structural engineering, educational certification and prosthetics development. Others focus on health care specialties ranging from geriatrics to traumatic brain injury rehabilitation. VA has been successful in finding women who possess qualifications in most of those areas, but VA has not been as successful identifying women veterans who have similar qualifications.

In reaffirming VA's commitment to build upon its record of appointing advisory committee members who are women veterans, VA invites the active participation of the Advisory Committee on Women Veterans. Recommended candidates should be forwarded to Dr. Irene Trowell-Harris, Director, Center for Women Veterans, who will then forward them to VA's Advisory Committee Management Officer. VA deeply appreciates the Committee's willingness to assist in this endeavor.

G. Strategic Planning

- 17. Recommend an examination of the data gathered in support of recent studies conducted by VA, such as the *5th National Survey of Veterans* and the *1999 Large Survey of Veterans*. This would determine if either study provides sufficient samples of women veterans by age, race/ethnicity, era of service, and non-users of VA health services to conduct regression analyses on the success of VA health and benefits programs in meeting the needs of women veterans. If an existing data set can be found, make it available to appropriate researchers who wish to study women veterans. If it does not exist, the Committee recommends that the Secretary of Veterans Affairs work with Congress to identify funding to collect such data.**

VA Response: The Office of Policy and Planning in collaboration with the Office of HSR&D will conduct a review of the findings from the 5th National Survey of Veterans and the 1999 Large Survey of Veterans to determine the adequacy of subject samples to support additional research inquiry. Based on the findings of this analysis, requests for proposals (RFP) will be solicited. If there is insufficient data available, alternate funding sources will be explored.

- 18. Request that the strategic planning process at national, regional/VISN, and local VA levels recognize and address issues arising from the growing numbers of active duty women and their changing military roles. These findings could impact future women veterans' benefits and care.**

VA Response: Strategic planning occurs at all levels of VHA. WVCs have been involved in local and VISN strategic planning processes either as part of the planning committee or as a reviewer to ensure goals pertaining to women veterans are included. With the development of a National WVHP Strategic Plan 2003-2007, staff at all levels of the organization will have guidance on the strategic direction and goals for meeting the needs of women veterans.

The National WVHP Strategic Plan addresses the recommendation. Goal #6 states: "Ensure VA is positioned to respond to the increasing population of women veterans." Objective 6.3 states that, "A comprehensive needs assessment (market research methodology to identify the changing needs of Women Veterans) will be developed." The targeted date of completion is FY 2003.

Strategic planning efforts at the national level define the organization's goals, objectives, strategies, and performance measures. Guidance is provided to field facilities on specific outcomes measures, performance target measures, and service delivery measures. Strategic planning efforts at the field level should focus on how to deliver the benefits and services to women veterans. The Department is implementing an integrated strategic planning process that is intended to ensure better alignment between the Secretary's priorities and the delivery of services.

19. Provide printed materials on women’s health issues and benefits in Spanish as well as in English. This material should be made available at all VA facilities and included in all outreach programs.

VA Response: Written materials using the Spanish language have been developed at VA facilities and utilized when appropriate. Local and VISN WVCs actively monitor needs of women veterans using their facilities and collaborate with other facility committees to ensure patient education materials, distributed to veterans, meet the needs of the veterans.

VA provides the following publications in Spanish:

- Federal Benefits for Veterans and Dependents -- VA Pamphlet 80-02-1 (Spanish edition available on the Internet only.)
- A Summary of VA Benefits -- VA Pamphlet 21-00-1
- Series of Benefits Fact Sheets

H. Women Veterans Who Are Homeless

20. Recommend each VISN establish a domiciliary unit exclusively for women veterans who are homeless.

VA Response: VA is learning that it is not always clinically sound to have women separated. In designing programs, it is important to have mechanisms available that respect the fact that women are different in their needs and approaches to situations. VA’s efforts will strive to focus on quality care to women veterans rather than the process of how that care is delivered.

VHA has found that even when there is a “women’s unit” (or particular beds/areas are set aside for women) and their gynecological and very personal needs are being met, the women say the rehabilitation programming is not designed for them. For instance, they say that the method of discussion or the facilitation of the groups and classes is not user friendly to women.

Domiciliary programs will be expected to define and articulate how they are going to make sure that women’s (as well as the men’s) needs are met in their existing programming, e.g., staff education and development of innovative processes and systems.

Domiciliary programs must have outreach and aftercare as part of their program planning and development. They are also expected to state how they are going to target women and provide outreach to them, get them into rehabilitation and then provide appropriate rehabilitation methods/programming and aftercare to maximize their rehabilitation success.

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- 21. The Committee recommends that the Secretary of Veterans Affairs work with the Secretary of Housing and Urban Development (HUD) to review the “Sense of Congress” found in Public Law 103-446 and to encourage grant proposals giving priority to veterans who are homeless under the McKinney Notice of Funding Availability (NOFA).**

VA Response: HUD is working with VA to include VA staff in the review of selected grant applications under their Continuum of Care Programs. As a result of the Interagency Council on the Homeless (ICH) meeting on July 18, 2002, VA is attempting to offer a coordinated grant application with HUD and HHS. This coordination, VA believes, will enhance opportunities for veterans, including women veterans, in veteran specific programs.

- 22. Request a briefing on the outcome of each of the 11 homeless pilot projects and plans for continuing those projects deemed successful. Further, after project analyses, develop guidelines for program case management for promulgation throughout VA and with community partners for women veterans who are homeless.**

VA Response: A briefing will be provided. Pilot programs in service to homeless women veterans are underway. VA staff has provided briefings detailing the processes of establishing these programs, locating veterans and evaluating outcomes.

In addition, under the Homeless Providers Grant and Per Diem Program, VA has collaborated with community partners throughout the country to develop additional programs to assist homeless women veterans and homeless women veterans with children. Expansion of these partnerships and programs is encouraged and supported. Public Law 107-95, Homeless Veterans Comprehensive Assistance Act of 2001 (December 21, 2001), identifies homeless women veterans, including those with children, as a special segment of the homeless veterans population and authorizes VA to develop a grant program to provide additional services to these homeless veterans with special needs. VA is writing regulations to implement this new grant program.

In response to requests from Congress for VA to provide more outcome evaluations of homeless programs, in FY 2000 VA set aside \$3 million dollars to address the needs of homeless women veterans and homeless women veterans with children. The programs, located in Atlanta, GA; Boston, MA; Brooklyn, NY; Cincinnati, OH; Cleveland, OH; Dallas, TX; Houston, TX; Los Angeles, CA; San Francisco, CA; Seattle, WA; and Tampa, FL, are designed to provide outreach to the community to identify homeless women veterans in need, provide case management for their medical and psychiatric needs, and provide assistance with navigating VA and the social welfare system. The programs are also designed to provide contract community-based residential treatment for women who need it.

Outreach workers have contacted more than 1,038 women and those eligible for VA services have been referred to the program, an average of 94 women at each site. Programs average a caseload of 30 active patients. To date, 396 women have been enrolled in the evaluation portion of the program, which involves lengthy interviews every 3 months for 3 years.

This program has positively impacted homeless women veterans:

- 26 percent received supportive contact (veterans did not desire any treatment from VA, but clinicians maintained contact in case of further need).
- 81 percent received referrals to other VA and non-VA services.
- 63.1 percent received assistance with obtaining or maintaining housing.
- 24.4 percent received rehabilitation counseling from program staff.
- 25.3 percent were engaged in psychotherapy treatment with the treatment staff.
- 27.4 percent had minor children for whom they were responsible.
- 23.5 percent of them (6.4 percent of total sample) received services from the program staff, specifically related to children.
- 9.4 percent received help with domestic violence issues.
- 7.3 percent have been enrolled in residential treatment programs.

23. Request that the VA Advisory Committee on Homeless Veterans address the issue of the definition of homelessness as defined by the McKinney-Vento Act. The Committee is particularly interested in those women veterans who are homeless stating they reside with family or friends, as they are presently excluded. The Committee additionally requests that the Secretary of Veterans Affairs include this as an item of discussion for the President’s Interagency Council on the Homeless.

VA Response: This recommendation will be referred to the VA Advisory Committee on Homeless Veterans to address the issue of the definition of homelessness. A member of the Advisory Committee on Women Veterans is an ex-officio member of the Advisory Committee on Homeless Veterans. She is in a strategic position to explore this issue with the Committee.

Increasingly there is emphasis on addressing the needs of the “chronically” homeless, which have the greatest need through collaboration with other agencies.

VA offers the full range of services to those women veterans who are “at risk” for homelessness.

24. Encourage the VISNs to work with community-based service providers to obtain services for the children of women veterans who are homeless and seeking assistance within VA.

VA Response: VA Social Work Service, Homeless Program Coordinators, Minority Veteran Coordinators and WVCs have resource information available to assist women veterans and their children in obtaining needed services. VA’s partnerships with community agencies

strengthen the ability of VA in addressing the needs of homeless children and provide a continuum of programs and services that would best meet their needs.

Male and female veterans with spouses and children are often faced with a difficult situation when seeking services from VA directly and with many of VA's specific service providers since VA cannot pay for services to the non-veteran family members. VA encourages its medical centers to work with service providers who can and will provide services to veteran dependents.

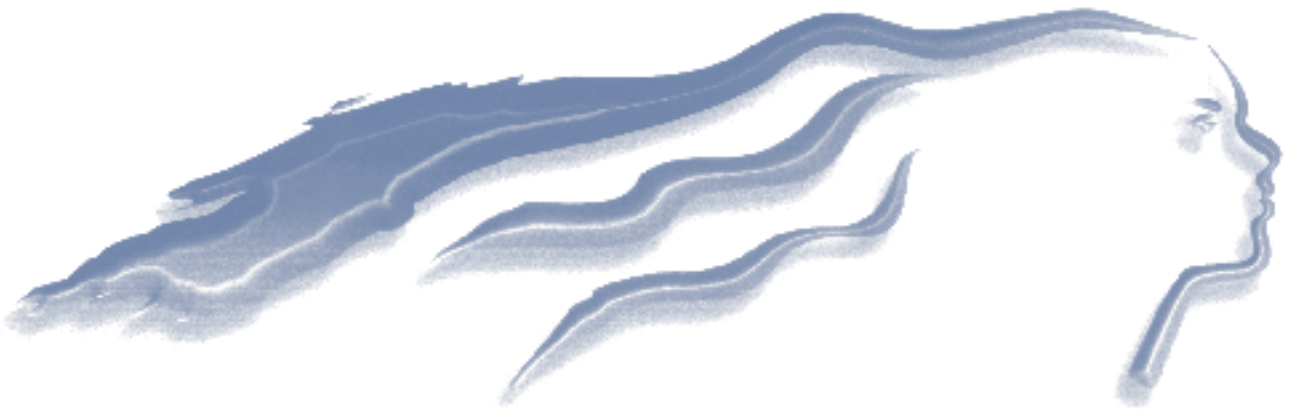
Recent efforts with HUD and HHS to hold State-level policy academies is an example of VA's national effort that can be resolved with local collaboration. In addition, VA through the ICH will make efforts to coordinate and partner funding efforts with HUD and HHS. Both of these efforts, VA believes, will have beneficial results.



Future Considerations

1. Foster collaboration with the Bureau of Census to ensure the national Census forms (long and short) include a direct approach to securing military service information. Return the “length of service” question to the long form. (Note: Reconsider in 2004 committee report.)
2. The Advisory Committee requests a briefing on the VA-DOD task force studying the need for sexual trauma services by members of the Selective Reserve and National Guard to coincide upon completion and publication of the ongoing study.
3. Request information on policies related to all military personnel, including Selective Reserve forces and members of the National Guard, receiving basic VA benefit information, including appropriate points-of-contact unique to their situation at the time of separation.
4. In light of the increased number of CBOCs, the shift to outpatient service, and the VA CARES initiative, the Committee requests several future briefings to include:
 - The level of mental health staffing in CBOC’s and primary care.
 - Veterans Equitable Resource Allocation (VERA).
 - Capital Asset Realignment for Enhanced Services (CARES).

APPENDICES





Historical Perspective

Women veterans were the best-kept secret for many years. The 1980 Census was the first time that American women were asked if they had ever served in the Armed Forces, and an astonishing 1.2 million said “yes.” Because very few of these newly identified veterans used VA services, Congress and VA began a concerted effort to recognize and inform them of their benefits and entitlements. Activities were initiated to increase public awareness about services for women in the military and women veterans.

Soon after the 1980 census, Congress granted veteran status to women who had served in the Women’s Army Auxiliary Corps (WAAC) during World War II.

In 1982, at the request of Senator Daniel Inouye, the General Accounting Office (GAO), conducted a study and issued a report entitled: “Actions Needed to Insure that Female Veterans Have Equal Access to VA Benefits.” This study found that:

- Women did not have equal access to VA benefits.
- Women treated in VA facilities did not receive complete physical examinations.
- VA was not providing gynecological care.
- Women veterans were not adequately informed of their benefits under the law.

At the same time, VA commissioned Louis Harris and Associates to conduct a “Survey of Women Veterans” to determine the needs and experiences of this population. This survey found that 57 percent of the women did not know they were eligible for VA services and programs. Another particularly troublesome finding was that women veterans reported twice the rates of cancer as compared to the women in the general adult population, with gynecological cancers being the most common.

The results of the Census and the Harris survey raised many questions concerning women veterans, but one conclusion was inescapable: the system was failing them. In April 1983, Harry Walters, Administrator of the Veterans Administration, began to remedy this situation by establishing a National Advisory Committee on Women Veterans.

In November 1983, following the first meeting of the VA Advisory Committee, Congress passed PL 98-160 mandating VA to establish an Advisory Committee on Women Veterans. The charge to the Committee was broad. Not only were they tasked with assessing the needs of women veterans with respect to adequate access to VA programs and services, but they were also empowered to make recommendations for change.

Under the leadership of Dr. Susan H. Mather, the Committee was entrusted with the responsibility to follow-up on these activities and report their progress to Congress in a biennial report.

The following events are historical markers since the establishment of the Advisory Committee on Women Veterans.

1984 First report of the Advisory Committee identified the need for strong outreach, and the lack of adequate privacy and gender-specific treatment for women at VA facilities as the most pressing areas of concern.

Pamphlets, posters and publications about the service of women veterans and their eligibility for VA services were developed.

President Reagan proclaimed the first “Women Veterans Recognition Week.” The states of New Jersey, California and Washington declared 1984 as “Women Veterans Year.”

1985 As a result of the Advisory Committee’s recommendations, VA appointed the first Women Veterans Coordinators.

The National Vietnam Veterans Readjustment Study, commissioned by Congress, was the first national study on veterans that included women.

1986 The Advisory Committee report focused on health care needs. Recommendations were made to expand VA health care to include osteoporosis, gynecological and hormonal care, research, mammography, Agent Orange exposure diseases and smoking cessation.

Women Veterans Coordinators were appointed in VA regional offices.

1987 Congress revisited the issue of women veterans in an oversight hearing. Women veterans testified to noted progress but expressed concern about the consistency of the quality of health care provided to women veterans at VA facilities.

1989 The Advisory Committee on Women Veterans began site visits.

1991 GAO was tasked by Congress to do a follow-up study on VA health care for women. Their 1992 report was entitled, “VA Health Care for Women – Despite Progress, Improvement Needed.”

1992 The 1991 GAO report, along with Congressional hearings related to sexual harassment and assault, led to the enactment of PL 102-585. It provided specific provisions for women’s health and broadened the context of Post-Traumatic Stress Disorder (PTSD) to include care for the aftermath of sexual trauma associated with military duty.

1993 Dedication of the Vietnam Women’s Memorial.

1994 Secretary Jesse Brown established the Women Veterans Program Office within the Office of the Assistant Secretary for Policy and Planning. Joan Furey was appointed Executive Director of the Women Veterans Program Office.

The Center for Women Veterans was created by Congress under PL 103-446. (See Appendix C for the mission and goals of the Center for Women Veterans.)

The National Center for Post-Traumatic Stress Disorder created a Women's Health Sciences Division at the Boston VA Medical Center.

Three research projects were proposed by VA as an alternative to a comprehensive epidemiologic study of the long-term health effects experienced by women who served in the Armed Forces in Vietnam, as mandated by PL 99-272. The original study was determined not scientifically feasible. The three research projects included:

- a study of post-service mortality (results were published in 1995);
- the re-analysis of psychological health outcome data collected for women in the National Vietnam Veterans Readjustment Study (completed in 1996); and,
- a study of reproductive outcomes among women Vietnam veterans.

VA funds the first national study on the quality of life of women veterans who use VA health care services.

1995 Joan Furey was confirmed as the first Director of the Center for Women Veterans.

Committee members increased communication with women veterans, increased individual site visits to VA facilities, and provided briefings to Congressional members and staff.

1996 The first "National Summit on Women Veterans Issues" was held in Washington, D.C., marking the first time women veterans from across the nation had the opportunity to come together with policy makers and VA officials.

1997 Kathleen Zeiler was appointed as the first full-time Director for the Women Veterans Health Program.

The Women in Military Service for America Memorial was dedicated.

The First National Conference of VA Women Veterans Coordinators was held in San Antonio, Texas.

1998 VA completed the "Women Vietnam Veterans Reproductive Outcome Study" and published its findings.

The 50th Anniversary of the Women's Armed Forces Integration Act.

1999 Carole Turner was appointed as the second Director for the Women Veterans Health Program.

Results of the 1998 VA study indicated that children of women who served in Vietnam had a higher rate of birth defects. This prompted a Congressional hearing.

For the first time, the Subcommittee on Minority Women Veterans was established within the Advisory Committee.

VA's decision to provide prenatal and obstetrical care to eligible women veterans signaled a new era in VA gender-specific services.

The Second National Conference of VA Women Veterans Coordinators was held in Chicago, Illinois.

2000 VA allocated funds for the first time (\$3 million) to support programs specifically for women veterans who are homeless. Three-year demonstration programs were designed at 11 locations across the country.

The Veterans Benefits and Health Care Improvement Act of 2000, PL 106-419, authorized special monthly compensation for women veterans with a service-connected mastectomy. Additionally, it provided benefits for children with birth defects born to women Vietnam veterans.

The Sunset Provision for sexual trauma counseling in VA was extended to December 31, 2004.

VA convened two task forces to study:

- the necessity for inpatient psychiatric units for women in each VISN, and
- the need to extend sexual trauma counseling to Reservists and National Guard who have been victimized while on inactive duty training days.

The second "National Women Veterans - Summit 2000" was held in Washington, D.C.

VHA Women Veterans Health Program was selected as the Bronze Winner of the 2000 Wyth-Ayerst HERA Award. Awards are presented to those demonstrating leadership in women and children's health.

2001 Women's Health National Strategic Work Group convened to develop progressive, state-of-the-art programs to provide high-quality comprehensive health care for FY 2002 through FY 2007. The Group commissioned Dr. Katherine M. Skinner to study the role of Women Veterans Coordinators.

September 11, 2001, changed the battlefield. Women in the Pentagon are now as vulnerable as those directly on the front lines. The likelihood of women casualties increases commensurately.

Dr. Irene Trowell-Harris was appointed and confirmed as the second Director of the Center for Women Veterans.

The Charter for VA Advisory Committee on Women Veterans was renewed.

Appointments of the first minority women veterans in leadership were made on the VA Advisory Committee on Women Veterans, in the positions of an African-American as Chair, and an American Indian as Co-Chair.

2002 The Third National meeting of the VA Women Veterans Coordinators was held in Las Vegas, Nevada.



Advisory Committee Site Visits A Cumulative Record

October 1987	St. Petersburg Beach, FL
May 1989	Minneapolis, MN
June 1993	San Antonio, TX
October 1994	Albuquerque, NM
May 1997	Los Angeles, CA
September 1998	Chicago, IL
June 1999	Seattle, WA
June 2001	Boston, MA
September 2002	Tampa, FL



Past Chairs of the Advisory Committee on Women Veterans

Dr. Susan Mather – Interim Designated Federal Official

COL Lorraine Rossi, USA, Retired (1983-86)

MG Jeanne Holm, USAF, Retired (1986-88)

RADM Frances T. Shea-Buckley, USN, Retired (1988-89)

MG Mary Clarke, USA, Retired (1989-92)

Shirley Ann Waltz Menard, Ph.D., R.N. (1992-94)

Dr. Susan Mather - Interim Chair (1994-96)

RADM Mary Nielubowicz, USN, Retired (1996-97)

MAJ Linda Schwartz, USAF, NC, Retired (1997-2000)

COL Karen L. Ray, USA, Retired (2000-02)



VA Advisory Committee On Women Veterans Membership Profile

KAREN L. RAY, RN, MPH, MA

COLONEL, USA, RETIRED

CHAIR 2000-2002

Colonel Ray is retired from the Army Nurse Corps where she held a variety of clinical and administrative positions in the area of community health nursing. Since her retirement she has been active in the health care arena and especially in projects directed at health promotion in the African-American community. She has served as the Project Director for the National Health Program of the Congress of National Black Churches, Inc. and as founder and editor of *The African-American HealthLink*, a nationally recognized health newsletter. She is currently co-owner of *Edge City Innovations, Inc.* a health care firm based in Northern Virginia. Her appointment in 2000 as the Chair of the Advisory Committee represents the first time an African-American woman veteran was selected to serve in this position. Colonel Ray was appointed to the Advisory Committee on Women Veterans in July of 1995.

CONSTANCE G. EVANS, RN, ARNP

COMMANDER, USPHS, RETIRED

Co-CHAIR 2000-2002

Commander Evans is an American Indian, Nez Perce Tribe. She served for four years with the Army Nurse Corps, including service in Vietnam. After her discharge from the Army, she transferred her Commission to the United States Public Health Services Corps, where she served as a family nurse practitioner. Commander Evans is well versed in the issues facing American Indians, including homelessness, children and families, employment and economic development. She is employed as adjunct faculty to the Lewis-Clark Star College Social Sciences Division to assist the American Indian instructor in teaching the Nez Perce language. She is also a private consultant on health care issues among reservation-based American Indians. She was nominated by the Veterans Committee of the National Council of American Indians. Her appointment in 2000 as the Co-Chair of the Advisory Committee represents the first time an American Indian woman veteran was selected to serve in this position. Commander Evans was appointed to the Advisory Committee on Women Veterans in July of 1995.

MARSHA TANSEY FOUR, USA

Ms. Four is a Vietnam veteran who served on active duty with the Army Nurse Corps from 1967 to 1970. Currently she is the Director of Homeless Veterans Services for the Philadelphia Veterans Multi-Service and Education Center, Inc. Ms. Four has been actively involved in veterans' issues on a local, regional and national level for many years. She was

the founder and executive director of the Philadelphia Stand Down from 1993 to 1998, and currently serves as the Ex-Officio Director of this volunteer project. She is also a member of VA VISN 4 Management Assistance Council and Homeless Working Group. A life member of the Vietnam Veterans of America, she serves on their National Board of Directors and is Chair of the Women Veterans Committee. Ms. Four has been appointed as a consultant to the Department of Veterans Affairs Advisory Committee on Homeless Veterans. She was appointed to the Advisory Committee on Women Veterans in March of 2001.

BERTHA CRUZ HALL, USAF

Mrs. Cruz Hall is a Hispanic veteran, who served in the United States Air Force for 4 years. She worked in personal affairs and assisted survivors of servicemen with obtaining benefits. Currently, she is employed by the Texas Veterans Commission, and provides direct counseling to veterans in reference to all matters relating to veterans benefits. Mrs. Cruz Hall is the State Women Veterans Coordinator for Texas. She represents veterans before the discharge review boards, and assists with claims appeals. Other affiliations include active member of the Tarrant County Veterans Council; District Service Officer, American Legion; executive committee member, Disabled American Veterans; and member of the advisory board for the Fort Worth Homeless Veterans Program. In addition to her knowledge of women veterans' issues, Mrs. Cruz Hall's extensive background in veteran's assistance activities is a valuable asset to this Committee. Mrs. Cruz Hall was appointed to the Advisory Committee on Women Veterans in February of 1998.

MARCELITE J. HARRIS

MAJOR GENERAL, USAF, RETIRED

General Harris retired from the United States Air Force in 1998, following a distinguished career. During her career, she made significant contributions to advancing the role of women in the military. Specific "firsts" in accomplishments include her selection as the first woman to command an aircraft maintenance squadron; the first woman deputy commander for maintenance in the Air Force; and the first woman technical training commander in the Air Force. General Harris was also the first African-American woman to be promoted to the grade of Brigadier General in the US Air Force. She served as the Air Force representative to the Defense Advisory Committee on Women in the Services; the United States representative to the Committee on Women in the NATO forces; and served on Senator Nancy Kassebaum-Baker's committee on the impact of mixed training on readiness. The recipient of numerous honors and awards, General Harris is presently employed in the aerospace industry. General Harris was appointed to the Advisory Committee on Women Veterans in March of 2000.

EDWARD E. HARTMAN, USA

Mr. Edward E. Hartman, a disabled veteran, served in the Persian Gulf War, and was appointed as Acting National Director of Voluntary Services of the million-member Disabled American Veterans (DAV) in March 2002. Mr. Hartman heads a corps of DAV members who, with members of the DAV Auxiliary, donate more than 2.4 million hours a year to volunteer work at VA medical facilities; directs the nationwide DAV Transportation Network; and coordinates activities involving DAV co-sponsorship of the annual National Disabled Veterans Winter

Sports Clinic and coordinates corporate sponsorship of the Program. Mr. Hartman is a life member of DAV Chapter 23. He has held various positions at DAV as the National Appeals Officer, Assistant Supervisory NSO in the Washington, DC Office, Associate National Director of Voluntary Services, Assistant National Director of Voluntary Services and presently serves as the Acting National Director of Voluntary Services. Mr. Hartman was appointed to the Advisory Committee on Women Veterans in January of 2002.

CONSUELO C. KICKBUSCH
LIEUTENANT COLONEL, USA, RETIRED

Colonel Kickbusch retired from the United States Army in 1997, following a distinguished career. Colonel Kickbusch was the recipient of numerous honors and awards during her military career, including the Legion of Merit. Before her retirement, she was the highest-ranking Hispanic woman in the combat support field. Following her retirement, Colonel Kickbusch founded her own consulting company. She has worked with young people, parents and educators in confronting issues of life skill, teen pregnancy, gang violence and parenting education; produced an educational video entitled "Porque No - Why Not?" which was developed to empower young people to believe in themselves. The video has motivational messages and techniques on how to succeed in life, and incorporates her personal experiences with overcoming the barriers of poverty and illiteracy. Colonel Kickbusch is also a highly sought-after motivational speaker on a wide variety of issues including diversity, organizational change, and personal empowerment. Colonel Kickbusch was appointed to the Advisory Committee on Women Veterans in March of 2000.

KATHY LA SAUCE
LIEUTENANT COLONEL, USAF, RETIRED

Colonel LaSauce retired from the Air Force in 1992 as the senior ranking woman pilot in the US military. She was among the first women to serve as Aircraft Maintenance Officer, and one of the first ten women trained as Air Force pilots. She accumulated almost 4,000 hours of international flight time as a Lockheed C-141 aircraft commander, instructor, flight examiner pilot, and Boeing 707 presidential support pilot. Prior to her retirement, Colonel LaSauce was the Deputy Commander for Air Transportation, 89th Military Airlift Wing; Commander, 93rd Aerial Port Squadron; and Assistant Deputy Commander, 89th Operations Group, 89th Airlift Wing, Andrews Air Force Base, Maryland. During her career, she represented the Air Force in a number of public appearances. Colonel LaSauce received numerous awards, including the California Professional Women of the Year for 1978, and the Citation of Honor that is one of the Air Force Associations' highest awards. She earned a masters degree in Aeronautical Science from Embry-Riddle Aeronautical University. Colonel LaSauce was appointed to the Advisory Committee on Women Veterans in January of 2002.

M. JOY MANN
MAJOR, U.S. AIR FORCE RESERVE

Major Joy Mann is the Commander of the 512th Mission Support Squadron, United States Air Force Reserve. Her squadron members provide personnel service, education and

training assistance, and computer and network service to over 1,800 Reserve members located at Dover Air Force Base, Delaware. Major Mann is an Air Reserve Technician—a Federal civilian employee who has dual status as a Reservist. She has completed the following military courses: Squadron Officers School and Air Command and Staff College. Her education includes a bachelor's degree and a master's degree in French literature from the University of Delaware. Major Mann is a lifetime member of the Reserve Officers Association, where she holds the Department of Delaware Air Force Vice President position. She is a volunteer member of the Delaware Committee for Employer Support of the Guard and Reserve, working as the State Ombudsman. Major Mann was appointed to the Advisory Committee on Women Veterans in October of 2000.

LORY MANNING
CAPTAIN, USN, RETIRED

Captain Manning retired from the U.S. Navy in 1994, after a 25-year career. A graduate of the Naval War College, Command and Staff College, she held increasingly responsible positions in the Navy, including tours of duty on the staff of the Chief of Naval Operations; Chief of Naval Personnel; and Chief of Legislative Affairs. Captain Manning was directly involved in the development of naval policy on the utilization of women. She is the recipient of numerous military awards, including the Legion of Merit. Currently, she serves as the Director of the Women in the Military and Hire a Vet Projects at the Women's Research and Education Institute (WREI), located in Washington, DC. Captain Manning was appointed to the Advisory Committee on Women Veterans in June of 1998.

MICHELE (MITZI) MANNING
COLONEL, USMC, RETIRED

Colonel Michele "Mitzi" Manning served in the U.S. Marine Corps from 1972-1999, and is currently attending Wesley Theological Seminary. She is a Certified Candidate for the Order of Deacon in Full Connection in the United Methodist Church, and hopes to serve as a chaplain to the elderly. Her assignments in the Marine Corps included command of a squadron and the Western Sector; U.S. Military Entrance Processing Command; Assistant Chief of Staff, Marine Forces Pacific; and as the Secretary of the Joint Staff. Her awards include the Defense Superior Service Medal with Oak Leaf Cluster, the Legion of Merit, the Meritorious Service Medal with three stars, the Navy Commendation Medal, the National Defense Service Medal with Bronze Star, the Sea Service Deployment Ribbon, and the Drill Instructor Ribbon. She currently serves as the Chaplain of the Women Marines Association. Colonel Manning was appointed to the Committee in July of 2000.

KATHLEEN A. MORRISSEY, R.N., B.S.N.
COLONEL, NJ ARMY NATIONAL GUARD

Colonel Morrissey is a Vietnam veteran, having served on active duty with the U.S. Army Nurse Corps from 1969 - 1971. Currently she is the State's Chief Nurse and Deputy Commander of Detachment 5, Headquarter STARC, New Jersey Army National Guard. Colonel Morrissey has been employed by the New Jersey Department of Military and Veterans Affairs since

1988, holding a variety of positions including: Deputy Director for the Division of Veterans Services and Administrator of the Office of Cemeteries and Memorials. Currently, she is the Assistant Director of New Jersey's Veterans Health Care Services. Colonel Morrissey is a member of the Veterans of Foreign Wars, the American Legion, the National Guard Association of the United States, and the American Nurses Association. Colonel Morrissey was appointed to the Committee in July of 2000.

JOAN E. O'CONNOR

COMMANDER, NAVAL RESERVE, RETIRED

Commander O'Connor retired from the Naval Reserve in 1999. She was a direct commissioned Public Affairs Officer, and served on active duty in Boston from 1980-1981. As Associate General Counsel for the Massachusetts Department of Veterans' Services, she is the Department's Hearing Officer and decides appeals from veterans who have been denied public assistance. She represents the Department at other state agencies, drafts legislation and regulations. Commander O'Connor is also the Department's Women's Coordinator. As such, she leads the Women's Network, a group who assist, advocate, educate, and inform the 26,000 women veterans in the State. Previously she was an Assistant City Solicitor in Somerville, Massachusetts, and a lawyer in private practice. She received her B.A. in English from Emmanuel College, Boston. She holds a master's degree in Public Relations from Boston University, and her law degree is from the New England School of Law. Commander O'Connor was appointed to the Advisory Committee on Women Veterans in January of 2002.

SHERYL SCHMIDT, USAF

Ms. Schmidt is an Air Force veteran who served on active duty from 1974 – 1980 in electronics installation and combat communications. She currently serves as the Deputy Secretary for Women Veterans Affairs with the California Department of Veterans Affairs and oversees programs for more than 150,000 women veterans. She is responsible for ensuring that issues important to women veterans remain part of the California public policy process. Her background in California's veteran's programs will also ensure that the issues and recommendations suggested by the Committee reach a broader number of women veterans. Ms. Schmidt received her bachelor's degree in Business Administration from St. Leo University; master's in Business Administration from California State University, Sacramento; and is a licensed CPA. Ms. Schmidt is a lifetime member of the Disabled American Veterans (DAV), American Veterans, (AMVETS), and the American Legion. She also serves on the California Military Museum Advisory Board and the Sacramento Women Veterans Resource Project (women veterans homeless transition center). Ms. Schmidt was appointed to the Advisory Committee on Women Veterans in January of 2002.



Center for Women Veterans Mission and Goals



MISSION

The mission of the Center for Women Veterans is to assure that women veterans receive benefits and services on par with male veterans, encounter no discrimination in their attempt to access these services, are treated with respect and dignity by VA service providers; and to act as the primary advisor to the Secretary for Veterans Affairs on all matters related to programs, issues, and initiatives for and affecting women veterans.

GOALS

Our goals were developed to assess women veterans' services within and outside the Department on an ongoing basis, to assure that VA policy and planning practices address the needs of women veterans, and foster VA participation in general Federal initiatives focusing on women's issues. Specific goals of the Center include:

- Identifying policies, practices, programs, and related activities that are unresponsive or insensitive to the needs of women veterans and recommending changes, revisions or new initiatives designed to address these deficiencies.
- Fostering communication between all elements of VA on these findings and assuring that women veterans' issues are incorporated into their strategic planning.
- Promoting and providing educational activities on women's issues generally, and women veterans specifically, for VA personnel and other appropriate individuals.
- Encouraging collaborative activities on issues related to women with other Federal agencies.
- Creating an informal forum for the open discussion of women veterans' issues for interested VA personnel.
- Developing an open dialogue with the women veteran community to assess their perception of VA services for women.
- Promoting research activities on women veterans' issues.
- Fulfilling all other functions of the Center as outlined by Congress in Public Law 103-446.

**Department of Veterans Affairs
Center for Women Veterans
Washington, DC 20420**

**2002 Report
VA Advisory Committee on Women Veterans
*Women Veterans...Forging the Future for Those
Who Follow*
April 2003**