

DEPARTMENT OF
VETERANS AFFAIRS

ADVISORY COMMITTEE ON
WOMEN VETERANS
2000 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.

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LETTER FROM THE CHAIR

As we embark on a new Century, it seems appropriate to reflect on the progress of the past and consider the opportunities of a new Millennium. It has only been 20 years since women veterans emerged from the anonymity of being "America's Best Kept Secret," to claiming their rightful place in the history of our Nation. During that time, little by little and inch-by-inch we crept into the vocabulary of the Congress, veterans service organizations and public opinion. In many ways, it has fallen to this living generation of women veterans to preserve the past and forge a legacy for the future. What can we say about the last 20 years – about the stressors of military life on the health, emotional well being and fitness of women? What changes will the new roles for women in the military have on their needs as veterans? Of this, one thing we can be sure, in the midst of all that has been done, and all that is in the process of evolving, you will find the work of the women and men who have served on the Department of Veterans Affairs (VA) Advisory Committee for Women Veterans.

Changes in the restructuring of the VA health care delivery system; budget constraints; advances in the diagnosis and treatment of health problems are dynamic forces that challenged the status quo and tested the creativity, as well as the commitment, of each member of this Committee. Extra effort was made by all to reach out and assess the quality of care for women veterans and consult with Congressional and VA leaders on a myriad of issues. These issues ranged from treatment for veterans who experienced sexual trauma, to VA Home Loan Programs on Native American reservations. We have tapped into the expertise of our Committee members to more adequately address the needs of minority women veterans, and as the number of women veterans who are homeless in America increased, this Committee fought to preserve funding for the VA demonstration projects to assist this special group.

Perhaps the best measure of how far we have come in the last two decades is the Congressional authorization of a special monthly compensation (SMC-k) for women veterans who have undergone a simple or radical mastectomy.

For the first time, we have successfully challenged the tradition that held there could be no difference in compensation based on gender.

This Committee made a strong argument for the fact that with a simple or radical mastectomy, the loss and disfigurement endured by women differ significantly from those experienced by men. Very simply, this legislation is a giant step for women veterans because it establishes a new precedent for how VA compensation and disability ratings can be defined. As you will see in the 2000 Report, the Advisory Committee has made a great effort to protect the hard-won improvements in VA services and moved the agenda to address the needs of the future. This charge was not a mere question of money, programs or services. This was a question of honor and stewardship. For all of the Advisory Committee members, this was a question of keeping faith with each of America's 1.2 million women veterans.

Sincerely,

Linda Spoonster Schwartz, RN, MSN, D.P.H
Chair 1998-2000

PART I

EXECUTIVE SUMMARY

This report of the Department of Veterans Affairs (VA) Advisory Committee on Women Veterans represents the first for the new century.

The current Advisory Committee on Women Veterans membership includes veterans from various educational and social backgrounds and those who served in the Army, Navy, Air Force, Selected Reserve and National Guard Forces. Their experience and expertise range from service in the Cadet Nurse Corps to service in Korea, Vietnam and the Gulf War. The Committee has received excellent support from the Center for Women Veterans (CWV) and other key VA officials who have contributed to ensuring that our responsibilities to assess the needs of women veterans and to help facilitate program changes are achieved.

The Advisory Committee on Women Veterans submits a biennial report that presents information about its activities and recommendations for improvement of programs and services for women veterans. The last report in 1998 contained 42 recommendations. VA concurred with 36 of these recommendations.

The primary concerns of the Advisory Committee on Women Veterans, as reflected in the 1998 report, were as follows:

- The future of VA programs for women
- The elimination of the Sunset Provision from VA's Sexual Trauma Counseling (STC) Program
- The enactment of legislation authorizing VA to provide sexual trauma counseling services to National Guard personnel and Reservists who encountered such experiences while on active duty for training
- The amendment of 38 U.S.C. § 1114(k) to authorize special monthly compensation (SMC-k) for women veterans who have undergone mastectomy
- Services for women veterans who are homeless

1. The future of VA programs for women.

Current health care enrollment figures indicate that approximately five percent of enrolled veterans are women. This disparate ratio of men-to-women in VA facilities presents specific problems for women veterans. Of particular concern is

the attitude that development of specialized in-house services for women is not a cost-effective approach to providing quality health care. With the shift of the Veterans Health Administration (VHA) from disease-oriented specialty care to holistically oriented primary care, the trend has been to mainstream some specialties, including women's health, into primary care clinics and teams. In response to the Committee's concern, VHA, in collaboration with the Center for Women Veterans (CWV), established a task force. Their charge was to assess the current status of women's services in VA, and provide recommendations to assist VA managers in developing cost-effective programs responsive to the needs of the women veterans population. The Advisory Committee on Women Veterans looks forward to receiving the task force's report.

2. The elimination of the Sunset Provision from VA's Sexual Trauma Counseling (STC) Program.

Public Law 106-117, the "Millennium Health Care and Benefits Act," extended VA's authority to provide STC on a priority basis through December 31, 2004. The Committee strongly believes that the STC Program should be a permanent program available within the Veterans Health Administration.

3. The enactment of legislation authorizing VA to provide sexual trauma counseling services to National Guard personnel and Reservists who encountered such experiences while on active duty for training.

The Advisory Committee on Women Veterans was disappointed that legislation was not enacted in support of this recommendation. However, members were pleased that Public Law 106-117 mandated that a VA and Department of Defense (DOD) Task Force be established to determine the extent to which members of the Selected Reserves and National Guard experience sexual trauma while serving on active duty for training. The Task Force was also tasked with determining the extent to which sexual trauma counseling services are utilized. The Committee looks forward to reviewing the findings of the task force.

4. The amendment of 38 U.S.C. § 1114(k) to authorize special monthly compensation (SMC-k) for women veterans who have undergone mastectomy.

The Advisory Committee on Women Veterans is pleased that Congress passed legislation in support of this recommendation and that the recommended changes are included in Public Law 106-419, "The Veterans Benefits Improvement Act of 2000."

5. Services for women veterans who are homeless.

The Advisory Committee on Women Veterans is pleased with VA's decision to allocate three million dollars in FY 2000 to support the development of demonstration programs designed to meet the treatment and support service needs of women veterans who are homeless. The Advisory Committee will be monitoring these programs over the next two years.

Since the publication of the Advisory Committee on Women Veterans 1998 Report, the Committee has continued its work in assessing VA programs and services for women veterans. During the last two years, Advisory Committee activities have included:

- Semi-annual meetings held in Washington, DC, VA Central Office. Numerous briefings and presentations provided key information regarding the status of current and proposed programs, legislation and policy relevant to women veterans. (See Appendix D.)
- Comprehensive site visits by the full Advisory Committee to VA facilities in the Seattle-Tacoma, Washington, area where services for women veterans were assessed.
- Participation in Summit 2000, the second *National Summit on Women Veterans Issues*. The Summit took place in Washington, DC, and was hosted by VA and co-sponsored by the White House Office on Women's Outreach and Initiatives and the Disabled American Veterans (DAV). Over 350 persons attended.
- Testimonies by the Chair of the Advisory Committee on Women Veterans, Dr. Linda S. Schwartz, before the Senate and House Veterans Affairs Committees. Dr. Schwartz also met with the Honorable Togo D. West Jr., Secretary of Veterans Affairs, and shared the concerns of his Advisory Committee regarding the need to prevent any erosion of programs and needed services for women veterans.
- Site visits by individual Committee members to VA facilities in Houston, TX; Tampa, FL; Wichita and Leavenworth, KS; and Washington, DC.
- Mrs. Constance Evans, a member of the Advisory Committee and the Naz Perce Tribe, provided an informative presentation on how issues of Native American culture and traditions may affect a veteran's ability to access VA benefit programs and health care services. Mrs. Evans also assisted in a seven-day sensitivity training session for VA employees on the Yakama Indian Reservation in Washington State. This training focused on Native American

cultures, with emphasis on treatment of Native American veterans who suffer from Post Traumatic Stress Disorder (PTSD).

Although VA continues to make positive strides in addressing the needs of women veterans, there is still much work to be done. The number of women on active duty continues to increase. In 1999, women comprised 15 percent of the active duty force and 20 percent of new recruits. Today, approximately 1.2 million women are veterans, comprising approximately five percent of the overall veteran population. VA projects that this percentage will double to 10 percent by the year 2010. These changing demographics within the veteran population underscore the fact that VA must continue to exhibit work progress to ensure that its services, programs and facilities meet the needs of women veterans and that they are assured they will receive quality care.

The Department of Veterans Affairs also faces new challenges in the provision of health care to women veterans. An example of this involves the complexities of legislative and regulatory policies that authorize VHA to provide maternity care to women veterans, but do not authorize or permit VA to allocate resources to provide care for any newborn.

This Report of the Advisory Committee on Women Veterans includes several concerns that have been discussed in previous reports, and remain issues for consideration as current and ongoing discussion. These are:

- Assure implementation of effective outreach to ensure that women veterans have access to information, authorized benefit programs and health care services;
- Assure that minority women veterans are identified and provided equal access to VA services;
- Assure that all VA health care programs are designed and implemented to meet the needs of women veterans who are homeless;
- Assure that VA will continue to provide appropriate health care and counseling to sexual trauma victims;
- Develop appropriate program enhancements to provide health care to Selected Reserve and National Guard personnel who experience sexual trauma while on active duty for training;
- Assure that adequate and consistent training is provided to women veterans coordinators; and
- Assure that women veterans coordinator positions are adequately staffed.

PART II

SUMMARY OF RECOMMENDATIONS

A summary of the Advisory Committee's primary recommendations for 2000 is as follows:

Department of Veterans Affairs

- Increase, improve and monitor outreach programs to women veterans with special emphasis on outreach to minority populations.
- Include use of ethnic media (print/radio/internet/TV), churches, community-based organizations, minority women's organizations and health fairs in outreach efforts to minority women. Increase efforts to Native American veterans living on reservations. Identify, obtain and incorporate current field-based audiovisuals that focus on women veterans.
- Provide an annual briefing to the Advisory Committee on women veterans programs and initiatives, summarizing the outreach efforts of each VHA Veterans Integrated Service Network (VISN) and VBA Service Delivery Networks (SDN). Include specific information on outreach efforts to minority populations and to community-based service providers.
- Contact all military personnel discharged from active duty for medical reasons to apprise them of their eligibility for VA benefits.
- Provide a briefing to the Committee on the progress made on any and all actions taken to encourage Congress to enact legislation to eliminate restrictions and time limitations on VA's authority to provide sexual trauma counseling.
- Provide an annual briefing to the Committee on the efforts by VA that have been made to ensure that consistent, high-quality and continuous training has been provided to appropriate VA personnel on treatment protocols, sensitivity concerns and other issues necessary to ensure effective sexual trauma counseling.
- Provide education and ongoing training on the use of "markers" in the development and rating of disability claims for any condition that is the aftereffect of a sexual trauma, to all rating specialists and appropriate members of the Board of Veterans Appeals who develop, process or review these types of claims.

- Maintain adequate resource levels for the 11 demonstration programs developed to meet the special needs of women veterans who are homeless to ensure appropriate evaluations of the programs' effectiveness.
- Encourage the VISNs to work with community-based service providers to obtain services for the children of women veterans who are homeless.
- Provide individual case management to women veteran clients who are homeless.
- Broaden the definition of "homelessness" to use the parameters specified in the McKinney Act, which extends eligibility for assistance to individuals living in sub-standard housing conditions.
- Ensure that the Center for Women Veterans is provided an annual update on the effectiveness of the VHA and VBA women veterans coordinators programs. Indicators of interest should include: personnel hours allocated to perform outreach duties, allocation of resources, training and educational opportunities, lines of communication to facility directors and training conducted for the women veterans coordinators.
- Include gender-specific information in all studies and surveys sponsored, funded or conducted by VA. The Advisory Committee recommends that this information, regardless of the sample size, be reported.
- Include information regarding issues affecting women veterans in new employee orientation briefings and in appropriate training for other VA employees. When appropriate, address concerns, protocols for treatment of sexual trauma, interventions, etc., with affiliating students, residents and visiting faculty at VA health care facilities and regional offices.
- Require VBA and the Board of Veterans Appeals (BVA) to develop a standard of accountability for training of all personnel who handle gender-specific disability claims, including claims for disability secondary to sexual trauma.
- Provide a briefing to the Advisory Committee on the findings and recommendations of the VA-DOD Task Force convened to study the need for sexual trauma services by members of the Selected Reserve and National Guard.
- Ensure that all military personnel, including Selected Reserve forces and members of the National Guard, receive basic VA benefit information

including appropriate points-of-contact unique to their situation at the time of separation.

- Disseminate information to all veterans about the availability of side-by-side burial for veterans married to veterans. Additional opportunities to serve dual veteran couples should also be explored.
- Recruit and hire qualified women veterans, with emphasis on identifying qualified minority women for positions within VA, including senior executive service positions, political appointee positions and membership on special boards and committees.
- Encourage other Federal agencies to recruit and hire qualified women veterans.
- Work with local tribal program officials to ensure Native American women veterans have access to vocational rehabilitation services.

Members of Congress and Department of Veterans Affairs

- Work with Congress to develop legislation to extend the regulatory time to use GI Bill benefits for all periods of service from 10 years to 20 years.

Departments of Labor and Veterans Affairs

- Request the Secretary at the Department of Labor (DOL) to encourage the Veterans Employment and Training Service (VETS) to recruit and hire qualified women veterans to fill vacant positions in the Disabled Veterans Outreach Program (DVOP) and to hire women veterans as Local Veterans Employment Representatives (LVERs) throughout its workforce network.
- Encourage collaboration between VBA and DOL VETS to ensure that Native American women veterans have access to Federal employment programs and services.

Bureau of the Census and Department of Veterans Affairs

- Continue collaboration with the Bureau of Census to ensure that the National Census forms (long and short) are inclusive of a direct approach to securing military service information that can be understood by all. Example: "Have you ever served in the United States military?" as opposed to, "Are you a veteran?"

PART III

RECOMMENDATIONS AND RATIONALE

A. OUTREACH

Recommendations

1. Increase, improve and monitor outreach programs to women veterans with special emphasis on outreach to minority populations.
2. Include use of ethnic media (print/radio/internet/TV), churches, community-based organizations, minority women's organizations and health fairs in outreach efforts to minority women. Increased efforts to reach Native American veterans living on reservations. Identify, obtain and incorporate current field-based audiovisuals that focus on women veterans.
3. Provide an annual briefing to the Advisory Committee on Women Veterans Programs and Initiatives, summarizing the outreach efforts of each VHA Veterans Integrated Service Network (VISN) and VBA Service Delivery Networks (SDN). Include specific information on outreach efforts to minority populations and to community-based service providers.

Rationale: (Recommendations 1-3) Since its inception, outreach has and continues to be a priority concern for this Advisory Committee. VA has made many important strides in its outreach programs; however, outreach efforts should be consistently monitored and re-evaluated as the women veteran demographics are continually changing. Women currently comprise more than 15 percent of the active force and 20 percent of new recruits. Of particular note, approximately 47 percent of these women belong to minority populations. When appropriate, outreach should focus on cultural issues relevant to these populations. Since these active duty women are "the veterans of tomorrow," and data indicates that women veterans comprise five percent of the current veteran population; the Committee believes it is important that outreach programs grow to keep pace with the increasing number of minority women in the overall veteran population. Among other approaches, VA should encourage outreach to community-based service providers to locate women veterans and to enhance and increase services available to them.

The Committee believes that VA should place news articles on VA benefits and health care services in medical, nursing, social work and psychiatric publications to alert community care providers of the existence and availability of VA services. The articles should encourage health care professionals to ask their female clients if they have ever served in the military. Most importantly, information on how a

veteran can access VA programs and services should also be publicized. Additionally, this Committee hopes that programs that are successful in any one VISN can be shared with and mirrored in other VA service delivery areas. An annual VA Outreach Report would be a valuable tool for monitoring this process. The Committee also recommends that VA identify, obtain and incorporate into VA's outreach programs current audiovisuals that focus on women veterans, e.g., the video "Angels' Landing," recorded by the WVC, VAMC Nashville, TN.

4. Continue collaboration with the Bureau of Census to ensure that the National Census forms (long and short) are inclusive of a direct approach to securing military service information that can be understood by all. Example: "Have you ever served in the United States military?" as opposed to, "Are you a veteran?"

***Rationale:** It is advantageous that Census data be broken out by veteran status to help identify the overall veteran population and its geographical location. This data assists VA in program development, allocation of resources and in obtaining an adequate statistical sample to provide meaningful data about women veterans, including minority women veterans.*

5. Contact all military personnel discharged from active duty for medical reasons to apprise them of their eligibility for VA benefits.

***Rationale:** Military personnel discharged from active duty for medical reasons may not be knowledgeable about the availability of specific VA services and programs and how to access these benefits. Because of the difference between the DOD and VA disability rating system, it is important that these veterans be contacted, prior to their separation, to assure they receive appropriate assistance and support.*

The mechanism for contacting these veterans is in place, as present law requires that DOD automatically transfer the medical records of these individuals to the VA at the time of discharge from the service. Discharge from Active Duty for medical reasons suggests that these veterans have incurred a service-related disability and may be eligible for VA disability compensation. It is within the mission of VA to focus outreach efforts to these veterans. Such efforts will assist disabled veterans to access VA programs and services in a timely manner.

B. SEXUAL TRAUMA COUNSELING AND CARE

Recommendations

6. Provide a briefing to the Committee on the progress made on any and all actions taken to encourage Congress to enact legislation to eliminate

restrictions and time limitations on VA's authority to provide sexual trauma counseling.

Rationale: *The Committee intends to monitor VA initiatives regarding the elimination of restrictions placed on their ability to provide sexual trauma counseling under the provisions of Public Law 102-585. This briefing should include an update on the availability of sexual trauma counseling services in the Readjustment Counseling Program, as well as access to health care to address the physical sequelae of these experiences. The Committee wishes to be informed of the efforts VA has made to determine what, if any, difficulties veterans encounter in accessing services from VA for the psychological and physical consequences of sexual trauma.*

7. Provide an annual briefing to the Committee on VA efforts that have been made to ensure that consistent, high-quality and continuous training has been provided to appropriate VA personnel on treatment protocols, sensitivity concerns and other issues necessary to ensure effective sexual trauma counseling.

Rationale: *Although VA concurred with this recommendation in the Advisory Committee on Women Veteran's 1998 Report, treatment of victims of sexual trauma is an important and continuing concern. Annual briefings on these issues will keep the Committee apprised of VA's treatment protocols and educational activities designed to promote the overall quality of care delivered to veterans who are victims of sexual trauma. Training should include clinical staff, Readjustment Counseling Service staff, Veterans Benefit Administration regional office staff and others as deemed necessary.*

8. Provide education and ongoing training, on the use of "markers" in the development and rating of disability claims for any condition that is the aftereffect of a sexual trauma, to all rating specialists and appropriate members of the Board of Veterans Appeals who develop, process or review these types of claims.

Rationale: *Victims of sexual assault or trauma, for various reasons, fail to report the assault while on active duty. As a result, their military medical records contain little or no specific medical or other evidentiary matter that would satisfy the VA evidence standards and substantiate their claims. However, there are other kinds of "markers" such as significant drop in performance evaluations, uncharacteristic behavior changes, increased medical visits, etc., that can support the claimant's case and help to substantiate the claim of residual disabilities.*

Many of the VA senior veterans claims representatives understand and know how to develop for these "markers," however, this staff awareness and practice is not a standardized process that is applied throughout the Veterans Benefits

Administration system. Training and acceptance of the “markers,” as qualifying evidence to support a claim, will help ensure consistent, sensitive handling of these cases and assure they are processed, evaluated and reviewed fairly throughout the VA claims network.

C. WOMEN VETERANS WHO ARE HOMELESS

Recommendations

9. Maintain adequate resource levels for the 11 demonstration programs developed to meet the special needs of women veterans who are homeless to ensure appropriate evaluations of the programs’ effectiveness.

***Rationale:** Women veterans who are homeless have unique needs such as privacy and personal safety, and they may require managed care. VA concurred with recommendations in the 1998 Committee Report, to solicit pilot programs geared to meeting the special needs of women veterans who are homeless. During FY 2000 the Center for Women Veterans and VHA’s Homeless Program Office selected eleven sites to develop demonstration programs for women veterans who are homeless. There is concern among Committee members that initial resources allocated to each program are not adequate to allow enough time to evaluate the overall program’s effectiveness and outcome.*

10. Encourage the VISNs to work with community-based service providers to obtain services for the children of women veterans who are homeless.

***Rationale:** Women veterans who are homeless often have children who, by legislation, do not meet the definition of “veteran” and therefore, are not eligible for VA services. Lack of childcare services and temporary shelter, etc., may prevent or discourage women veterans from participating in VA programs that ultimately could help them develop the employment and living skills necessary to become independent. Services that could help these women are often available through the local community. VISNs should encourage their medical centers, hospitals, vet centers, etc., to outreach to and partner with these community-based service providers to obtain needed services for all women veterans with dependent children, and particularly for those who are homeless, to facilitate their participation in the VA entitlement programs.*

11. Provide individual case management to women veteran clients who are homeless.

***Rationale:** Each VA homeless veteran program and its selected community provider partners should be trained to address the specific needs of women veterans who are homeless. This alignment of resources would allow for the*

development of good networks to identify the best community-based services available to woman veterans who are homeless.

12. Broaden the definition of “homelessness” to use the parameters specified in The McKinney Act, which extends eligibility for assistance to individuals living in sub-standard housing conditions.

Rationale: *The McKinney Act is the Federal standard for allocating Government resources for homeless persons in America. This law defines “homelessness” to include living in substandard housing or sleeping in cars. VA’s definition of “homelessness” does not include these provisions, which places veterans who are homeless in a separate and unequal category. It is important that there be a standardized definition for all Government agencies that provide services to the homeless, including individuals living in sub-standard housing.*

D. HEALTH CARE

Recommendations

The Advisory Committee on Women Veterans commends VA’s support for the women veterans coordinators program and its recognition of the continuing importance of this role in service to women veterans.

13. Ensure that the Center for Women Veterans is provided an annual update on the effectiveness of the VHA and VBA women veterans coordinators programs. Indicators of interest should include: personnel hours allocated to perform outreach duties, allocation of resources, training and educational opportunities, lines of communication to facility directors and training conducted for the women veterans coordinators.

Rationale: *The women veterans coordinators report receiving varying levels of training and indicate that their duties differ from station to station and across Network lines. Their positions are not uniformly placed in the facility’s chain of command. Monitoring of these important positions can be helped by providing the Center for Women Veterans with an annual summary on these dimensions and established measures of program effectiveness.*

14. Include gender-specific information in all studies and surveys sponsored, funded or conducted by VA. The Committee recommends that this information, regardless of the sample size, be reported.

Rationale: *Progress has been made in research specific to women veterans. However, VA has not routinely reported the data relative to women veterans. Any available information on women veterans (even surveys with small sample sizes - despite lack of statistical significance) would be helpful to the Committee, the Center for Women Veterans and the VA in future strategic planning.*

E. STAFF EDUCATION

Recommendations

15. Include information regarding issues affecting women veterans in new employee orientation briefings and in appropriate training for other VA employees. When appropriate, address concerns, protocols for treatment of sexual trauma, interventions, etc., with affiliating students, residents and visiting faculty at VA health care facilities and regional offices.

Rationale: *Because they are fewer in number, and often are victims of sexual trauma, women veterans have specific concerns about and needs for personal privacy and safety. All VA employees, who are responsible for the care of women veterans, or with whom women veterans typically have contact, should respect and honor these needs. These problems and concerns are not always self-evident, VA health care providers should be given training relative to these issues.*

16. Require Veterans Benefits Administration and the Board of Veterans Appeals (BVA) to develop a standard of accountability for training of all personnel who handle gender-specific disability claims, including claims for disability secondary to sexual trauma.

Rationale: *The Committee believes it is essential that all appropriate VA personnel receive training and periodic updates, on gender specific disability claims, including claims for disability secondary to sexual trauma and their related issues, in order to ensure consistency in the claims' development and rating evaluation process. VA has invested considerable resources in developing a series of training materials, including videotapes, on the processing of specific gender-related conditions on women veterans health claims and for sexual trauma claims of all veterans. The fact that these videotapes and other training materials are available does not assure VBA and BVA personnel are using them. These education tools are very thorough, and their use will help ensure that consistent standards for claims processing are applied and used throughout VA in processing and developing these claims.*

F. SELECTED RESERVE AND NATIONAL GUARD BENEFITS

Recommendations

17. Provide a briefing to the Committee on the findings and recommendations of the VA-DOD Task Force convened to study the need for sexual trauma services by members of the Selected Reserve and National Guard.

18. Ensure that all military personnel, including Selected Reserve forces and members of the National Guard, receive basic VA benefit information including appropriate points-of-contact unique to their situation at the time of separation.

***Rationale:** (Recommendations 17 and 18) The post-Cold War military is more dependent on the Selected Reservists and National Guard personnel than ever before. Members of these support services are called to active duty and deployed overseas in increasing frequency. They can be injured or subjected to sexual assault or trauma during deployments, training and routine drill periods. In the spirit of the "Total Force" concept, VA and DOD must make every effort to ensure that these personnel receive proper care for injury, including the after effects of a sexual trauma, incurred while serving their country.*

G. NATIONAL CEMETERY ADMINISTRATION

Recommendations

The Committee commends the National Cemetery Administration on its decision to reserve side-by-side graves for veteran spouses of deceased veterans so that both individuals, who are separately entitled to space in the cemetery, can be buried side-by-side.

19. Disseminate information to all veterans about the availability of side-by-side burial for veterans married to veterans. Additional opportunities to serve dual veteran couples should also be explored.

***Rationale:** As the number of women serving in the Armed Forces increase, so will the number of dual veteran couples. The demand for VA to provide couple-friendly services is likely to grow. Since veterans who do not avail themselves of other VA services may wish to be buried in national cemeteries, the provision of side-by-side graves for veteran spouses should be widely disseminated.*

H. EMPLOYMENT OF WOMEN VETERANS IN THE FEDERAL GOVERNMENT

Recommendations

20. Recruit and hire qualified women veterans, with emphasis on identifying qualified minority women, for positions within VA, including senior executive service positions, political appointee positions and membership on special boards and committees.

21. Encourage other Federal agencies to recruit and hire qualified women veterans.

22. Request the Secretary at the Department of Labor (DOL) to encourage the Veterans Employment and Training Service (VETS) to recruit and hire qualified women veterans to fill vacant positions in the Disabled Veterans Outreach Program (DVOP) and to hire women veterans as Local Veterans Employment Representatives (LVERs) throughout its workforce network.

***Rationale:** (Recommendations 20-22) Women veterans—especially minority women—are not represented in positions within VA or DOL VETS in numbers comparable to their percentage in the veteran population. This is especially true with respect to appointed positions including advisory positions—only two percent of such positions have women veteran incumbents. There are many reasons for the dearth of women veterans in these positions. The growth in the percentage of the Selected Reserve, National Guard and Active Duty forces who are women will drive a concomitant growth in the percentage of veterans who are women; therefore, increasing the pool of qualified women eligible for employment and appointment to these positions. When seeking applicants for vacant positions at all levels, officials should go beyond the “usual sources and methods.” Throwing a wider net will result in the identification of qualified women veterans, including minority women, for these positions.*

23. Work with local tribal program officials to ensure Native American women veterans have access to vocational rehabilitation services.

24. Encourage collaboration between VBA and DOL VETS to ensure that Native American women veterans have access to Federal employment programs and services.

***Rationale:** Access to vocational rehabilitation services and other employment programs is more difficult for veterans residing on Native American reservations. Unique and intensified efforts need to be developed to outreach and locate these individuals.*

I. EDUCATION

Recommendation

25. Work with Congress to develop legislation to extend the regulatory time to use GI Bill benefits for all periods of service from 10 years to 20 years.

Rationale: With VA support, the 106th Congress considered legislation to increase the value of Montgomery GI Bill benefits. This Committee commends these efforts. Consideration should be given to lengthening the “use or lose” delimiting benefit period from ten to twenty years, as an additional way to improve veterans educational benefits. This extension would allow veterans who choose full-time parenting—most of whom are women—to use their benefits to prepare them to return to the workforce after meeting their child care needs. Additionally, an extension of this “delimiting period” will permit increased access for older veterans who may choose to return to the workforce after initial retirement or after they acquire new skills to maintain their workforce credentials.

PART IV

VA Response to Recommendations

A. OUTREACH

1. Increase, improve and monitor outreach programs to women veterans with special emphasis on outreach to minority populations.

VA Response: Veterans Health Administration (VHA) conducted a survey of the local Women Veterans Coordinators (WVC) to identify outreach activities undertaken to inform women veterans and community-based providers of services available to women at VA facilities. Local Veterans Integrated Service Network (VISN) and national program brochures and newsletters have been developed to support these efforts. Outreach venues utilized by WVCs included:

- Focus groups at hospitals and VET centers
- Health fairs and disease awareness/recognition days
- Federal women's programs and women veterans recognition activities
- Local and State veterans service organization program events and women veterans organization programs
- Patient education
- Training programs with Veterans Benefits Administration (VBA)
- Brochures and pamphlets
- Transition Assistance Program (TAP) sites
- Local County Veterans Service Officers conferences and training programs

Additionally, programs at the VET centers provide outreach and other community-based service functions as an integral part of its mission. VET centers employ people with knowledge of the local veteran population and the community to locate, contact and inform many women veterans in need of counseling for war trauma and/or military-related sexual trauma. Based on over 100,000 referrals annually to VA medical centers, the VET centers are also a point of access for many women veterans to health care.

The CWV also hosts open forums and town hall meetings across the country which afford Center staff an opportunity to educate women veterans about the VA accomplishments and to improve services for women veterans. These meetings also provide a forum to provide comprehensive information about VA benefit programs and health care services for women veterans; discussions about new ideas and initiatives developed to address problems that women veterans experience in accessing VA services; opportunity to discuss their experiences and voice their concerns about VA services in their local community; and assistance in

accessing entitlements. The CWV hosts approximately one or two of these events each month.

CURRENT STATUS: To date, VHA has held numerous briefings with minority and women groups; and have also worked with field coordinators, VSOs, local state and Federal agencies in outreach efforts.

2. Include use of ethnic media (print/radio/internet/TV), churches, community-based organizations, minority women's organizations and health fairs in outreach efforts to minority women. Increase efforts to Native American veterans living on reservations. Identify, obtain and incorporate current field-based audiovisuals that focus on women veterans.

VA Response: *Representatives from VA women's programs at the national, regional and local levels frequently participate in community health fairs, recognition ceremonies for women veterans and other community-based events designed to provide information to women and their families about services available to them from various providers. Such activities often take place in community or religious institutions that provide outreach to minority populations. Where appropriate, printed materials on women's health education are made available in Spanish, as well as English. Women veteran's health staff actively participates in numerous homeless veterans Stand-Down programs each year. The Stand-Downs are offered nationwide. Statistics relative to Stand-Down participants reflect an increasing number of women veterans who are homeless seek services and assistance in accessing VA and community-based programs.*

The CWV has participated in outreach events sponsored by organizations that work with Native American, African American and Hispanic veterans and organizations. A list of the activities for the CWV can be reviewed at: <http://www.va.gov/womenvet> "Summit 2000 - An Overview; Center for Women Veterans."

CURRENT STATUS: The Web page for the Center is frequently updated to reflect current activities. Distribution of printed materials has been made to the media, veterans, field coordinators, VSOs, and other agencies outside of VA. This recommendation is implemented.

3. Provide an annual briefing to the Advisory Committee on Women Veterans on programs and initiatives, summarizing the outreach efforts of each Veterans Health Administration (VHA) Veterans Integrated Service Network (VISN), and Veterans Benefits Administration (VBA) Service Delivery Networks (SDN). Include specific information on outreach efforts to minority populations and to community-based service providers.

VA Response: *The CWV will coordinate efforts on outreach initiatives for women veterans with the Directors of the Women Veterans Health Program, Center for Minority Veterans, and the National Women Veterans Coordinator in VBA.*

CURRENT STATUS: Annually, VHA, NCA and VBA brief the full Advisory Committee on all VA activities. This recommendation is implemented.

4. Continue collaboration with the Bureau of Census to ensure that the National Census forms (long and short) are inclusive of a direct approach to securing military service information that can be understood by all. Example: "Have you ever served in the United States military?" as opposed to, "Are you a veteran?"

VA Response: *The VA Office of Policy and Planning represents the Department on the Interagency Committee for the American Community Survey (ACS), which replaces the census "long form." VA representatives are pursuing the veteran status/identification question on the ACS. The veteran question is not covered on the Census "short form," and we do not believe it is likely we could have the veteran question added.*

CURRENT STATUS: This recommendation is outside the jurisdiction of VA and falls within the Bureau of the Census. However, efforts are continuously made to ensure this question is covered in all TAP and DTAP briefings. A request has been made to the Office of Policy and Planning to revisit the issue with ACS.

5. Contact all military personnel discharged from active duty for medical reasons to apprise them of their eligibility for VA benefits.

VA Response: *VBA currently focuses outreach efforts to military personnel pending discharge for medical reasons through the Disabled Transition Assistance Program (DTAP) briefings. VBA, in conjunction with the Departments of Defense, Labor and Transportation conduct DTAP sessions with a strong emphasis on assisting veterans in obtaining gainful employment.*

CURRENT STATUS: This recommendation is still under current discussion, and more data will be available in the 2002 Report. VBA conducted over 5500 briefings in FY 2001, with emphasis on employment. VA coordinators are sent to visit hospitalized military personnel.

B. SEXUAL TRAUMA COUNSELING AND CARE

6. Provide a briefing to the Committee on progress made, to date, on actions taken to encourage Congress to enact legislation to eliminate restriction and time limits on VA's ability to provide sexual trauma counseling. This briefing should include an update on the availability of sexual trauma counseling services in the Readjustment Counseling Program, as well as access to health care to address the physical sequelae of these experiences.

***VA Response:** The Department has a formal process for proposing and evaluating items for inclusion in the legislative package that VA submits to Congress. The CWV will propose and submit for evaluation, a legislative initiative responsive to the intent of this recommendation. It is anticipated this proposal will be submitted for consideration during the second session of the 107th Congress.*

The CWV will continue to coordinate an annual briefing for the Committee on VA's Sexual Trauma Counseling Program to include services provided through VHA health care facilities and readjustment counseling centers.

CURRENT STATUS: The Millennium Bill included new legislation that authorized VA to treat veterans for sexual trauma through 2004. More information will be available in the 2002 report of the Advisory Committee on Women Veterans.

7. Provide an annual briefing to the Committee on VA efforts that have been made to ensure that consistent, high-quality and continuous training has been provided to appropriate VA personnel on treatment protocols, sensitivity concerns, and other issues necessary to ensure effective sexual trauma counseling.

***VA Response:** The CWV will continue to coordinate an annual briefing provided by Veterans Benefits Administration, Veterans Health Administration and Readjustment Counseling Service on the education and training efforts with emphasis on women veterans issues and the provision of sexual trauma counseling.*

CURRENT STATUS: Training is an on going effort.

8. Ensure rating specialists who process or review disability claims for conditions arising from sexual trauma events, including appropriate members of the Board of Veterans Appeals, are educated on the use of "markers" in the development and rating of such claims. This will help ensure these claims are processed, evaluated and reviewed fairly and consistently throughout VA.

VA Response: All VBA Veterans Service Representatives (VSR) are trained to look for alternative evidence (markers) when developing and rating Military Sexual Trauma (MST) claims. VBA concurs that periodic refresher training will continue to improve the quality of the ratings of these sensitive claims. The CWV will work with the Compensation and Pension Advisory Committee on Women Veterans in assessing the educational needs of the VSRs.

In regard to training for members of the Board of Veterans Appeals (BVA), the Board is firmly in favor of training as it relates to disability claims for conditions arising from sexual trauma events; however, the Board believes such training should include information about the rule articulated in Colvin v. Derwinski, 1 Vet.App. 171 (1991). In Colvin, the United States Court of Appeals for Veterans Claims stated that BVA (and VBA adjudicators) are prohibited from refuting or substituting expert medical conclusion in the record with their own unsubstantiated medical conclusions. In other words, BVA and regional office (RO) adjudicators may not disregard the diagnoses of medical examiners and rely on their own medical judgment. BVA and RO adjudicators may consider only independent medical evidence to support their findings. BVA has case law authority and the ROs have procedures (contained in M21-1), for handling such claims; and these, at least to some extent, draw attention to other items of evidence that may suggest behavioral changes, etc. Training in this area should include a review of the legal authority already in place.

Additionally, while BVA views education on the use of markers in handling sexual trauma cases as beneficial, VA strongly recommends against the notion that only "specially trained" Board members or Counsel be allowed to adjudicate these cases. This is an unnecessary imposition on BVA case management.

Finally, the Board will work with the CWV to identify speakers who will provide instruction at BVA on the issues described.

CURRENT STATUS: This recommendation has been implemented. Additional information will be included in the 2002 report of the Advisory Committee on Women Veterans.

C. WOMEN VETERANS WHO ARE HOMELESS

(See "Current Status" at the end of recommendation 11)

9. Maintain adequate resource levels for the 11 demonstration programs developed to meet the special needs of women veterans who are homeless to ensure appropriate evaluations of the programs' effectiveness.

VA Response: *VA understands the Advisory Committee's concern that there will be insufficient resources to allow adequate evaluation of the 11 pilot programs. However, VHA is confident that the decision to eliminate "special purpose funding" and transfer the funding for these programs into the VERA fiscal model will not have a negative effect on these programs. The CWV will monitor the impact this decision may or may not have on the development of these 11 programs during their first three years.*

10. VA should encourage the VISNs to work with community-based service providers to obtain services for the children of women veterans who are homeless. This will make it possible for the women veterans to participate in the VA programs to which they are entitled.

VA Response: *The 11 pilot programs for women veterans who are homeless were required to have a component that addresses the needs of women with children, and were specifically asked to include models of VA-community collaboration in their design. We anticipate that, following the completion of the pilot program, these programs will provide VA with models for providing services for homeless women veterans with children through community-based services, that can be adopted by other VA homeless programs.*

11. Each veteran program or provider of services for homelessness should designate a case manager and assign responsibilities for specific services. These case managers should be trained to address the specific needs of women veterans who are homeless.

VA Response: *The staff of VA's homeless programs has access to educational programs that include information on the needs of women who are homeless. The 11 pilot programs have dedicated staff to provide case management and other services to women veterans. This staff has received special training on the needs of women veterans who are homeless. Again, we anticipate that the experience of the staff in these programs will assist us in designing education modules specific to the women veterans' population in the homeless community.*

Each VBA regional office has outreach coordinators for both homeless and women veterans. Historically, most regional offices have neither the resources nor the veteran population to justify making these collateral assignments full-time positions. Many outreach coordinators work with more than one of the identified "special" veteran groups, (such as homeless, minority, women and ex-POW) which optimizes these limited resources.

CURRENT STATUS: Recommendations 9, 10 and 11 were addressed in Public Law 107-95, "Homeless Veterans Comprehensive Assistance Act of 2001," which passed the Congress on December 11, 2001, and was signed by the President on December 21, 2001. Among other provisions, the law calls for VBA to establish

full-time coordinators in the 20 largest regional offices that serve veterans who are homeless. Implementation of the law will be addressed more fully in the 2002 report of the Advisory Committee on Women Veterans.

12. Broaden the definition of “homelessness” to use the parameters specified in the McKinney Act, which extends eligibility for assistance to individuals living in sub-standard housing conditions.

VA Response: *The rationale for this recommendation in the 2000 Advisory Committee Report incorrectly states the definition of homelessness under the McKinney Act. The VA definition of “homelessness” is the same that is used by the Department of Housing and Urban Development (HUD). For example:*

The McKinney Act, Section 11302 defines homelessness as follows:

(a) In general, “For purposes of this chapter, the term “homeless” or “homeless individual or homeless person” includes –

(1) An individual who lacks a fixed, regular, and adequate nighttime residence; and

(2) An individual who has a primary nighttime residence that is

(A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

(B) an institution that provides a temporary residence for individuals intended to be institutionalized; or

(C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

(b) Income eligibility

(c) Exclusion, for purposes of this chapter, the term “homeless” or “homeless individual” does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law.

Title 38 U.S. Code - the law covering the administration of veterans benefits, defines homelessness in Sec. 3771. That definition is as follows:

For purposes of this subchapter:

(1) The term “veteran” has the meaning given such term by paragraph (2) of section 101(38 USC).

(2) The term “homeless veteran” means a veteran who is a homeless individual.

(3) The term “homeless individual” has the meaning given such term by section 103 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11302).

VA agrees that it is important that all Federal agencies use the same definition of terms when describing homeless services, outcomes, performance measures, etc. VA has recommended that the Interagency Council on the Homeless (ICH), a multi-agency working group that meets to work on interagency efforts to assist the homeless, standardize terminology used in various homeless program monitoring and evaluation.

CURRENT STATUS: VA plays an active role on the ICH, and the definition of “homeless” has been defined in the same term as the definition used by the Department of Housing and Urban Development (HUD), for the purpose of obtaining benefits from VA. This issue is ongoing, and will be addressed more fully in the 2002 report of the Advisory Committee on Women Veterans.

D. HEALTH CARE

13. Ensure that the CWV is provided an annual update on the effectiveness of the VHA and VBA women veterans coordinators programs. Indicators of interest should include: personnel hours allocated to perform outreach duties, allocation of resources, training and educational opportunities, lines of communication to facility directors and training conducted for the women veteran coordinators.

VA Response: *VHA has provided briefings to the Advisory Committee on Women Veterans twice a year and will continue to do so. In regard to training activities, the 4th Annual Clinical Update Conference on Women Veterans Health was held in Washington, DC, in August 2000. The purpose of the conference was to provide participants with knowledge on the current trends in the treatment and management of sexual trauma. Health care providers involved in women’s health including MDs, RNs, NPs, CNSs, PAs, social workers, psychologists and educators attended the conference. The Director of the CWV reviewed significant changes in legislation brought about by P.L. 106-117, “The Veterans Millennium Health Care and Benefits Act” which made it mandatory for VA to provide sexual trauma counseling. E. Cameron Ritchie, LTC, M.D., Program Director for Mental Health and Women’s Issues in the Office of the Assistant Secretary of Defense/Health Affairs, provided an update on Department of Defense military sexual trauma programs. Carole L. Turner, RN, MN, Director, Women Veterans Health Program, made presentations at two local women’s health conferences on “The Impact of Sexual Trauma on the Mind, Body & Soul,” hosted by the Lexington, KY, VA Medical Center in May 2000, and the Mid-Atlantic Health Care Network in September 2000.*

VBA has provided briefings to the Advisory Committee twice a year and will continue to do so. Within VBA, resources allocated to the women veterans coordinators positions vary from regional office to regional office, and are contingent upon the available veteran population. Office of Field Operations (OFO) Letter 201-00-09, dated March 2000, issued a suggested position description addendum for women veterans coordinators. The package also included a sample “contract” that allows regional office management and coordinators to negotiate time and resources available for outreach.

CURRENT STATUS: These recommendations have been addressed in the Women Veterans Health Program, National Strategic Workgroup Preliminary Report, November 2001. The outcome will be fully discussed in the 2002 report of the Advisory Committee on Women Veterans.

14. Include gender-specific information in all studies and surveys sponsored, funded or conducted by VA. The Advisory Committee recommends that this information, regardless of the sample size, be reported.

***VA Response:** Some of the VA surveys, such as the National Survey of Veterans and program evaluations, include gender information. In cases where the final reports do not detail data by gender, such data will be available after the completion of each study.*

CURRENT STATUS: The information is being reported and future reports will show gender cohorts.

E. STAFF EDUCATION

15. Include information regarding issues affecting women veterans in new employee orientation briefings, and in appropriate training for other VA employees. When appropriate, address concerns, protocols for treatment of sexual trauma, interventions, etc., with affiliating students, residents and visiting faculty at VA health care facilities and regional offices.

***VA Response:** Every VA medical center has a designated WVC who is responsible for developing and implementing orientation programs for new employees. Various formats are utilized to orient staff regarding issues affecting women veteran. These include: videos, oral briefings and written literature. In addition to activities noted above, numerous local facilities and VISNs have hosted women's health clinical updates and mini-residencies that have included presentations on sexual trauma, abuse and domestic violence targeting women's health care provider audiences. Additionally, VISNs have a designated lead WVC who participates in the identification and development of VISN women's health educational opportunities.*

VBA requires all new VSR to attend their centralized National "Opportunity" Training Program during which they receive a presentation by a representative from the CWV who covers women veterans issues, including, sensitivity concerns and sexual trauma counseling.

The “One VA” New Employee Orientation Program is conducted quarterly for employees new to VA Central Office (VACO) within the last 90 days. During the program, information concerning the active VACO Federal Women’s Program (FWP) is presented and information flyers about the FWP are included in the folders prepared for participants. In addition, all employees are required to attend prevention of sexual harassment and ethics training, which are offered separately as part of the overall new employee orientation program. The day-long orientation program also includes a separate segment on the Employee Assistance Program (EAP). This session is presented by a trained social worker from the VACO Health Unit. The EAP counselor is available to provide short-term counseling to all employees on matters of personal concern such as mental and emotional distress, self-esteem, and family issues. In addition, employees may receive referrals to an outside resource/professional.

CURRENT STATUS: A section on women veterans’ issues will be incorporated into the “One VA” new employee orientation program.

16. Require VBA and BVA, to develop a standard of accountability for training of all personnel who handle gender-specific disability claims, including claims for disability secondary to sexual trauma.

***VA Response:** VBA provides regional office staff access to copies of satellite broadcasts and training letters; and has established an extensive Intranet training site, which is accessible and utilized by all VBA staff. These materials allow the regional offices to conduct either initial or refresher training as needed. Compensation and Pension Service also continues to develop and enhance the VBA women veterans coordinators Intranet Web site to include additional training tools specific to issues related to sexual trauma, sensitivity, and women-specific rating issues.*

BVA will include information on these issues in its training programs and will work closely with the CWV and the Advisory Committee to ensure that the information referred to in the rationale section of Recommendation 16 is incorporated into and utilized in BVA training.

VBA and BVA have conducted numerous joint training initiatives. Additionally, the training tools described above are also available to BVA employees.

CURRENT STATUS: The Board will work with the Advisory Committee to establish standards of accountability for training. This will be discussed more in the 2002 report of the Advisory Committee on Women Veterans.

F. SELECTED RESERVE AND NATIONAL GUARD BENEFITS

17. Provide a briefing to the Committee on the findings and recommendations of the VA-Department of Defense (DOD) Task Force convened to study the need for sexual trauma services by members of the Selected Reserve and National Guard.

VA Response: *The study on the extent to which members of the Selected Reserve and National Guard need sexual trauma services is currently under development by the National Center for Post Traumatic Stress Disorder (PTSD), Women's Health Sciences Division, VAMC Boston, MA; the Executive Division, VAMROC White River Junction, VT; and the Center for Health Quality Outcomes and Economic Research (CHQOER), VAMC Bedford, MA. The projected completion date of this study is March 2003. VHA will be happy to provide a briefing to the Committee when the study is completed.*

CURRENT STATUS: The telephone survey form is completed, and the status will be discussed in the 2002 report of the Advisory Committee on Women Veterans.

18. Ensure that all military personnel, including Selected Reserve forces and members of the National Guard, receive basic VA benefit information including appropriate points-of-contact unique to their situation at the time of separation.

VA Response: *VBA Manual M-21-1, Part VII, 6.08c. specifically addresses VBA's outreach responsibilities as they apply to the National Guard and Selected Reserve through the Military Services Program. Regional office staffs offer benefits counseling and information briefings to military units located within their State jurisdiction. They also offer training programs and seminars for the local military training officers. Training sessions may include both state and local benefits.*

CURRENT STATUS: VA, DOD and DOL continually brief military personnel. This recommendation is in the process of being implemented.

G. NATIONAL CEMETERY ADMINISTRATION

19. Disseminate information to all veterans about the availability of side-by-side burial for veterans married to veterans. Additional opportunities to serve dual veteran couples should be sought.

VA Response: *National Cemetery Administration (NCA) distributes information about memorial benefits at the local, state and national veterans service organizations programs, county and state agencies and venues specifically geared to providers of burial services.*

CURRENT STATUS: NCA is open to any suggestions the Advisory Committee may have in regards to other outreach avenues. This recommendation is in the process of being implemented.

H. EMPLOYMENT OF WOMEN VETERANS IN THE FEDERAL GOVERNMENT

20. Recruit and hire qualified women veterans, with emphasis on identifying qualified minority women for positions within VA. Include senior executive service positions, political appointee positions and membership on special boards and committees.

21. Encourage other Federal agencies to recruit and hire qualified women veterans.

VA Response: *(Covers 20 and 21) As of January 31, 2001, VA employed 68 women in senior executive positions. This includes Senior Executive Service (SES) and Title 38 equivalent executive positions. Of the 68, 13 are minorities. Forty percent of the Department's Performance Review Board are women, and 37 percent of the Department's Executive Resources Board are women. VA continues to pursue the employment of women in executive level positions. Women veterans comprise 3.7 percent of VA's total workforce, 242 are in grades 13 or above. Minority women veterans comprise 40 percent of the women veterans employed by VA, of which 8 percent are in grades 13 or higher.*

CURRENT STATUS: The number of women veterans has increased since the last report, and the change will be reflected in the 2002 report of the Advisory Committee on Women Veterans. This recommendation is in the process of being implemented.

22. Request the Secretary at the Department of Labor (DOL) to encourage the Veterans Employment and Training Service (VETS) to recruit and hire qualified women veterans to fill vacant positions in the Disabled Veterans Outreach Program (DVOP) and to hire women veterans as Local Veterans Employment Representatives (LVERs) throughout its workforce network.

VA Response: *The Secretary will convey the Committee's recommendation to the Secretary of Labor.*

CURRENT STATUS: This recommendation will be aggressively pursued with DOL, and the status will be provided in the 2002 report of the Advisory Committee on Women Veterans. This recommendation is outside VA's jurisdiction and has been referred.

23. Encourage collaboration between VBA and DOL VETS to ensure that Native American women veterans have access to Federal employment programs and services.

VA Response: *The Secretary will convey the Committee's recommendation to the Secretary of Labor.*

CURRENT STATUS: This recommendation will be aggressively pursued with DOL and BVA, and the status will be provided in the 2002 report of the Advisory Committee on Women Veterans. This recommendation is outside VA's jurisdiction and has been referred.

24. Work with local tribal program officials to ensure Native American women veterans have access to vocational rehabilitation services.

VA Response: *The VBA Vocational Rehabilitation and Employment Service recognizes the increased need for outreach to all Native American veterans and added this issue as a scope of access initiative.*

CURRENT STATUS: Recommendation is being implemented. Additional information will be forthcoming.

I. EDUCATION

25. Work with Congress to develop legislation to extend the regulatory time to use GI Bill benefits for all periods of service from 10 years to 20 years.

VA Response: *VA is cognizant of the need to make meaningful improvements to the GI Bill to ensure that it is relevant to serve as an incentive to broaden the spectrum of individuals entering the military and improve the ranks of veterans seeking to attain their educational goals. The Congressional Commission on Service Members and Veterans Transition Assistance reviewed a number of proposals, including the 10-year eligibility period, but focused on the importance of assuring the GI Bill will enable a veteran to meet college costs. Likewise, VA*

has been reviewing various legislative measures that would enhance the Montgomery GI Bill for this purpose. At some time in the future, VA may wish to address other GI Bill enhancements, including the Committee's recommended extension of the period a veteran has to use his or her education benefits.

CURRENT STATUS: The issue is currently under discussion within the Department. An update will be provided in the 2002 report of the Advisory Committee on Women Veterans. This recommendation is in the process of being implemented.

PART V

CONTINUING CONCERNS

The following represents issues the Advisory Committee on Women Veterans has addressed in previous reports. As of this report, these issues have not been thoroughly addressed by legislative or programmatic responses. The Advisory Committee has identified these issues as areas of continued concern and requests that VA provide annual updates on the progress made in addressing them:

1. Development and authorization status of legislation to permit MEDICARE subvention for VA health care programs and services. Including assurance that funds recovered under this reimbursement program are retained by VA as resources to support and enhance medical care for all veterans.
2. Establish women veterans councils within all VISNs and each health care facility. These councils will provide guidance and assistance in assuring that local programs and services are responsive to the needs of the women veteran community. The Council membership should include VA personnel from the medical facility, VET center and VBA regional office, in addition to women veterans, including minority women and disabled women veteran stakeholders. The Committee understands that VHA is planning a survey to determine the existence and membership composition of such groups in its field facilities. The Committee looks forward to reviewing the results of this survey.
3. Include women veterans of color in all aspects of VA health care research and demographic studies that impact women's health. The Committee will continue to monitor these issues and request periodic updates from relevant VA program officials.
4. Establish and maintain a consistent level of staff training focusing on treatment protocols, sensitivity concerns, and other issues instrumental to providing effective sexual trauma counseling. Continue to educate staff within VA to ensure quality of care for all veterans. Participants should include clinical personnel, readjustment counseling service, and Veterans Benefits Administration regional offices.
5. Monitor the effectiveness of VA outreach to minority women veterans including Native American women veterans living on and off the reservations.

6. Include gender-specific information in all research studies and surveys sponsored funded or conducted by VA.
7. Identify and eliminate barriers women veterans may experience in accessing VA benefits and services. The Committee requests a briefing on the results of the "National Study on Barriers to VA Care for Women Veterans," including any recommendations that may have evolved from this study.
8. Provide inpatient psychiatric care for women veterans within each VISN catchments area.
9. Ensure equitable representation of women veterans in leadership positions within the Department of Veterans Affairs. The Advisory Committee on Women Veterans will monitor the progress in this area through personnel reports that provide demographic data reflecting the number and percentage of women veterans, from the highest ranks, and include those appointed to VA work groups, task forces, advisory committees and as consultants. This data will also include the status of minority women veterans.
10. Continue the position of women veterans deputy field director in VHA. The Committee endorses and will continue to monitor the continuation of these positions.

PART VI

APPENDICES

Appendix A
Historical Perspective

Appendix B
Site Visit Summaries

Appendix C
Survey of Perceptions and Trends

Appendix D
Briefings to the Advisory Committee on Women Veterans

APPENDIX A

HISTORICAL PERSPECTIVE

In 1993, as the Department of Veterans Affairs (VA) became more aware of the needs of women veterans, then Secretary Jesse Brown established the first VA Women Veterans Program Office. Within months of the establishment of this Office, Congress passed PL 103-446, which established the Center for Women Veterans. The Center was structured to report directly to the Secretary and tasked to provide consultation and advice on all issues affecting women veterans. Joan A. Furey, a Vietnam veteran, was appointed as the first Director of the Center. Since its inception in 1995, the Center for Women Veterans has maintained high visibility and credibility within the veteran community. Center staff has contributed to the increased effectiveness of women veterans programs, improved service delivery to women veterans and provided a venue for communications between VA and women veterans.

The establishment of the Center, with a focus on women veterans, has resulted in many new initiatives such as research studies, wellness programs and outreach activities that have enhanced services and programs to the growing numbers of women veterans. Research and data began to emerge which captured the realities of the experiences of women who served in the military. Not only did these new endeavors better define women veterans and their health needs, they also provided information for strategic planning and the development of effective and appropriate treatment programs for these veterans. In 1994, the National Center for Post-Traumatic Stress Disorder (PTSD), created a Women's Health Sciences Division at the Boston VA Medical Center. This innovative program, which is dedicated to addressing gender-specific issues linked to PTSD, was designed to study the interactions of stress, trauma and personal assault, and the residual health problems that were related to a woman's service in the military. In that same year, the VA Health Services Research and Development Service began developing a national registry of women veterans for the purpose of identifying all women separated from military service since January 1, 1942. The registry was designed to provide a pool of names for researchers to use when attempting to study women veterans. Other studies investigated the perceptions and experiences of women veterans in their efforts to access VA health care systems, quality of life and the unmet needs of women veterans.

In 1995, VA health care services underwent a sweeping reorganization that was designed to shift the focus of delivery systems from a disease-oriented model to a more holistic primary care approach. Just as gender-specific care for women veterans was finally becoming part of VA's thinking, the concept of mainstreaming and reducing specialized services threatened the hard-won progress to improve health care for women veterans. This reorganization heightened the resolve of the

Advisory Committee on Women Veterans to closely monitor changes in women veterans health services to assure that standards of care were not being compromised. To best assess the effects of the VA reorganization, Committee members increased communication with women veterans; increased individual site visits to VA facilities; and provided briefings to Congressional members and staff. In September 1996, the first "National Summit on Women Veterans Issues" brought together women veterans and other interested parties to discuss and identify solutions to the many and diverse problems encountered by women veterans. This Summit marked the first time women veterans from across the Nation had the opportunity to come together with policymakers and VA officials. The fruits of this dialogue became the focus of the Advisory Committee's activities for the ensuing years.

In October 1997, thousands of women veterans converged on Washington, DC, to celebrate the dedication of the Women in Military Service for America Memorial, located at the entrance to Arlington National Cemetery. Women veterans from every period of war and those that served in peacetime, every service and every rank joined together to remember the past and celebrate the future. This event sparked more events to honor the service of women who had served in the military.

In 1998, we observed the 50th anniversary of the signing of the Women's Armed Forces Integration Act, which gave permanent status to women in all Regular and Selected Reserve components of the four military services. That same year, VA completed the Women Vietnam Veterans Reproductive Outcome Study that compared the birth outcomes of over 4,000 women veterans who served in Vietnam and an equal number of their counterparts who did not serve in-country but served during the Vietnam Era.

Results released in 1999, indicated that the children born to women who served in Vietnam had higher rates of birth defects than the children born to Era-women veterans. These findings were so striking that Congress held a series of Hearings on the subject and several members of the House and Senate introduced legislation to compensate children with birth defects born to mothers who served in Vietnam. Both VA and the Advisory Committee on Women Veterans strongly supported these measures.

The dawn of the new Millennium also marked the 50th anniversary of the beginning of the Korean War and the 25th anniversary of the end of the Vietnam War. Along with these historic benchmarks, the number of women serving in the active and reserve components of the United States Armed Forces continues to increase.

The Advisory Committee on Women Veterans endeavored to make comprehensive assessments of the evolving needs of women veterans. For the first time, a Subcommittee on Minority Women Veterans was established within the Advisory Committee on Women Veterans. This Subcommittee focused attention and awareness on the special needs of the growing numbers of women of color serving in the Armed Forces.

VA's decision to provide prenatal and obstetrical care to eligible women veterans signaled a new era for the Department of Veterans Affairs. Although maternity care could not be provided in-house, arrangements for these services with other providers proved to be especially challenging since there were no provisions for the care of the newborn infant. To better assure quality of care, the dilemma of securing care for the infants was resolved using a case-by-case basis.

During FY 2000, VA allocated, for the first time, \$3 million to support programs for women veterans who are homeless. This funding was used to establish 11 demonstration programs designed to meet the clinical, social and economical needs of women veterans who are homeless and provide supportive services required to help this growing population. The sites, selected through a national request for funding proposal process, are located in Boston, MA; Atlanta, GA; New York, NY; Tampa, FL; Cleveland, OH; Cincinnati, OH; Dallas and Houston, TX; Los Angeles and San Francisco, CA; and Seattle, WA.

Although the Advisory Committee on Women Veterans had repeatedly recommended lifting the Sunset Provision for the sexual trauma-counseling program, Congress elected only to extend the authority until December 31, 2004. To assess the need for additional resources, VA convened two task forces. One was designed to study the necessity for inpatient psychiatric units for women veterans within each VISN and the other to study the need to extend sexual trauma counseling to Reservists who may have been victimized while on inactive duty training days.

During the Spring 2000, the Senate and House Veterans Affairs Committees called upon the Chair of the Advisory Committee on Women Veterans to present testimony at three Congressional hearings that were convened explicitly to consider legislative remedies on issues that pertained exclusively to women veterans. As a result of findings from the VA Women Vietnam Veteran Reproductive Study, Congress examined the question of compensating the children with birth defects born to mothers who served in Vietnam. The House Veterans Affairs Committee also held a June 8, 2000, Special Hearing to review all the recommendations made by the Advisory Committee on Women Veterans in the 1998 Report to Congress. Legislators were particularly interested in the recommendation to authorize Special Monthly Compensation (SMC-k) to women veterans who receive VA service-connected compensation benefits for mastectomy. As a result of these hearings and the cooperative efforts of

Congress, Veterans Benefits Administration, the Center for Women Veterans and the Advisory Committee on Women Veterans, legislation authorizing SMC-k for women veterans with a service-connected mastectomy and compensation for children with birth defects born to women Vietnam veterans was passed and signed into law. These legislative measures are historic, as they mark the first time Congress formally acknowledged that men and women could have different physiological and psychological responses to the same illness or disability. This clearly established a precedent that opens the door for future consideration of health as it relates to gender.

The Women Veterans Summit 2000, held in June of that year, signaled yet another milestone in the emergence of the expressed needs of women veterans. Hundreds of women veterans came together for three days of briefings and workshops to identify unmet needs and approaches to improving present programs and services for the future and to celebrate a legacy forged by them and the women veterans of the 20th Century.

APPENDIX B

SITE VISIT SUMMARIES

Advisory Committee on Women Veterans Members conducted 7 individual site visits during this reporting period. Members visited VA facilities as follows:

Wichita, KS, Medical Center and Regional Office
Leavenworth, KS, Eastern Kansas Health Care Center
Seattle, WA, Puget Sound Health Care System
Tampa, FL, Medical Center's Women Veterans Health Care Program
Fayetteville, NC, Medical Center
Houston, TX, Medical Center and Regional Office
Washington, DC, Medical Center

The full Committee visited VA facilities in Chicago and Seattle.

The sites visited had developed many programs addressing women veterans issues in positive ways, although some negative issues were identified. However, the Committee found that for every negative issue that was encountered, there was another site that addressed that same issue and had a positive outcome. Many of the issues requiring attention were within the control of local facility management; however, some appeared to require attention from the Network or Headquarters level. The few issues requiring VA attention are specified as follows:

A) ROLE CLARIFICATION

The need to have the women veterans coordinator (WVC) position classified as a full-time position was a consistent theme. The Committee was advised that the WVC position carried with it substantial administrative burdens, particularly with the generation of reports coupled with other duties associated with the clinical practice. Most reports stressed the need for the coordinator to have a clinical background in order to be more effective in identifying the health care resources a woman veteran required. It is the Committee's belief, which is shared by various field personnel, that WVCs must have access to the senior leadership at their facility if they are to be effective in addressing women veterans issues. Unfortunately, many WVCs did not have the direct input on matters relating to their duties and assignments.

The effectiveness of women veterans councils varied from facility to facility. Although each facility had an established council, some never actually met. Council members at some facilities expressed frustration because minutes were not taken at meetings, nor were they generated or distributed. Other councils

were highly successful in assisting their facilities with identifying specific patient care needs. A number of facilities had no apparent procedures for tracking the councils' meetings and the status of any recommendations made. Membership was found to be inconsistent, and there were no known standards or administrative procedures for their operation. This appears to be a VA system-wide issue.

B) MECHANICS

Specific goals on women veterans' issues are not included in all of the VA facilities strategic plans. The identification of these goals would be useful in addressing the concerns and fears of women veterans that women veteran programs will be cut because of budget constraints.

There is a strong need for the establishment and maintenance of data collection systems and other vehicles that would help facilities predict the future needs of women veterans. Correctly projecting the potential numbers of future clients will aid planners in identifying emerging needs.

There is evidence of confusion surrounding eligibility criteria. Some women veterans encountered barriers in accessing treatment because of confusion over eligibility criteria, e.g., a woman veteran was denied hospitalization for PTSD due to sexual trauma, because she served less than two years in the military.

Authorization of maternity and obstetrical care should take into consideration the comprehensive care of infant and mother. Since VA is not authorized to allocate resources for non-veteran newborns, significant issues arise around the care of newborns, as well as spousal involvement in infertility treatment. Both of these limitations could have an impact on the well being of a woman veteran.

Privacy issues continue to remain an area of concern for many women veterans. Newer VA facilities are better able to address women veterans privacy needs than older facilities, as they are more likely to have private rooms with baths and dedicated waiting areas for the women's clinics. Older facilities continue to work to resolve privacy issues. Adding to the concerns for privacy was the need to move patients to various rooms during their stay in order to accommodate new admissions.

Generally the canteens were well stocked with women's items. Those items not in stock could be ordered through the canteen staff.

C) STANDARDS

Considerable concern was expressed over the length of time it takes veterans to get specialized care. There was particular concern over the waiting times for gynecological care and access to providers with exceptional reputations in a specific area of practice. (e.g., women's health and sexual trauma counseling). The main confusion appears to be over an acceptable wait-period for specialty care. This confusion is made worse when the veteran requests a specific provider. Concern was also expressed about the risk of "high profile" providers suffering "burn out" from carrying a heavy caseload.

VA health care providers, at several of the facilities visited, would benefit from sensitivity training on the needs of women veterans and other minority groups.

Access to care, especially in remote areas, is a major issue among the veterans of this area. Some reflected a desire for mobile treatment teams in both primary and mental health care.

The Advisory Committee observed a number of VA facilities provided care to active duty military personnel. Although this practice is viewed in a positive light, and there is interest in extending this service to more active duty military personnel, the Committee is concerned about the ability of the facilities to provide enough health care professionals to accommodate this additional patient population. There was particular concern among the veteran population about the number of providers skilled in such areas as substance abuse and/or PTSD treatment. Although some of the provider "shortfall" is made up through the fee-basis program, concern was expressed about the standards used to determine what level of patient demand/volume would warrant the recruitment of specialty providers (e.g., gynecologist) to enhance existing staff skills.

D) OUTREACH

Outreach was mentioned in every report. Several sites had robust programs that connected with women veterans. A number discussed the possibility of partnering with veterans service organizations to identify women veterans and/or focus assets on priority needs. In most locations, women veterans were not aware of the availability of the women veterans coordinator or the existence of the women veterans councils. Many stated they did not know how, where or to whom they could express misgivings or particular concerns about their treatment.

Outreach to active duty women was a particular concern among the women veterans. Many mentioned that women leaving the Armed Forces are not made aware of their VA entitlements and that they are eligible for VA health care services. Although there are some programs available to increase service

members' awareness of their benefit eligibility, more needs to be done in the area of providing this information to separating service women.

Outreach programs and their effectiveness for women veterans who are homeless varies by location. More needs to be done to educate staff (VA and non-VA) that work with the homeless population that there is a need to ask women if they are veterans.

SUMMARY

Each of the 7 sites visited had many programs of which staff members and VA could be proud; however, the potential to improve always exists. The Advisory Committee believes that sharing success stories with one another is one way VA facilities can do this. Identifying specific levels of VA management - local, network or national - responsible for addressing specific issues can facilitate progress and improve services.

APPENDIX C

SURVEY ON PERCEPTIONS AND TRENDS

During *Summit 2000*, women veterans were asked to respond to a survey that was developed by the Advisory Committee as a tool to gauge sentiments about VA services and programs. Although the response number was small, the Advisory Committee can consider the results as a “snapshot in time” and as an instrument for gaining some insight into the thinking of the respondents. When they evaluated their experiences in VA medical centers or outpatient clinics, VA received high marks for the following:

- Interpersonal skills
- Knowledge about health problems specific to women
- Recognition of the veteran status of the women
- Patient education

Sensitivity to the woman veteran was marginal. The most frequent complaint concerned long waiting times for clinical appointments, difficulty in getting a clinic appointment within a reasonable time, and of primary concern, the rude and chauvinistic treatment received from some male physicians.

A majority of the respondents identified physical safety, privacy and confidentiality as major concerns. One woman referred to her inpatient stay as: *“Psychiatric care is essential for many women veterans. To place a woman on the same ward (in a private room) as men, when she is suffering from sexual trauma /PTSD and depression only fuels more problems. The nurses had to watch me all the time because I was the only woman on the ward, and it was full at the time with male patients. While an inpatient I had to go to group – only woman- I said nothing. I just wanted to go home and continue my care elsewhere. I will say that my female counselor is great so I am pleased with care.”* Another wrote, *“MD’s and RN’s talk about patients in the hallway. Make negative comments about patients.”*

Although not all of the respondents had contact with VA regional offices, the women who did gave high ratings for:

- Sensitivity
- Recognition of veteran status
- Interpersonal skills

The most notable complaints were made relative to the excessive processing times related to disability claims and obtaining rulings from the Board of Veterans Appeals.

Some women took the opportunity to use the survey to express their reaction to the *Summit 2000*. For example: *"The Summit is a great way for women veterans to receive information concerning benefits and updates. There should be a summit every 2 to 4 years for these concerns to be addressed. Suggest that veteran info be updated on a regular basis on web page."* Another respondent indicated: *"The Summit was quite an educational experience and was enriching. Putting human faces in such a large bureaucracy is always rewarding. I only hope that the work done these past few days will result in positive changes that won't take years to be effective. I congratulate the leaders of the Summit on a successful event. I will return!"*

APPENDIX D

BRIEFINGS TO THE ADVISORY COMMITTEE ON WOMEN VETERANS

The Advisory Committee received the following briefings during the period covered by this report:

Center for Women Veterans

Joan Furey, Director: Update on Issues, June 2000

Alice Raatjes, Associate Director: Committee 2000 Budget

Joan Furey: Homeless Initiative for Women Veterans, March 2000

Joan Furey: Update on Initiatives, March 1999

Joan Furey: 1998 Committee Report and Response, 1998

Joan Furey: 1998 Report on Women Veterans' Access to Health Care, 1998

Joan Furey: Committee's Statutory Reporting Requirements, 1998

Office of the Secretary

Susan McHugh, Special Assistant, October 1999

Office of Finance

Kathleen Hamilton, Budget Analyst, October 1999

National Cemetery Administration

Vincent Barile, Deputy Under Secretary for Management: Update and Issues, March 1999

Roger R. Rapp, Deputy Under Secretary for Operations: Overview on the National Cemetery Administration, June 1998

Veterans Benefits Administration

Nora Egan, Deputy Under Secretary for Management and

Robert Epley, Director, Compensation and Pension Service:

Update on Special Monthly Compensation (SMC-k) for Mastectomy, March 2000

Linda Petty, Women Veterans Coordinator: Training Rating Specialists, Replicating the Compensation & Pension Processing Center at Great Lakes, IL, Claims Backlog, March 1999

Joseph Thompson, Under Secretary for Benefits: Update on VBA Issues, October 1999

Nora Egan and Robert Epley: Response to the 1998 Advisory Committee Report and Recommendations, SMC-k for Mastectomy, Duty to Assist, Well-grounded Claims - *Morton v West*, October 1999

Nora Egan: Briefing--Commitment to Women's Issues During VBA Reorganization, June 1998

Linda Petty, Update: Veterans Benefits Initiatives, June 1998

Veterans Health Administration

Carole Turner, Director, Women's Health Programs: Update on the Women's Health Programs and a training tape: "Female Anatomy—Diseases of the Breast" March 2000

Dr. Thomas Garthwaite, Acting Under Secretary for Health: Update on VHA Issues, October 1999

Dr. Susan Mather, Chief Consult for Environmental Medicine and Public Health: Response to 1998 Advisory Committee Recommendations Regarding Women Veterans Health Issues, October 1999

Marsha Hoegle, VISN Support Service Center: Community-based Outpatient Clinics, March 1999

Kathy Zeiler VHA Women's Program: Update on Women's Health Issues, Women's Health Software Package, Maternity and Newborn Care, Eligibility Reform, March 1999

Dr. Thomas Garthwaite, Women's Program Reorganization, June 1998

Kathy Zeiler: Update-Women Veterans Health Program, June 1998

Kenneth Clark, Chief Network Officer: Summary - Network Strategic Plan, 1998-2002, June 1998

Dr. Katherine Skinner, VA Medical Center Bedford, MA: Women Veterans Health Status, June 1998

Dr. Jessica Wolfe, VA Medical Center Boston, MA: Barriers to Care, June 1998

Office of Public Affairs

Everett Chasen, Director, News Service: Role of Public Affairs in Outreach, June 1998

Women Veterans Who Are Homeless

Peter Dougherty, VA Homeless Program: Update on the Program for Veterans who are Homeless, March 1999

Department of Labor

Al Borrego, Assistant Secretary of Labor for Veterans Employment and Training (VETS): Update on Employment and Training, June 1998

Cornelia H. Moore, Regional Administrator, Region 3, Women's Bureau: Update on Initiatives, June 1998

Legislative Initiatives

House Veterans Affairs Committee Members and Staff: Briefing, March 2000

Phil Riggin, Deputy Assistant Secretary for Congressional Affairs: Briefing, March 1998

Majority and Minority Staff Directors, House Committee on Veterans' Affairs: Briefing, June 1998

Minority Veterans Issues

Constance Evans, Member of the Advisory Committee on Women Veterans: Briefing on Native American Veterans' Issues, March 2000

Willie Hensley, Director, Center for Minority Veterans: Overview on the Center for Minority Veterans; Briefings: Oneida Sharing Agreement, Establishment of Vet Centers on Reservations, Outreach to Native American women, Benefits Manual in Spanish language, Tracking Compensation and Pension Awards by Ethnicity June 1998

Research and Surveys

Dr. Jessica Wolfe: Women Veterans Health Status Survey - Initial findings, March 1999

Dr. Susan Mather: Update on Gulf War Illness—Current Research and Treatment, October 1999

Dr. Susan Mather: Vietnam Veterans Reproductive Outcome Study, October 1999

H. David Burge, Center for Veterans Analysis & Statistics: Survey of Veterans
June 1998

Rebecca Klemm, Klemm Analysis Group: Research on Gulf War Illness—Women
Veterans, June 1998

Sexual Trauma Counseling Services

Charles Flora, Deputy Director, Readjustment Counseling Services: Response to
1998 Committee Recommendations, Update on sexual trauma counseling

Charles Flora: Update and issues, March 1999

Charles Flora: Services for Women, June 1998

Site Visits: Specific Briefings and Meetings

Puget Sound Area—June 1999

- VISN 20 - Overview and Initiatives: Tim Williams, Chief Executive Officer; Dr. Smith, Chief Medical Officer; Sandy Nelson, Chief Operations Officer
- Addictions Treatment Center: Gail Rowe, Ph.D.
- Overview of VA Puget Sound Health Care System (PSHCS) Women's Programs: Georgia Vitense, Women Veterans Coordinator
- VA PSHCS Research on Women Veterans: Dr. Kathy Bradley and Dr. Kay Johnson, Seattle Women's Clinic
- Meeting with VA PSHCS Women Veterans Coordinators
- Outreach Efforts: Frankie Manning and Steve Linden
- Community-Based Outpatient Clinic Visit
- PTSD and Mental Health Issues: Dr. Kathie Larsen, Dr. Miles McFall, Anne Gregory, Dr. Dale Smith, Dr Robert Barnes, Dr. Andre Tapp, Marcia Vergin, Seattle VET Center; Ron Boxmeyer, Joan Fiset and Debra Bretey, Tacoma VET Center; Amy Truscot, VBA Regional Office
- Mental Health Clinic Tour
- Compensation and Pension Examination Process: John Beckham and Peggy Standring

- Gulf War Veterans: Dr. Cindy Dougherty and Debbi Strako
- VBA Regional Office Briefings and Discussions
- Homeless Program: Alan Castle, Mary Hammons, Linda McKendry
- Tour Theodora Shelter
- Tour Seattle VET Center
- Tahoma National Cemetery Tour and Briefing
- Tours and Briefings at American Lake VAMC
- Women's Clinic: Dr. Loueen Boyle
- Extended Care and Alzheimer's Program: Dr. Sharon Falzgraf, Dr. S Asthana; Mental Health and Blind Rehabilitation: Dr. Andre Tapp, Dr. Dale Smit, Dr. Richard Pollar, Connie Hyndman, Anne Gregory, and Mike Weatherly
- Domiciliary: Jim Burke
- Homeless: Dave Hamilton and Chaplain Norm Waer
- Compensated Work Therapy Therapeutic Residence: Bill Farless
- Minority Women Issues - Native American Women Veterans
- Forum with Native American Veterans
- Tour VET Center, Tacoma
- Visit Mandela House Shelter
- Women Veterans Town Hall Meeting

Chicago—September 1998

- VISN 12 overview, including Women's Health Programs and VA Hines Veterans Programs and Services: Renee Oshinski, VISN 12 Chief Financial Officer; Dr. Gwen Garmon, Women's Health Programs; John Denardo, VA Hospital Director; Dr. Gary Almy, Chief of Staff;

Dr. Laura Nosek, Associate Director for Clinical Administration; Jacqueline Kuchyak, Associate Director for Administrative Support

- Hines Women Veterans Programs and Services, Dr. Gail Welch, Women's Health Director; Diane Shearod, Women Veterans Coordinator
- Tours and Briefings at West Side and Lakeside, VAMC
- Community-based Outpatient Clinic Tour
- VET Center Tour and Discussion of Community Resources and Homeless Shelters
- VBA Regional Office Discussions: Michael Olsen, Director; John McCourt, Assistant Director; Sheila Henderson, VBA Women Veterans Coordinator; Veronica Bevis, Trauma Rating Specialist
- National Cemetery Administration Overview: William Murphy, Director, Abraham Lincoln National Cemetery
- Chicago Veterans Advisory Council Meeting
- Tour and Briefing on Compensation and Pension Program, North Chicago
- Women Veterans Open Forum, North Chicago
- Tour and Discussions at Evanston VET Center
- Women Veterans Open Forum, West Side Division

Veterans Service Organizations

- Veterans Service Organization Liaison, Allen Kent, June 1998