

**DEPARTMENT OF
VETERANS AFFAIRS**

**ADVISORY COMMITTEE ON WOMEN
VETERANS
REPORT 2008**

***Recognizing Women Veterans...
American Heroes***

AUGUST 2008

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DEPARTMENT OF VETERANS AFFAIRS
Center for Women Veterans
Washington DC 20420

June 30, 2008

The Honorable James B. Peake
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

I am pleased to provide you with the 2008 Report of the Advisory Committee on Women Veterans (Committee). This Report contains an overview of the Committee's evaluations and recommendations for the enhancement of programs and services for women veterans administered by the Department of Veterans Affairs (VA).

The Committee brings immeasurable expertise to collaboratively support VA's initiatives to serve women veterans who have demonstrated fidelity, courage, dedication, and unconditional commitment to serve our great nation. As we continue to transform in the 21st century, it is clear that a large number of women play an integral part in all branches of the U.S. Armed Forces and provide value chains of excellence to strengthen our war fighting capabilities and force protection.

Statistical data and various reports show that over the past few years, VA has experienced a growing number of women veterans seeking health care and other services through its various benefits and health care programs. The new and complex needs of today's women veterans, particularly those who served in Operations Enduring and Iraqi Freedom, require that VA assess the effectiveness of its existing gender specific programs and initiate new ones that strategically address the many needs of this cohort in a way that is inviting, compassionate, and demonstrate a driven yield toward the best outcomes.

The Committee strongly believes that this 2008 Report delineates 20 rigorously studied recommendations and rationales that can provide constructive strategies to enhance VA's ongoing initiatives and programs to address the benefits and health care needs of women veterans. It is clearly recognized that the outstanding accomplishments of this Committee could not have been achieved without the tireless support from the Director and staff of the Center for Women Veterans, the Women Veterans Strategic Health Care Group, and the valuable insight from our ex-officio members and advisors.

I am honored to have served as the Chair of the Advisory Committee on Women Veterans. On behalf of this Committee, I extend my deepest gratitude and

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Secretary James B. Peake

appreciation to you for allowing us to serve our fellow comrades. We must and we will succeed in our efforts to provide high quality health care and benefits "second to none" for our women veterans.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Shirley A. Quarles".

Shirley A. Quarles, R.N., Ed.D
Colonel, USAR
Chair, Advisory Committee on Women Veterans

Enclosure

PART I

Executive Summary

The 2008 Report of the Advisory Committee on Women Veterans provides recommendations and supporting rationales that address the following issues:

- Behavioral and Mental Health Care
- Health Care
- Veterans Benefits Administration
- Outreach
- Training
- Women's Health
- Women Veterans Program Managers and Women Veterans Coordinators
- VA National Cemetery Administration
- Women Veterans Who are Homeless
- Business

The report of the Advisory Committee on Women Veterans (Committee) is submitted biennially by the Committee. The Committee is appointed by the Secretary of Veterans Affairs (Secretary) for a 2- or 3-year term. Current Committee membership includes representation by veterans from the Air Force, Navy, Army and Marine Corps, as well as the Reserves. Members represent a variety of military career fields and possess extensive military experience, to include service in the Vietnam War, the Persian Gulf War, and Operation Enduring Freedom/Operation Iraqi Freedom.

A total of 20 recommendations with supporting rationale, as well as responses from the Department of Veterans Affairs (VA), are provided in this report. Recommendations stem from data and information gathered in exchange with VA officials, Department of Labor (DOL) officials, members of House and Senate Congressional Committee staff offices, women veterans, researchers, veterans service organizations, internal VA reports, and site visits to Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) facilities. The Committee feels confident that the 20 recommendations and supporting rationale will reflect value-added ways for VA to strategically and efficiently address many needs of women veterans.

Highlights

- That general mental health care providers are located within the women's clinic during hours of operation to facilitate the delivery of mental health services.

- That VA provides veterans with therapy and readjustment counseling that includes family members when clinically indicated, not only at Vet Centers but also at VA medical centers (VAMCs). Eligible married women veterans and those with children deserve therapy delivered by professionals with the credentials and the experience to deliver family, couples, and marriage therapy when it is likely to foster positive mental health outcomes and smooth women veterans' readjustment.
- That women veterans, upon their request, have access to female mental health professionals, and if necessary, use fee basis to meet the veteran's needs. This is particularly important when the woman veteran has had a personal history of sexual trauma.
- That the position of Women Veteran Program Manager (WVPM) is established as a permanent full-time management position in all VA medical centers.
- That VA regional office (VARO) directors be required to provide Women Veterans Coordinators (WVCs) a designated number of protected administrative hours per week to provide direct assistance to women veterans.
- That VBA establishes a method to identify and track outcomes for all claims involving personal assault trauma, regardless of the resulting disability, such as PTSD, depression, or anxiety.
- That VA update its Web site to provide sufficient information for women veterans to locate and contact the Health Care for Homeless Veterans (HCHV) coordinator or alternate in their respective regions in order to find immediate shelter regardless of the time of day or night her need arises.
- That NCA enhance targeted outreach efforts in those areas where burial usage by women veterans does not reflect the women veterans' population by proactively providing burial benefits information to women veterans, their spouses, and their children.
- That the Center for Veterans Enterprise (CVE) establish procedures and systems to enable the routine collection and reporting of data specific to women veteran-owned businesses, including verification of other statuses such as minority or service-disabled, which may enable increased access to Federal contracts.

PART II

Summary of Recommendations

1. That the Veterans Health Administration (VHA) establishes a domestic violence (intimate partner violence) program under the Women's Mental Health Program in the Office of Mental Health Services and include domestic violence initiatives in VA's Uniform Mental Health Services Package.
2. That general mental health care providers are located within the women's clinic during hours of operation to facilitate the delivery of mental health services.
3. That VA provides veterans with therapy and readjustment counseling that includes family members when clinically indicated, not only at Vet Centers but also at VAMCs. Eligible married women veterans and those with children deserve therapy delivered by professionals with the credentials and the experience to deliver family, couples, and marriage therapy when it is likely to foster positive mental health outcomes and smooth women veterans' readjustment.
4. That women veterans, upon their request, have access to female mental health professionals, and if necessary, use fee basis to meet the veteran's needs. This is particularly important when the woman veteran has had a personal history of sexual trauma.
5. That VA supports legislation regarding entitlement of newborns born to women veterans receiving VA maternity benefits. These infants, who are not statutory beneficiaries, should be treated as eligible beneficiaries for purposes of initial neonatal care.
6. That VA provides the Advisory Committee on Women Veterans (ACWV) an annual report, by gender, of clinical quality measures related to the provision of health care to veterans. Recommend VA take measures to assure gender parity related to disease prevention and health promotion.
7. That the Environment of Care (Privacy) Check List is included as a part of VAMCs, Outpatient Clinics, and Community Based Outpatient Clinics (CBOCs) quarterly environmental rounds. Recommend also that the local VAMC WVPM be part of the Environmental Rounds Inspection Team.
8. That VA develops a formal program for tracking of mammography results and follow-up of abnormal mammograms to ensure that women veterans receive consistent, timely, and high-quality care. Request VA Office of Quality and Patient Safety provide ACWV an annual report on the mammography tracking program to include data on timeliness-to-treatment for abnormal results.
9. That the Veterans Benefits Administration (VBA) establishes a method to identify and track outcomes for all claims involving personal assault trauma, regardless of the resulting disability, such as PTSD, depression, or anxiety.

10. That VA reviews, revises, and/or establishes formal processes and policies for consistently developing, producing, and test marketing veteran outreach materials to include all print and electronic media to ensure women veterans are clearly depicted as recipients of VA benefits, health care, and services. Their representation in this media targeted to the general population of veterans should accurately and proportionately reflect the women veterans' population as well.
11. That VA advertises through national media outlets to facilitate the delivery of and promote the awareness of health and benefits programs provided for women veterans and their dependents under laws administered by the Secretary.
12. That VA requests veterans service organizations (VSO) that are recognized by VA for claims processing require training for their service officers in the awareness of and sensitivity to signs of military sexual trauma, domestic violence, and/or personal assault.
13. That VA promotes women veterans' health care through Welcome Home programs for OEF/OIF veterans by incorporating a special track for women veterans. This includes a visit to women's health services and an introduction to the WVPM, or designee.
14. That VA appoints an alternate WVPM who can assume responsibilities when the WVPM is unavailable. Recommend that this alternate receive a minimum of 10 hours training and is a member of the medical center's Women Veterans Advisory Committee. This alternate position should be added to VHA Handbook 1330.02, "Women Veterans Program Manager (WVPM) Position."
15. That the position of WVPM is established as a permanent full-time management position in all VA medical centers.
16. That VARO directors be required to provide Women Veterans Coordinators (WVCs) a designated number of protected administrative hours per week to provide direct assistance to women veterans, collaborate with other coordinators, receive and conduct training, plan and conduct outreach, and accomplish other activities in support of the VBA women veterans program. The specific number of hours would be at the discretion of the director, based on the women veterans' population within the catchment area of the VARO, but in no case would the WVC have less than 10 hours per calendar week to devote to the women veterans program. Further, we recommend all new coordinators be required to participate in WVC orientation upon appointment and that they be allowed to receive ongoing professional development specific to their WVC role.
17. That the VARO directors' performance measures include specific monthly goals to track performance standards for WVCs that ensure key objectives related to the women veterans programs are being achieved. By making them part of the monthly goal evaluation, they will be elevated in importance and reviewed on a regular schedule that will help to ensure focus on the program and successful outreach and assistance to women veterans.
18. That VA update its Web site to provide sufficient information for women veterans to locate and contact the Health Care for Homeless Veterans (HCHV) coordinator or

alternate in their respective regions in order to find immediate shelter regardless of the time of day or night her need arises.

19. That NCA enhance targeted outreach efforts in those areas where burial usage by women veterans does not reflect the women veterans' population by proactively providing burial benefits information to women veterans, their spouses, and their children.
20. That the Center for Veterans Enterprise (CVE) establish procedures and systems to enable the routine collection and reporting of data specific to women veteran-owned businesses, including verification of other statuses such as minority or service-disabled, which may enable increased access to Federal contracts.

PART III

Recommendations, Rationales, and VA Responses

A. Behavioral and Mental Health Care

Recommendations:

1. That the Veterans Health Administration (VHA) establishes a domestic violence (intimate partner violence) program under the Women's Mental Health Program in the Office of Mental Health Services and include domestic violence initiatives in VA's Uniform Mental Health Services Package.

Rationale: *Given the societal issues of domestic violence and the growing women veterans population, it is reasonable to expect that VA will be faced with ever increasing numbers of victims of domestic violence.*

The Committee is concerned about the apparent fragmentation, lack of central oversight, and inconsistent local VA medical center (VAMC) resources regarding domestic violence. Women Veterans Program Managers (WVPMs) and Veterans Integrated Service Network (VISN) Lead WVPMs report that domestic violence victims may be assessed and treated differently depending on the individual VAMC. Fact sheets on domestic violence are found on the National Center for Posttraumatic Stress Disorder (PTSD) Web site (<http://www.ncptsd.va.gov>). VA provider training is found as a subchapter under Military Sexual Trauma (MST) training in the MST Veterans Health Initiative (VHI) Independent Study Course on VA's intranet Web site.¹

Central oversight of domestic violence by the Women's Mental Health Program and inclusion in the Uniform Mental Health Services Package should ensure that VAMCs will better serve women veterans who are victims of domestic violence and meet standards for the Joint Commission on Accreditation of Healthcare Organizations, State reporting requirements, and appropriate staff education and training.

VA Response: Concur in principle. While VA concurs that appropriate mental health services and other health care can and should be provided to eligible veterans who are survivors of domestic violence and/or at risk for committing domestic violence because of anger control problems in relation to mental health problems, VA does not concur with the recommendation that VHA establish a separate domestic violence (intimate partner violence) program under the Women's Mental Health Program in the Office of Mental Health Services (OMHS) and include domestic violence initiatives in VA's Uniform Mental Health Services Package. While domestic violence is an important issue, it is not only a mental health issue. A comprehensive domestic violence program provides services far beyond the scope of mental health and other health care issues. For example, a

¹ Kimerling, R.; Briefing to Advisory Committee on Women Veterans; *Intimate Partner Violence*; March 2007

comprehensive domestic violence program would include providing shelters, legal advice, care for children involved, etc.

In addition, mental health staff who work with victims of domestic violence take responsibility to refer such veterans to other health services in VA when relevant and to community agencies that can provide other components of the complex spectrum of services that veterans need that are beyond the scope of health care delivery per se.

Action: VA will continue to provide those mental health services in already-existing mental health programs and make referrals to ensure other non-mental health services also are provided.

Target date: Ongoing

2. That general mental health care providers are located within the women's clinic during hours of operation to facilitate the delivery of mental health services.

Rationale: *The 2007 Veterans' Disability Benefits Commission report reveals that the most common conditions for which VAMCs treated female veterans in 2004 were hypertension, depression, and hyperlipidemia.² The report reveals further that veterans whose primary disability is a mental disorder, suffer not only more mental health problems than the general population, but their physical health is well below the population norm. Of all veterans with mental disabilities, those diagnosed with PTSD had the lowest physical health scores.*

Similarly, studies have found an association between sexual assault history and poorer health status, as well as an increase in the number of medical and psychiatric conditions. Dr. Elizabeth Yano, in an October 2007 briefing to the Advisory Committee on Women Veterans (ACWV) titled, "Update on Women Veterans Health Research: Implications for Practice and Policy on Military Sexual Trauma (MST)," and research conducted by Dr. Rachel Kimerling, "The Veterans Health Administration and Military Sexual Trauma," noted that MST was reported by 22 percent of all women veterans and 14.5 percent of women veterans returning from Iraq and Afghanistan.³

There is a growing initiative in the civilian and VA medical communities to integrate mental health and primary care as a way of enhancing recovery.⁴ It is perceived that combining mental health and primary care will meet the multiple needs of patients.⁵

VA Response: Concur in principle. VA supports the recommendation for integration of primary care and mental health services for women's primary care in VHA. However, currently there is variability in women's clinics across the VA

² Veterans' Disability Benefits Commission; *Honoring the Call to Duty: Veterans Disability Benefits in the 21st Century*; October 2007; p. 50)

³ Kimerling, R., et al; *The Veterans Health Administration and Military Sexual Trauma*; American Journal of Public Health; December 2007; Vol. 97, No. 12:2160)

⁴ Stroul, B.; *Integrating Mental Health Services into Primary Care Settings*; Summary of the Special Forum Health at the 2006 Georgetown University Training Institutes

⁵ Frayne, S. M., et at; *Gender and Use of Care: Planning for Tomorrow's Veterans Health Administration*; Journal of Women's Health; Nov 8, 2007

system in terms of the setting and the scope of services they offer and the extent to which mental health services could be meaningfully incorporated into all existing clinics. For example, some women's clinics provide only pap smears and mammograms, and other primary care services are provided in the general primary care clinic, where mental health staff is integrated. A goal of VA's Mental Health Strategic Plan is to develop collaborative care models for mental health disorders in primary care. VA currently supports both co-located and collaborative models for integrated services, as suggested in this recommendation, as well as care management models. VA's policy is that a blended model incorporating both approaches is the preferred strategy for integrating mental health and primary care. Accordingly, VA supports this approach to integrating mental health and primary care, for female as well as male veterans and we look toward increasing efforts to accomplish this goal.

Action: The OMHS will work with primary care in Patient Care Services (PCS) and the Office of the Deputy Under Secretary for Health for Operations and Management to survey the field to identify the current range of services and best practice models. After a review of survey results are analyzed, recommendations on care models will be developed and implemented.

Also, VA's Quality Enhancement Research Initiative will continue to examine different models of care and approaches for providing mental health services to veterans, including women veterans. For example, a recently funded rapid response project will examine the implementation and sustainability of VA women's mental health clinics as well as women veterans' mental health care preferences, use and experiences. This will help inform the OMHS and PCS about best practices and care models, as well as women veterans' needs and preferences.

Target Date: The survey is expected to be released to the field by January 2009. Results will be reviewed by PCS and OMHS, under the guidance of the Chief Consultant for PCS. Follow-up recommendations will be submitted to the Health Systems Committee and the Principal Deputy Under Secretary for Health (PDUSH). A progress report will be provided to the Advisory Committee on Women Veterans by the end of May 2009.

- 3. That VA provides veterans with therapy and readjustment counseling that includes family members when clinically indicated, not only at Vet Centers but also at VAMCs. Eligible married women veterans and those with children deserve therapy delivered by professionals with the credentials and the experience to deliver family, couples, and marriage therapy when it is likely to foster positive mental health outcomes and smooth women veterans' readjustment.**

Rationale: *VA's mission, to care for our Nation's veterans, has remained fairly consistent over time even though the military force and thereby veterans' demographics have changed considerably over the years. Our military has evolved from a predominantly unmarried, male force to a force of ~15 percent women,⁶ with over half of its service members with family obligations.⁷ Much*

⁶ DoD Active Duty Military Personnel by Rank/Grade; September 30, 2007

like the Department of Defense (DoD), VA must recognize the important role intact families can fulfill in buffering disabled veterans from social stressors as they transition from military to civilian life.

The Committee realizes VA's ability to provide collateral services to family members is significantly restricted by current statute. However, VA must change with the changing demographics of our veterans, adjusting its support and services to meet their needs. This is particularly critical when the stress on veterans and their families is acute due to the uncertainties of war, multiple deployments, and stress related mental health disabilities incurred in combat zones. In testimony to Congress on April 25, 2007, Mental Health America Vice President for Government Affairs Ralph Ibson stated that, "Research on PTSD, for example, has shown that it has had severe, pervasive negative effects on marital adjustment, general family functioning, and the mental health of partners, with high rates of separation and divorce and interpersonal violence. PTSD can also have a substantial impact on veterans' children. This Committee agrees with Mr. Ibson's assertion that VA must include immediate family members in mental health services (when needed) to help foster the veterans' readjustment or recovery. The Committee firmly believes VA must seize this opportunity to learn from the experiences of DoD in the area of family therapy and support as a cost effective means of preventing future, significantly worse mental health outcomes for veterans and their family members.

VA Response: Concur. VA Medical Centers: According to 38 USC 1782, family psychoeducation may be provided to those veterans who are receiving service-connected treatment and their family members as necessary in connection with their treatment. Other veterans and their family members can receive family psychoeducation services only if those services were initiated during the veteran's hospitalization and the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital. Within that legislative guidance, VA fully supports providing family services. To that end, since fiscal year (FY) 2005, the OMHS has provided training to clinicians on two evidence-based models of family psychoeducation – behavioral family therapy and multiple family group therapy. It may be appropriate for older children to participate in family psychoeducation and certainly the clinician can triage the child to recommend a community referral.

Vet Centers: Vet centers provide readjustment counseling to eligible combat veterans and family members when necessary for military-related problems.

Action: Vet centers and medical centers will continue to provide family services to veterans according to Congressional mandates. In addition, training for VA staff on evidence-based approaches to couples and family therapy will continue. Collaboration at the local level between the Vet Centers and medical centers will continue to ensure that the full range of mental health and readjustment counseling are available to veterans and their families. A report will be provided to the Committee covering data on family services provided in medical centers for eligible veterans and their families and number of staff trained in behavioral family therapy and multiple family group therapy.

⁷ *Demographic Profile of the Military Community (2005)*; Office of the Deputy Under Secretary of Defense (Military Community and Family Policy)

Target date: A report with information on family care in mental health settings will be provided in October 2008.

- 4. That women veterans, upon their request, have access to female mental health professionals, and if necessary, use fee basis to meet the veteran's needs. This is particularly important when the woman veteran has had a personal history of sexual trauma.**

Rationale: *We continue to hear from women veterans that many of them prefer same-sex mental health professionals. Some women will even refuse treatment if only male providers are available. Additionally, some women are not comfortable in mixed gendered therapeutic groups. The presence of, or access to, women providers will increase patient satisfaction and provide a more acceptable therapeutic environment for women veterans.*⁸

VA Response: Concur. In accordance with the Uniform Mental Health Services in VA Medical Centers and Clinics Handbook 1160.01, women veterans who are being treated for military sexual trauma-related mental health conditions should have the option of seeing a same-sex mental health provider. Women veterans who are being treated for other mental health conditions should have the option of a consultation from a same-sex provider regarding gender-specific issues (e.g., a women veteran may be in a substance abuse group with a male provider may request to see a female provider to discuss gender specific issues). For some medical centers and clinics, this may require referral to a provider at a nearby VA facility, use of telemedicine, or use of sharing agreements, contract or non-VA fee basis care. The target date in the handbook for full compliance is the end of FY 2009.

Action: The OMHS will work with the Deputy Under Secretary for Health for Operations and Management to develop a mechanism to track availability of women mental health providers and services provided.

Target Date: A report focusing on the progress of VA medical facilities toward compliance with the requirements of the Uniform Mental Health Services Handbook will be provided to ACWV in November 2009.

B. Health Care

Recommendations:

- 5. That VA supports legislation regarding entitlement of newborns born to women veterans receiving VA maternity benefits. These infants, who are not statutory beneficiaries, should be treated as eligible beneficiaries for purposes of initial neonatal care.**

Rationale: *While an infant is not a statutory beneficiary for VA benefits, based on testimony provided by the Principal Deputy Under Secretary for Health, VA*

⁸ Washington, D.L., et al; *Women Veterans' Perceptions and Decision Making about Veterans Affairs Health Care*; Military Medicine; Aug. 2007; 8.:812 2007

should support this benefit.⁹ Currently, eligible women veterans are not provided the cost of care and comprehensive services for their newborns.

There are increasing numbers of women veterans of childbearing age. As of September 30, 2004, there were over 775,000 women veterans under the age of 45.¹⁰ Eighty-six percent of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) women veterans are under age 40. Providing for the cost of maternity services but not also providing for the newborn presents unfair financial burdens to the woman veteran that male veterans do not share.

In DoD medical facilities, ineligible infants born to eligible beneficiaries are covered for newborn care until discharged from the hospital. Since VA has no facilities with obstetrical care and all care must be provided in civilian institutions, women veterans will continue to be at a financial disadvantage.

VA Response: Concur in part. Because newborn infants are not veterans, VA does not currently have statutory authority to provide care. VA gave testimony on May 21, 2008, before the Senate Committee on Veterans' Affairs on section 201 of Senate Bill S2799, which would authorize VA to furnish care to a newborn child of a woman veteran who is receiving VA maternity care. VA supported this provision with modifications so that it applies only to cases where a covered newborn requires neonatal care services immediately after delivery. This authority should not extend to routine well-baby services.

6. That VA provides the ACWV an annual report, by gender, of clinical quality measures related to the provision of health care to veterans. Recommend VA take measures to assure gender parity related to disease prevention and health promotion.

Rationale: Screening rates for cervical and breast cancers are high for women veterans. However, for certain gender neutral prevention programs women's rates are significantly lower than those of men. Data on gender and VHA Performance Measures indicate that men's performance scores were statistically higher than women in colorectal cancer screening, lipid screening, diagnosis of hypertension, diabetes related screenings, influenza vaccinations, and smoking cessation.

Additionally, an evaluation of over 56,000 diabetic veterans receiving care in VA indicated women had significantly lower odds of receipt of pneumonia vaccine, influenza vaccine, and evaluation fasting lipids as compared to men.¹¹ In another study, "Gender Differences in Smoking Cessation Services Received Among Veterans," women veterans were less likely to receive nicotine patches for smoking cessation.¹² Further research is required to determine the reasons for these gender disparities.

⁹ Testimony provided by the Principal Deputy Under Secretary for Health before the Senate Committee on Veterans Affairs; May 21, 2008; S. 2799, Section 201

¹⁰ VetPop 2004

¹¹ Bean-Mayberry, B., et al; *Do Gender and Race Affect Quality of Care in the VA HealthCare System?*; SGIM Annual Meeting; April 2007

¹² Sherman, S., et al; "Gender Differences in Smoking Cessation Services Received Among Veterans;" *Women's Health Issues*; May-June 2005; Volume 15, Issue 3, Pages 126-133

VA Response: Concur. VA recently delivered a "Hospital Quality Report Card" to Congress which provided a breakdown by gender of clinical quality measures tracked across our healthcare system, including Health Efficiency Data Information Set (HEDIS) measures of outpatient preventive services and chronic disease care, behavioral health measures (depression, substance abuse, and PTSD screening) and Joint Commission ORYX® measures of inpatient care. Across a broad variety of measures, the care received by women veterans in the VA health care system appears to be comparable or superior to that received by the average American patient, including provision of gender-specific care such as cervical cancer screening and mammography. Nonetheless, it appears that the care for women in VHA lags behind men in patterns similar to that seen in other health systems. The reasons for such differences are not readily apparent and warrant closer investigation.

VA's Health Services Research and Development Service (HSR&D) in the Office of Research and Development (ORD) has identified quality of care for women veterans and gender disparities in care as important research priorities. In HSR&D's "2008 Priorities for Investigator-Initiated Research," research assessing the quality of care to women veterans is identified as a priority, as is the development and assessment of innovative models of care to improve quality of care. This research is aimed at informing VA policies and programs for women veterans. It will be the foundation for implementation of new practices to foster disease prevention, health promotion and improved health care outcomes for women veterans as well as address any gender disparities. Translation of this research into practice will be facilitated by VA's Quality Enhancement Research Initiative (QUERI) and other ORD and VHA collaborations.

Action: The Office of Quality and Performance in VHA plans additional analysis and research, including augmented sampling of women veterans, to identify possible explanations for these differences.

Target Date: The "Hospital Quality Report Card" will be revised and reissued annually. A copy of this report will be provided to the ACWV.

- 7. That the Environment of Care (Privacy) Check List is included as a part of VAMCs, Outpatient Clinics, and Community Based Outpatient Clinics (CBOCs) quarterly environmental rounds. Recommend also that the local VAMC WVPM be part of the Environmental Rounds Inspection Team.**

Rationale: *All veterans will be assured of the safety, privacy and dignity for which they are titled. Including this step as part of the environmental rounds will ensure that Health Insurance Portability and Accountability Act standards are met and medical center staff is made aware of VA privacy standards.*

This proactive approach would identify privacy deficiencies early on and allow mitigation of any deficiencies in a timely and cost effective manner.

VA Response: Concur. VA has placed a high priority on privacy and dignity for all veterans as they receive health care in VA facilities. The Environment of Care (Privacy) checklist is currently recommended in *VHA Services for Veteran Women*, VHA Handbook 1330.1, as a checklist, to be administered at least annually. VA also concurs that the role of the WVPM includes oversight of the environment of care for women patients.

Action: In the pending revision of VHA Handbook 1330.1, a requirement that attention be given to the Environment of Care privacy elements on an ongoing basis through regular Environmental Rounds and a recommendation that the WVPM be regularly included in the Environmental Rounds to ensure that the needs of women veterans in the facility physical environment are being adequately addressed are under review.

Target Date: VHA Handbook 1330.1 is expected to be revised by winter 2009 and the Center for Women Veterans will be asked to concur on the handbook revision.

8. **That VA develops a formal program for tracking of mammography results and follow-up of abnormal mammograms to ensure that women veterans receive consistent, timely, and high-quality care. Request VA Office of Quality and Patient Safety provide ACWV an annual report on the mammography tracking program to include data on timeliness-to-treatment for abnormal results.**

***Rationale:** According to the National Institute of Cancer, women have a lifetime risk of over one in eight of developing breast cancer. Mammography screening has a high rate of success in detection of early breast cancer, and prompt treatment of these early cancers can result in successful outcomes. Effective breast cancer tracking systems have been shown to increase the five-year survival rate.¹³*

The ACWV has continued to receive information through site visits and briefings that mammogram results are often tracked inconsistently. Data on follow-up of abnormal results to ensure prompt intervention is lacking. While some VAMCs have in-house mammography, a large number of women veterans' mammograms are performed at non-VA mammography centers through contract or fee-basis arrangements. While large mammography centers usually provide high quality tests, outsourcing of mammograms is often cited as a complication to follow-up of test results. However, the Mammography Quality Standards Act (as amended by the Mammography Quality Reauthorization Act of 1998 and 2004) states that a written report shall be provided to the patient's physician. Additionally, this Act requires that a summary of the written report shall be sent directly to the patient in terms easily understood by a lay person. A breast cancer tracking system should be utilized at all facilities. The identification of abnormal results and the responsibility for optimal timeliness-to-treatment is critically important in breast cancer screening.

VA Response: Concur in principle. VA is committed to the follow-up of significant findings of all diagnostic tests conducted, and to timely dialog with the veteran about the findings. In addition, abnormal or indeterminate mammogram results are particularly time-sensitive, and must be given immediate attention. Currently, each facility is to develop a system to track mammogram results through the processes of follow-up diagnostic testing and referral for treatment. These are often conducted by utilizing employees as Mammogram Coordinators. A review of these practices is currently underway.

¹³ Callahan, M. and Sanderson J.; *A Breast Cancer Tracking System*; The Permanente Journal; Fall 2000; Volume 4, No. 4

Presently, the VA computerized patient record system/veterans health information systems and technology architecture (CPRS/Vista) does not have the capability, on a national level, to electronically identify and track abnormal mammograms. Programming enhancements have been funded that will enable CPRS track mammography results (including fee basis outsourcing) and will standardize diagnostic codes for mammography results. Assuming programming enhancements occur in a timely fashion, facilities will be required to enter results of outside mammograms and initiate tracking of abnormal results by April 2009.

Action: The Women Veterans Health Strategic Health Care Group (WVHSHG) will continue to work with Diagnostic Services, the Office of Quality and Safety, and the Office of Information on monitoring of consistent tracking of abnormal mammogram results and of the timeliness to treatment for abnormal or suspicious findings.

Target Date: These functionalities are expected to be added to CPRS/VISTA in spring 2009 and progress will be reported to the Committee in June 2009.

C. Veterans Benefits Administration

Recommendation:

9. That the Veterans Benefits Administration (VBA) establishes a method to identify and track outcomes for all claims involving personal assault trauma, regardless of the resulting disability, such as PTSD, depression, or anxiety.

Rationale: *MST is a highly charged issue attaining increased visibility and attention in the military services, the veteran population, among elected officials, and in the news media. Much research on women veterans' health has focused on the prevalence of sexual harassment and sexual assault in the military, psychiatric conditions related to trauma, and the negative impact of PTSD on women veterans health functioning.¹⁴ VBA is currently not able to identify and track claims involving personal and sexual assault.*

At Town Hall meetings in New Jersey, North Chicago, Palo Alto, and Washington D.C., women veterans who were victims of personal or sexual assault consistently told this Committee that they were denied disability compensation for physical and mental disabilities related to MST.

It is vitally important that VBA develop the ability to identify and track the status and outcome of claims for victims of personal/sexual assault. VBA cannot speak with any authority as to the number of MST related claims submitted annually, processing times for these claims, grant rates, denial rates, or the types of disabilities most often associated with MST. The development of tracking systems could further guide studies and research on all aspects of MST.

VA Response: Concur in principle. VBA can currently identify and track claims for military sexual trauma (MST) if the claims were labeled as such when they were entered into our claims processing system. VBA will work closely with

¹⁴ Goldzweig, C. L., Balekian, T. M., Rolon, C., Yano, E. M., & Shekelle, P.G.; *The State of Women Veterans' Health Research: Results of a Systematic Literature Review*; *Journal of General Internal Medicine*; 2006; 21(S3): S82-S92

Veterans Health Administration (VHA) officials to obtain a list of individuals treated for MST by VHA so we can match the list against our system to identify any records that were not already labeled as claims for MST. This process would produce a more complete list of MST claimants.

D. Outreach

Recommendations:

- 10. That VA reviews, revises, and/or establishes formal processes and policies for consistently developing, producing, and test marketing veteran outreach materials to include all print and electronic media to ensure women veterans are clearly depicted as recipients of VA benefits, health care, and services. Their representation in this media targeted to the general population of veterans should accurately and proportionately reflect the women veterans' population as well.**

***Rationale:** During the February 2008 Committee meeting, several members of the committee observed that women veterans were not depicted as recipients of VA services in: HealthierUS Veterans "Get Fit for Life" Exercise DVD; VA Research brochure ORD #01-05-2007; and the VA Office of Research & Development brochure titled "Working to Improve the Health and Care of Veterans Who Served in Iraq & Afghanistan."*

***VA Response: Concur.** VA is making a concerted effort to include women veterans as recipients of VA benefits and services in all media and outreach materials and activities. The Administrations and Staff Offices will continue to monitor their outreach products and media services and activities to ensure that they are reflective of the diverse veteran population we serve.*

- 11. That VA advertises through national media outlets to facilitate the delivery of and promote the awareness of health and benefits programs provided for women veterans and their dependents under laws administered by the Secretary.**

***Rationale:** During the October 2007 Advisory Committee on Women Veterans meeting, the Deputy Assistant Secretary for Congressional and Legislative Affairs provided an update on HR 3681, currently titled the "Veterans Benefits Awareness Act of 2008," which was aimed at improving VA outreach to veterans. Introduction of this bill is timely in light of the need for increased outreach to 1.75 million women veterans, a population that is expected to continue to grow as a result of the number of women serving in the latest military conflict.*

The need for national advertising is also justified in a study in which VA researchers confirmed that women veterans had outdated and inaccurate perceptions of VA healthcare facilities, which discouraged them from inquiring about and using VA services.¹⁵

***VA Response: Concur.** On June 16, 2008, Secretary Peake revised the VA advertising policy and delegated authority for the purchase of media advertising*

¹⁵ Washington, D., et al; *Women Veterans' Perceptions and Decision-Making about Veterans Affairs Health Care*; Military Medicine; August 2007; Vol. 172

for certain purposes. After coordinating with the Assistant Secretary for Public and Intergovernmental Affairs, VA Under Secretaries may purchase advertising in media outlets for the purpose of promoting awareness of benefits provided under laws administered by their organizations, for personnel recruitment, and for certain loan guarantee activities.

E. Training

Recommendation:

- 12. That VA requests veterans service organizations (VSO) that are recognized by VA for claims processing require training for their service officers in the awareness of and sensitivity to signs of military sexual trauma, domestic violence, and/or personal assault.**

Rationale: *This information and training should be incorporated into the certification process for service officers by working with the National Association of State Departments of Veterans Affairs and the VSOs with a presence in the VA regional offices (VAROs). Having advocates knowledgeable in the most common stressors and/or physical manifestations of sexual trauma may alert the service officer to additional problems and put the officer in a position to recommend and/or assist in making a referral to an appropriate clinician. Additionally, when service officers are more aware of these conditions they will be better able to help the female veteran in filing for service-connected disabilities.*

VA Response: Concur in principle. The Compensation and Pension Service manages the Training Responsibility Involvement Preparation (TRIP) training program for veteran service officers. The section on Post Traumatic Stress Disorder contains the following statement on developing cases due to military sexual trauma:

“Tell the trainees that VA strives to be overly sensitive to claims of this nature for what should be obvious reasons. The stock development letters that are used to solicit descriptions of the stressful incidents are carefully worded accordingly. The trainees should be reminded of the sensitive nature of these claims as well. They should be careful NOT to apply their own personal values or value judgments to the claim or claimant.”

Successful completion of the TRIP course is one of the criteria for allowing accredited service officers access to VBA computer applications. Each veterans service organization that has been recognized by VA for purposes of claims representation is responsible for maintaining a training program to ensure that its accredited representatives are qualified to assist veterans in the preparation, presentation, and prosecution of claims. VA will share this recommendation and response with veterans service organizations and their service officers.

F. Women Veterans Health

Recommendation:

- 13. That VA promotes women veterans' health care through Welcome Home programs for OEF/OIF veterans by incorporating a special track for women veterans. This includes a visit to women's health services and an introduction to the WVPM, or designee.**

***Rationale:** Women are one of the fastest growing segments of the veteran population. Welcome Home events, mandated by VA for each VAMC, offer VA an opportunity to make a special appeal to women and introduce them to the programs and services now available through their facilities.*

***VA Response: Concur.** VA promotes women veterans' health through many outreach efforts, and recognizes the value of the Welcome Home programs in reaching OEF/OIF veterans. Each Welcome Home activity is designed locally, and activities vary, however, VHA will ask the Women's Health Program to develop a template to accomplish the objective which will be shared with all facilities.*

***Action:** Additionally, VHA will ensure that the Women's Health Program is an integral part of the Welcome Home planning group at each facility.*

G. Women Veterans Program Managers and Women Veterans Coordinators

Recommendations:

- 14. That VA appoints an alternate WVPM who can assume responsibilities when the WVPM is unavailable. Recommend that this alternate receive a minimum of 10 hours training and is a member of the medical center's Women Veterans Advisory Committee. This alternate position should be added to VHA Handbook 1330.02, "Women Veterans Program Manager (WVPM) Position."**

***Rationale:** With the needs of an increasing number of women veterans and the complexity of their care, an alternate WVPM would help to ensure continuity of care. The alternate would be familiar with all the programs and points of contact that women veterans may need to receive medical or psychological help.*

An alternate is also important because of the high turnover rate of the WVPM position. Over the last 3 years, the Women Veterans Health Strategic Health Care Group annual reports have reflected a 16 percent turnover rate (on average) in this position.

***VA Response: Concur in Principle.** VA agrees that the WVPM serves vital functions in response to veterans which need to be regularly available as an integral part of VA services. Please see the VA response to Recommendation #15 regarding the mandate for a full-time WVPM at every VA facility. As with any permanent full-time employee in VA, ensuring appropriate coverage and back-up during an employee's absence is standard procedure.*

***Action:** Appropriate coverage/backup will be coordinated by the facility to ensure coverage and follow-up in the absence of the full-time WVPM.*

15. That the position of WVPM is established as a permanent full-time management position in all VA medical centers.

Rationale: *There have been a number of changes since the last submission of a recommendation for a full time WVPM position. With OEF/OIF, the population of women veterans has risen significantly and is projected to double in the next few years. Today, 41 percent of eligible returning OEF/OIF women have used VHA services at least once. This is in sharp contrast to past statistics that showed only 14 percent of all women veterans sought medical care in the VA. As indicated by testimony of the Principal Deputy Under Secretary for Health, VA also strongly supports the concept of having at least one full-time employee at each VA medical center to ensure access to care for women veterans.*¹⁶

Most OEF/OIF women veterans are of childbearing age, with 86 percent of them under the age of 40. At the majority of medical centers, the WVPM is responsible for everything relating to women veterans. This is a management position and the WVPM is responsible for developing and implementing all services for women veterans. This can include providing oversight of the Women's Clinic; addressing complaints and privacy concerns; conducting outreach; ensuring follow up of all abnormal mammograms and pap smears, organizing meetings and services for OEF/OIF veterans; participating in facility environment reviews, and offering assistance with housing needs for homeless women veterans. A WVPM must be available at all times to serve the increased numbers of women veterans requesting services and assistance.

VA Response: Concur. VHA issued a memorandum dated July 8, 2008, directing the establishment of full-time WVPM at each VAMC by December 1, 2008.

Action: Progress in position posting, recruitment, and filling this position will be reported on a quarterly basis to the Deputy Under Secretary for Health for Operations and Management (10N). In addition, vacancies and new WVPM names will be reported to Chief Consultant, WVHSHG, through 10N, on a regular basis as they occur.

Target date: There will be a full-time WVPM at each VAMC by December 1, 2008.

16. That VARO directors be required to provide Women Veterans Coordinators (WVCs) a designated number of protected administrative hours per week to provide direct assistance to women veterans, collaborate with other coordinators, receive and conduct training, plan and conduct outreach, and accomplish other activities in support of the VBA women veterans program. The specific number of hours would be at the discretion of the director, based on the women veterans' population within the catchment area of the VARO, but in no case would the WVC have less than 10 hours per calendar week to devote to the women veterans program. Further, we recommend all new coordinators be required to participate in WVC orientation upon appointment and that they be allowed to receive ongoing professional development specific to their WVC role.

¹⁶ Testimony of the Principal Deputy Under Secretary for Health before the Senate Committee on Veterans Affairs; May 21, 2008; S. 2799
Section 206

Rationale: Current data from DoD confirm a continued increase in the number of women serving in the military and VA projects a steady increase of women eligible for veteran's benefits.^{17 18} WVCs are a key point of contact for women veterans entering the VBA system, addressing and coordinating their unique needs with knowledgeable and focused claims assistance. Ensuring WVCs have an appropriate dedicated time block to perform their additional duties would allow them to produce well-coordinated outreach events; provide gender sensitive and first-rate claims assistance; and consistently advocate on behalf of the women veterans community.

During ACWV site visits and town hall meetings in New Jersey, Illinois, and California, women veterans reported to this Committee that they felt "lost in the shuffle" of the VBA system when they apply for compensation and pension benefits and WVCs reported they lack the time necessary to carry out their additional duties. The Committee believes VA must make this commitment of time and resources to enable each VARO to provide women veterans consistent and relevant services across the Nation.

VA Response: Concur in principle. We agree that the individuals who serve as VBA's Women Veterans Coordinators (WVCs) must be given sufficient time and training to effectively carry out their important outreach, claims assistance, and advocacy responsibilities. As recommended, the amount of time allotted to WVCs to perform their duties should be determined by the needs of the women veterans in the area served by each regional office. While we do not believe it appropriate to specify a minimum number of hours, we agree that regional offices should develop a local plan for accomplishing their women veterans program responsibilities to ensure sufficient time and resources are devoted to achieving their objectives and the needs of women veterans in their area are fully supported. We also agree it is essential that our women veterans coordinators receive the training and development needed to effectively carry out their responsibilities. A comprehensive training program for regional office WVCs is being developed for FY 2009 that will include satellite training broadcasts, regularly scheduled conference calls, and a three-day national training conference in November. Information and best practices derived from the conference, broadcasts, and conference calls will be made available on the WVC Compensation and Pension website.

- 17. That the VARO directors' performance measures include specific monthly goals to track performance standards for WVCs that ensure key objectives related to the women veterans programs are being achieved. By making them part of the monthly goal evaluation, they will be elevated in importance and reviewed on a regular schedule that will help to ensure focus on the program and successful outreach and assistance to women veterans.**

Rationale: The Committee is deeply concerned about the strength and consistency of outreach to women veterans in VAROs across the country. In March 1999, the Secretary responded to similar concerns raised by the Director,

¹⁷ Statistical Information Analysis Division (SIAD) on Active Duty Military Personnel by Rank/Grade; Sep 30, 2007; Women Only

¹⁸ Vet Pop 2007

Center for Women Veterans, by issuing a memorandum to all Central Office and field facility key officials emphasizing VA's commitment to the Women Veterans Program. In March 2000, the Associate Deputy Under Secretary for Operations followed up with a letter emphasizing the importance of the WVC position and providing basic language to be used as an addendum to her position description and performance standards. The letter also provided Core Operating Standards for WVCs and a Memorandum of Understanding to be signed by the WVC, her supervisor, and the regional office director. However, the letter fell short of directing full implementation of these standards and the goals relating to the Women Veterans Program were not incorporated into the directors' performance standards. The letter also failed to address accountability for the program in any way.

On site visits and at the 2008 National Summit on Women Veterans' Issues, WVCs consistently report to this Committee that they experience great difficulty getting the time, resources, and training essential to successfully assist women veterans in their regions.

Ensuring that the VARO directors' performance measures include specific monthly goals measuring the performance of WVCs would increase the strength and consistent application of VBA's organizational objectives regarding the women veterans program.

VA Response: Concur in principle. VBA recognizes the importance of ensuring that WVCs are dedicated to the goals and objectives of the women veterans program. VBA leaders are committed to the goals of the Center for Women Veterans, and regional office directors are regularly encouraged to provide all necessary support to WVCs. The Deputy Under Secretary for Benefits spoke at the recent 2008 National Summit on Women Veterans, where he affirmed VBA's support of this important program. VBA is planning a women veterans coordinators training conference in November of this year. Among the goals of this conference will be to identify ways to strengthen VBA's women veterans program and achieve greater consistency and accountability among regional offices in carrying out women veterans program responsibilities. Conference participants will also be charged with determining an appropriate way to measure the success of the women veterans program at both the local and national levels.

H. Women Veterans Who Are Homeless

Recommendation:

- 18. That VA update its Web site to provide sufficient information for women veterans to locate and contact the Health Care for Homeless Veterans (HCHV) coordinator or alternate in their respective regions in order to find immediate shelter regardless of the time of day or night her need arises.**

Rationale: *Women veterans face issues that the majority of their male counterparts do not. Often times they have experienced domestic violence or sexual assault and many are solely responsible for the care of minor children. Counselors, civilian health care providers, and women veterans themselves must*

be able to easily find and access the many VA and community resources available to them if there is to be any hope of finding assistance in an emergency or of establishing a viable safety plan to prevent an emergency.

The Committee applauds the many VA programs that support and assist homeless women veterans and appreciates recent updates to the VA Web site making information regarding the homeless program more prominent and accessible. While understanding that safety concerns necessitate not listing actual shelter locations on the Web site, recent attempts to contact HCHVs indicate the currently listed contact information frequently does not provide 24-hour assistance to potentially homeless women veterans.

VA Response: Concur. Currently, through VA's Homeless Programs Web page, users can access the contact information of each of the Health Care for Homeless Veterans (HCHV) programs around the country. This information offers users of the Web site a way to contact homeless services in their area, however, these programs do not provide services or access 24 hours a day. When the HCHV coordinator is unavailable, VA will modify the Web site to direct callers to contact the local VA medical center's emergency room. All VA medical centers provide referral to emergency shelter services as per the "Uniform Mental Health Services in VA Medical Centers and Clinics Handbook."

I. VA National Cemetery Administration (NCA)

Recommendation:

- 19. That NCA enhance targeted outreach efforts in those areas where burial usage by women veterans does not reflect the women veterans' population by proactively providing burial benefits information to women veterans, their spouses, and their children.**

Rationale: *In comparing statistics indicating the number of deaths of women veterans each year and women veterans' usage of burial benefits, as indicated by statistics provided by NCA in June 2008, this Committee is concerned that women veterans, on average, are underrepresented among those interred in national and State veterans' cemeteries.¹⁹ The Committee feels very strongly that women veterans and their family members must be fully informed about veterans burial benefits to ensure women veterans are given the opportunity to be laid to rest in a national shrine with the dignity, respect, and compassion they deserve in recognition of their service.*

VA Response: Concur. NCA will carefully analyze data concerning rates with which women veterans are electing burial in VA national cemeteries. Data findings will be used to target areas of the country where usage rates are particularly low, and to develop strategies to reach out to women veterans in those areas.

NCA continually assesses opportunities to reach more veterans, both female and male, through outreach activities. In the future, as opportunities present

¹⁹ VetPop 2004

themselves, NCA will make a concerted effort to include underrepresented veteran populations, to include women veterans, in its outreach endeavors.

Each year, NCA conducts a robust outreach program to educate and inform all veterans – including women veterans – about the memorial and burial benefits they have earned. NCA does not offer any gender-specific benefits. NCA programs serve all veterans equally, regardless of gender. All eligible veterans are entitled to the same NCA memorial benefits: burial in a VA national cemetery, a government headstone or marker, a Presidential Memorial Certificate and a U.S. burial flag.

While NCA has a national outreach each year, the majority of its outreach programs are conducted primarily by cemetery directors and employees at the community level. Each year, NCA participates in thousands of local events such as VSO meetings, stand-downs, community fairs and celebrations, and other civic events. On the national level, NCA participates in 12 to 14 national conventions each year, primarily conferences of VSOs and professional organizations such as the National Funeral Directors Association. This year, specifically targeting women veterans, NCA participated in the Women in Military Service for America Reunion and the National Summit on Women Veterans' Issues.

J. Business

Recommendation:

- 20. That the Center for Veterans Enterprise (CVE) establish procedures and systems to enable the routine collection and reporting of data specific to women veteran-owned businesses, including verification of other statuses such as minority or service-disabled, which may enable increased access to Federal contracts.**

***Rationale:** During the presentation by the CVE in October 2007, the Deputy Director provided general data regarding women-owned small businesses and veteran owned small businesses. When asked for women-veteran data, the Deputy Director indicated that the data would be difficult to collect from the Central Contractor Registry (CCR) and CVE database, particularly for subcontracting statistics.*

This Committee is interested in data specific to women veterans-owned small businesses to assess rates at which women veterans are starting small businesses, growth, the utilization of women veteran-owned businesses for government contracting, and other relevant information.

VA Response: Concur in principle. CVE does not have the ability to establish procedures and systems to collect this information. While CVE does not have lead action in tracking the increased access to Federal contracts by women-owned/veteran-owned small businesses, it remains very interested in this information. The Office of Small and Disadvantaged Business Utilization/CVE will be supporting the Interagency Task Force for Veterans Business Development, which is being organized by the Administrator of the Small Business Administration (SBA), as required by Public Law (PL) 110-186. The

mission of the Task Force, as identified in Title I, Section 102 of the law, "is to coordinate the efforts of Federal agencies necessary to improve capital and business development opportunities for, and ensure achievement of the pre-established Federal contracting goals for, small business concerns owned and controlled by service-disabled veterans and small business concerns owned and controlled by veterans."

Action: CVE will introduce this recommendation as an action item at the Interagency Task Force meeting, and continue to report to the Advisory Committee and Center for Women Veterans staff regarding progress toward actualizing this recommendation.

PART IV

Appendices

Appendix A

Historical Perspective

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

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

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

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

At the same time, VA commissioned Louis Harris and Associates to conduct a “Survey of Female Veterans: A Study of the Needs, Attitudes and Experiences of Women Veterans,” published in August 1985, to determine the needs and experiences of this population. This survey found that 57 percent of the women did not know they were eligible for VA services, benefits, and programs. Another particularly troublesome finding was that women veterans reported twice the rates of cancer as compared to the women in the general adult population, with gynecological cancers being the most common.

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

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

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

The following events are historical markers since the establishment of the Advisory

Committee on Women Veterans.

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

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

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

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

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

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

Women Veterans Coordinators were appointed in VA regional offices.

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

1988 A Veterans Health Administration office to address women's health issues was first created.

1989 The Advisory Committee on Women Veterans began site visits.

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

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

1993 Dedication of the Vietnam Women's Memorial.

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

The Center for Women Veterans was created by Congress under Public Law 103-446, "Veterans' Benefits Improvements Act of 1994."

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

Three research projects were proposed by VA as an alternative to a comprehensive epidemiologic study of the long-term health effects experienced

by women who served in the Armed Forces in Vietnam, as mandated by Public Law 99-272, "Veterans' Health-Care Amendments of 1986." The original study was determined not scientifically feasible. The three research projects included:

- a study of post-service mortality (results were published in 1995);
- the re-analysis of psychological health outcome data collected for women in "The National Vietnam Veterans Readjustment Study" (completed in 1988); and,
- a study of reproductive outcomes among women Vietnam veterans.

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

1995 Joan Furey was appointed as the first Director of the Center for Women Veterans. Committee members increased communication with women veterans, increased individual site visits to VA facilities, and provided briefings to Congressional members and staff.

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

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

The Women in Military Service for America Memorial was dedicated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The population of women veterans as a percentage of all veterans is expected to increase as the number of former military service women continues to grow.

Dr. Irene Trowell-Harris testified before then Subcommittee on Health, House Committee on Veterans' Affairs on services in VA for women veterans.

2003 According to VA's Office of Policy, Planning & Preparedness VetPro program (based on the 2000 Census) of the 25.6 million veterans, 1.7 million are women veterans. In 2002, the 1.7 million women veterans constituted 6.5 percent of all veterans living in the United States, Puerto Rico, and overseas.

VA has seen a significant increase in the number of women veterans who receive benefits and health care services from the Department. The number of women veterans enrolled in VA's health care system grew from approximately 226,000 in FY 2000 to nearly 305,000 in FY 2002, an increase of approximately 35 percent. Women veterans enrolled in VA in Fiscal Year (FY) 2003 were 331,000 (up 8.6 percent from FY 2002) and of those enrolled in FY 2003, 195,516 (up 7.2 percent from FY 2002) actually used the system.

VA celebrated the 20th Anniversary of the Advisory Committee on Women Veterans on September 15, 2003, at the Women in Military Service for America Memorial (WIMSA) with Senator Daniel K. Inouye presenting the keynote

address. Committee past and present chairs, co-chairs and members were honored at the ceremony.

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

- 2004 The Fourth National Conference of VA Women Veterans Coordinators was held in Las Vegas, Nevada.

The third "National Summit on Women Veterans Issues - Summit 2004" was held in Washington, DC.

The Sunset Provision for sexual trauma counseling in VA was extended permanently.

- 2005 The Charter for VA Advisory Committee on Women Veterans was renewed.

- 2006 Dr. Susan Mather retired from the Department of Veterans Affairs on January 3. Dr. Mather served as the Designated Federal Official (DFO) for the Advisory Committee on Women Veterans from 1983 until 1995. She continued to serve as an ex officio member on the Committee from 1995 until her retirement in 2006. Dr. Mather had a distinguished career serving those we are so honored to serve.

The Fifth National Conference of VA Women Veterans Program Managers was held in Orlando, Florida.

The entire Journal of General Internal Medicine for March 2006 was dedicated to research on women veterans. There were 16 articles, covering various issues, to include VA health care utilization, health and mental health issues among women veterans.

- 2007 The Charter for VA Advisory Committee on Women Veterans was renewed. Carole Turner, the second Director for the Women Veterans Health Program, retired from VA January 2007.

Dr. Betty Moseley Brown testified before the House Veterans' Affairs Committee Subcommittee on Health to highlight VA services available for women veterans.

- 2008 Women's Veterans Health Program Office was elevated to the Women Veterans Health Strategic Health Care Group, effective March 2008. Patricia M. Hayes, PhD, was appointed Chief Consultant April 13, 2008. The Advisory Committee recommended the realignment of the Women Veterans Health Program Office to the status of a Strategic Healthcare Group and the Program Director position be designated as a Chief Consultant in the 2006 report.

The fourth "National Summit on Women Veterans' Issues - Summit 2008" was held in Washington, DC. Members of the Advisory Committee on Women Veterans served as facilitators for the various workshop sessions and the town hall meeting.

Dr. Paula Schnurr, Deputy Executive Director for VA's National Center for Post Traumatic Stress Disorder (PTSD), received the 3rd annual Ladies Home Journal "Health Breakthrough Award" for her work with PTSD and women veterans.

Memo signed July 8, 2008 regarding the hiring of a full-time Women Veterans Program Manager at each medical center. The establishment of a full-time Women Veterans Program Manager position at VA medical centers had been recommended by the Advisory Committee in the 2006 report.

There are 1.7 million women veterans comprising 7 percent of the total veteran population. As the number of women in the military increases, it is estimated that 10 percent of all veterans will be women by the year 2020.

As of July 2008, there are currently over 27 research projects funded by VA's Health Services Research & Development Service addressing women veterans' issues.

Versions of the "Women Veterans Health Care Improvement Act of 2008" introduced in both the House (H.R. 4107) and the Senate (S. 2799); some aspects related to improving health care services for women veterans have passed.

Appendix B

Past Chairs and Current Chair of the Advisory Committee on Women Veterans

Susan H. Mather, M.D., M.P.H.-Interim Designated Federal Official
(1983-86 - estimate)

COL Lorraine Rossi, USA, Retired (1986)

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

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

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

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

Susan H. Mather, M.D., M.P.H – Interim Chair (1994-1996)

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

MAJ Linda Schwartz, USAF, NC, Retired (1998-2000)

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

Marsha T. Four, USA (2002-06)

COL Shirley A. Quarles, USA, NC (2006-present)

Appendix C

VA Advisory Committee on Women Veterans Membership Profile

Shirley Ann Quarles, R.N., Ed.D.

Colonel, USAR

Chair 2006-2008

Shirley Ann Quarles is a Colonel in the Army Nurse Corps, U.S. Army Reserves and a Professor at the Medical College of Georgia's School of Nursing. She served as a research scientist and Clinical Practice Guidelines Coordinator for the Atlanta Research and Education Foundation. She was responsible for facilitating current research findings and its applicability to clinical practice guidelines in the Veterans Health Administration. She proposed, participated, and conducted research projects related to improve healthcare outcomes and conducted ongoing research in women's health. She received her Ed.D. in Higher Education Administration: Research Education, her M.Ed. in Community Health Education, and her B.S. in Nursing. She also served as an Affiliate Professor, Nell Hodgson Woodruff School of Nursing, Emory University. Dr. Quarles was appointed to the Advisory Committee on Women Veterans in January 2005.

René A. Campos

Commander, USN, Retired

Ms. Campos retired with more than 30 years of honorable service from the U.S. Navy. Some of her duties included Branch Head of the Enlisted Performance Evaluations, Officer/Enlisted Program Manager, Officer-in-Charge of Personnel Support Detachment, and Director of Resource Management Office. Ms. Campos is currently the Deputy Director of Health Affairs, Government Relations, Military Officers Association of America (MOAA). Her duties include lobbying and advocating for service-members and their families on issues related to Wounded Warrior, Seamless Transition and VA Health Care. She represents active duty, Guard and Reserve, retirees, veterans, survivors, and family members. She has a Bachelor of Art degree in Psychology and Criminal Justice from Columbia College and a Masters degree in Business Administration (MBA) from the University of Phoenix. Ms. Campos received the Navy Commendation Medal for directing base closure efforts and transfer of 3,000 personnel records from Philadelphia, PA to the Detachment. She was appointed to the Advisory Committee on Women Veterans in September 2007.

Helena R. Carapellatti

Chief Master Sergeant, ANG, Retired

Ms. Carapellatti enlisted and served on active duty in the U.S. Air Force (USAF) from 1979 to 1984. She joined the Air National Guard (ANG) in 1987 and retired from the ANG at the rank of Chief Master Sergeant in 2006. Her last assignment in the ANG was as the Superintendent of Policy & Procedures at the National Guard Bureau. In this position, she reviewed, wrote, and published policy and procedures for Air National Guard supply activities nationwide. She also assisted in policy review and rewrites of DoD, USAF, and other National Guard policies. Ms. Carapellatti is pursuing a master's degree in Sociology at the University of Maryland. She tutors with the Literacy Council

of Prince George's County and she owns a business with her spouse. She was appointed to the Advisory Committee on Women Veterans in September 2007.

Pamela J. B. Cypert

First Sergeant, USA, Retired

Pamela Cypert retired from the military after a 21-year career. First Sergeant Cypert's leadership positions included senior drill sergeant, military police assignment manager, and first sergeant. She broke several barriers: first female Installation Drill Sergeant of the Year for Fort McClellan, AL; first female First Sergeant of an Airborne Military Police Company in the U.S. Army; and first female paratrooper in her brigade to attain the prestigious title of a Centurion Jumper. Her duty stations included Texas, Alabama, Germany, Virginia, and North Carolina. Upon her retirement from the Army in 2003, she began her career in state government with the Kentucky Department of Veterans Affairs and currently serves as the Executive's Staff Advisor to the Commissioner of the Kentucky Department of Veterans Affairs and Women Veterans Coordinator for the Commonwealth of Kentucky. She earned her B.S. in Psychology from Fayetteville State University and a Master's Degree in Mental Health Counseling from the University of Louisville. 1SG Cypert was appointed to the Advisory Committee on Women Veterans in September 2005.

Gwen M. Diehl

First Sergeant, USA, Retired

Ms. Diehl retired from the US Army with 20 years of honorable service, at the rank of Sergeant First Class. She served in Operation Desert Shield and Operation Desert Storm and was awarded the Bronze Star. In her 20-year military career, Ms. Diehl held an impressive range of assignments from a Military Records Clerk and Records Section Supervisor in Personnel Service Companies, to overseeing the deployment and redeployment of the 1,000 members of the Support Squadron 3rd Armored Cavalry Regiment (ACR) to Operations Desert Shield and Desert Storm. In her current position, Ms. Diehl is the confidential Staff Assistant to the Director at the Illinois Department of Veterans' Affairs. She is a public speaker for the Department, and provides explanations of programs and courses of action to Legislators' offices, veterans' organizations, and the inquiring public. Ms. Diehl has an Associates Degree in Business Administration and a Bachelor of Science Degree in Management. Sergeant Diehl was appointed to the Advisory Committee on Women Veterans in September 2002.

Velma Hart

USAR

Velma Hart served in the Army Reserves for nearly 10 years in both the signal and administration corps and was discharged as a Sergeant. She has been an association professional for over 20 years, having served six non-profit organizations, ranging from 501 (c) (3) to 501 (c) (19) within the Washington, D.C. area. She earned her Certified Association Executive (CAE) designation and was the recipient of the Greater Washington Society of Association Executives Scholarship, which is awarded annually to outstanding leaders in the field of association and nonprofit management. Ms. Hart is a member of AMVETS (American Veteran) and currently serves as their National Finance Director/Chief Fiscal Officer. She was appointed to the Advisory Committee on Women Veterans in August 2006.

Kathleen Janoski**Chief Petty Officer, USN, Retired**

Kathleen Janoski retired from the U.S. Navy with 23 years of service at the rank of Chief Petty Officer. As a Navy Photographer's Mate, Ms. Janoski's assignments included photojournalism, public affairs, community events, and forensic photography. Her duty stations included Naval Technical Training Center, Pensacola, FL; Navy Recruiting District, New Jersey; Atlantic Fleet Audio-Visual Command/Combat Camera, Norfolk, VA; USS L.Y. SPEAR (AS-36), Norfolk, VA; Navy Recruiting Command Headquarters, Arlington, VA, and the Armed Forces Institute of Pathology, Washington, DC. Ms. Janoski has an A.S. in Business Administration from Tidewater Community College and a B.A. in Humanities from the University of Pittsburgh. She is a lifetime member of the Disabled American Veterans and is a representative for WAVES National on the Allegheny County (PA) Veterans Advisory Board. Currently, she is working in private industry. Chief Petty Officer Janoski was appointed to the Advisory Committee on Women Veterans in September 2005.

Marlene Kramel, R.N.**USA**

Marlene Kramel served as a First Lieutenant in the Army Nurse Corps, with service in Viet Nam. She began her military service as a staff nurse in pediatrics at Letterman Army Hospital, Presidio, CA. In March 1966, she was deployed with the 67th EVAC Hospital to Viet Nam, where she assumed responsibility for setting up the ICU and recovery units. During her 38 years as a registered nurse, Ms. Kramel served as a staff nurse, head nurse, mental health clinic nurse, psychiatric nursing supervisor, and full-time Women Veterans Program Manager, a position she held for 12 years at the VAMC in Alexandria, Louisiana. Ms. Kramel's clinical background in mental health nursing (American Nurses Association certification in psychiatric and mental health nursing) enabled her to establish a strong sexual trauma program at the medical center. She retired in October 2002, but remains actively involved with VA, veterans' organizations, and the community. She is a lifetime member of the DAV and the VFW. Ms. Kramel was appointed to the Advisory Committee on Women Veterans in August 2006.

The Honorable Mary Antoinette (Toni) Lawrie**Air Force**

Mary Lawrie served as a Captain in the Air Force Nurse Corps in Florida, Viet Nam, and Mississippi. Prior to her military service, she was a volunteer in the Peace Corps. Ms. Lawrie began her VA service at the VAMC in Bay Pines, Florida, where she served as the coordinator of the Women Veterans Health Program until her retirement in 2005. She is a former Commissioner for the State of Florida Department of Veterans Affairs. Ms. Lawrie has authored publications including one on "Meeting the Needs of Women Veterans," and received numerous awards in recognition for her service to women veterans. She was appointed to the Advisory Committee on Women Veterans in August 2006.

The Honorable Brenda Moore**USA**

Brenda L. Moore began her military career in the Women's Army Corps in 1973 and served in positions of increasing responsibility until 1979, when she was discharged. Her last military service included serving as Assistant for Women's Affairs at the Schweinfurt Military Community, Third Infantry Division. She earned a Ph.D in sociology from the University of Chicago and her thesis was "Effects of the All-Volunteer Force on Civilian Status Attainment." Dr. Moore was a Presidential Appointee to the American Battle Monuments Commission in 1994, and served as a member of the Defense Advisory Committee on Women in the Services (DACOWITS). She is currently an associate professor of sociology at the University at Buffalo (SUNY); and author of the books: *To Serve My Country, To Serve My Race: The Story of the Only African American WACs Stationed Overseas during World War II*; and *Serving Our Country: Japanese Women in the Military During World War II* (Rutgers University Press, 2003), as well as a number of scholarly papers on the topic of men and women in today's military. Dr. Moore was appointed to the Advisory Committee on Women Veterans in August 2006.

Jacqueline Morgan, M.D., M.P.H.

Colonel, USAF, Retired

Vice-chair

Jacqueline Morgan retired from the Air Force in 2000 after 20 years of honorable service. She received a Doctor of Medicine degree from Louisiana State University School of Medicine in New Orleans in 1965. She also earned a Masters of Public Health in 1995. Dr. Morgan is board certified in Public Health and General Preventive Medicine. After completion of a rotating internship, she entered private practice in general medicine in Louisiana. Dr. Morgan entered the Air Force in July 1980 and served in numerous locations including Louisiana, California, Texas, Washington State and Washington, DC. Her overseas assignments included Germany and Turkey. In her last assignment, she served as the Command Surgeon/Director of Medical Services and Training, Headquarters Air Education and Training Command. Dr. Morgan was appointed to the Advisory Committee on Women Veterans in January 2005.

Barbara Pittman

Technical Sergeant, USAF, Retired

Ms. Pittman retired from the U.S. Air Force with 20 years of honorable service. She worked as a Paralegal Technician in the service. In addition to working as an Air Force Paralegal, she performed duties as a first responder to aircraft accidents in Germany and volcanic eruptions and evacuations in the Philippines. After retiring from the USAF, Ms. Pittman worked as a legal technician for Marine Spill Response Corporation (MSRC), the United States Air Legal Services Agency, Information Litigation Branch as a Freedom on Information Act (FOIA) Manager and the Department of Veterans Affairs, Office of General Counsel (OGC). She currently works for the Government of the District of Columbia, Executive Office of the Mayor as the Veterans Benefits Special Assistant to the Mayor. Ms. Pittman has a Bachelor of Science in Business Management and a minor in marketing. She also has a Paralegal degree from the Community College of the Air Force at Maxwell AFB. She was appointed to the Advisory Committee on Women Veterans in September 2007.

Lupe G. Saldaña

USMC

Lupe Saldaña began his public service career as a Commissioned Officer in the U. S. Marine Corps from 1965 to 1971. He rose to the rank of Captain while serving a tour of duty in Vietnam in 1968. In 1971, he resigned his commission as a Regular Marine Corps Officer to become an advocate for veterans issues. Mr. Saldaña joined the American G.I. Forum in 1972 and was elected Washington D.C., State Commander in 1974 and National Commander in 1979 to 1981. He retired as a senior manager in the Environmental Protection Agency, where he served as Chairperson for the EPA Hispanic Advisory Council, an independent organization of Hispanic employees. Prior to this service, Mr. Saldaña worked at the Health and Human Services and the U.S. Bureau of the Census where he assisted the Director of the Census Bureau to establish the first National Hispanic Advisory Committee for the 1980 bicentennial Census. On January 2004, he co-founded FECHA, Federal Employee Coalition of Hispanic Associations and served as Chairperson of the organization. He was appointed to the Advisory Committee on Women Veterans in September 2005.

The Honorable Sara A. Sellers

Chief Master Sergeant, USAF, Retired

Chief Master Sergeant Sellers retired from the United States Air Force after 30 years of service. She received many awards and commendations during her service. She is a member of the VFW, The American Legion, the DAV, Vietnam Veterans of America, and the Air Force Sergeants Association. She also served on the Defense Advisory Committee on Women in the Services (DACOWITS) and is a former Commissioner on the American Battle Monuments Commission. In addition, she is also active in many civic and charitable organizations. She was appointed to the Advisory Committee on Women Veterans in June 2004.

Celia Szelwach

USA

Ms. Szelwach was commissioned as an officer in the Army Transportation Corps, after graduating from the U.S. Military Academy at West Point in 1990. Her career began during the Desert Shield/Desert Storm era at Fort Bragg, North Carolina, where she became a senior paratrooper, earned numerous commendations, and achieved the rank of Captain. Since completion of her military commitment in 1995, Ms. Szelwach has served in a variety of roles in Corporate America, including management of her own consulting company. She is currently a doctoral candidate and serves as the Ethics and Compliance Manager for The PBSJ Corporation, a national engineering consulting firm. In 2007, she founded the Women Veterans Network (WOVEN™), a global online community connecting women veterans of all ages, services, ranks, experiences, and geographies. She was appointed to the Advisory Committee on Women Veterans in August 2006.

Joanna Truitt

Joanna Truitt served in various leadership positions in several institutions of higher education across the country. She served as the Associate Dean of Students and Director of Student Activities at The Catholic University of America and the Associate Director, University Union, at Towson University. She currently serves as the DC Director of the American Legion Auxiliary. The American Legion Auxiliary reopened the DC office in early 2006 after a long hiatus. Ms. Truitt is active in social and civic organizations. She was appointed to the Advisory Committee on Women Veterans in August 2006.

Virgil L. Walker**CMsgt, ANG**

Virgil Walker enlisted in the Oklahoma Air National Guard in Tulsa, OK. He reenlisted worked in information management and customer service, as well as participating in civic events. He later produced many live radio discussions regarding the Air National Guard's goal to train more minorities to be pilots, as well as recruit more minorities overall. He also developed and implemented a Diversity Action Plan for the 137th Airlift Wing Recruiting Office, which was widely supported. This led to his assisting the State Force Management Team to design a Diversity Strategy for the State of Oklahoma. Sergeant Walker also helped support the Defense Advisory Committee on Women in the Services (DACOWITS) at the Pentagon and is now employed in private industry. He was appointed to the Advisory Committee on Women Veterans in September 2005.

Rosemarie Weber**Master Gunnery Sergeant, USMC, Retired**

Ms. Weber retired from the U.S. Marine Corps with 26 years of honorable service, at the rank of Master Gunnery Sergeant. She served with the Coalition Provisional Authority in Baghdad, Iraq, where she worked with the Ministry of Defense. She also served as the Deputy Inspector General for the Second Marine Aircraft Wing. She was awarded the French National Service Medal, Silver Award by the President of France. Ms. Weber worked at the Women in Service to America Memorial and at The Cohen Group with former Secretary of Defense, William S. Cohen, where she advised the Secretary and his consulting staff on enlisted and Marine Corps matters. She currently serves as the Executive Assistant in the Department of Defense Travel Management Office. Ms Weber was appointed to the Advisory Committee on Women Veterans in September 2007.

Appendix D

Past and Present Members of the Advisory Committee on Women Veterans

Disclaimer:

This information is provided based on a review of the records and in consultation with past members. There may be some names missing. If you have additional names, please email the Center at 00W@mail.va.gov

1983-1984

COL Lorraine Rossi, USA, Retired, Chair
Karen Burnett, USA
COL Pauline Hester, USAR
MG Jeanne Holm, USAF, Retired
Charles Jackson
Margaret Malone, USA
Joan E. Martin
Carlos Martinez
Sarah McClendon, USA
Estelle Ramey, Ph.D.
Omega L. Silva, M.D.
Jessie Stearns
SSgt Alberta I. Suresch, USAF, Retired
Jo Ann Webb, USA
BG Sara Wells, USAF, Retired
June A. Willenz

*Until his death in December 1983 Charles A. Collatos, Commissioner of Veterans Services, State of Massachusetts, was a member of the Committee.

1985-1986

COL Lorraine Rossi, USA, Retired, Chair
Cosme J. Barcelo, Jr.
COL Hazel E. Benn, USMC, Retired
COL Pauline Hester, USAR
MG Jeanne M. Holm, USAF, Retired
MCPO Charles R. Jackson, USN, Retired
Karen L. Johnson, USA
Margaret Malone, USA
Joan E. Martin
Sarah McClendon, USA
RADM Frances Shea-Buckley, USN, Retired
Omega L. Silva, M.D.
Jessie Stearns
SSgt Alberta I. Suresch, USAF, Retired
Jo Ann Webb, USA
June A. Willenz

1987-1988

MG Jeanne M. Holm, USAF, Retired, Chair
Cosme J. Barcelo, Jr.
COL Hazel E. Brown, USMC, Retired
RADM Frances Shea-Buckley, USN, Retired
Gloria Crandall, USAF
BG Diann A. Hale, NC, USAF, Retired
Charles R. Jackson
Lucille James, USCG
Margaret M. Malone, USA
Sarah McClendon, USA
LTC Judith Patterson, USAF, Retired
Omega L. Silva, M.D.
Mary R. Stout, USA
COL Eloise B. Strand, USA, Retired
SGT Alberta I. Suresch, USAF, Retired
CAPT Irene N. Wirtschafter, USNR, Retired

1989-1990

RADM Frances Shea-Buckley, USN, Retired, Chair
MG Mary Clarke, USA, Retired
Gloria Crandall, USAF
Doris Gross, USN
Lucille James, USCG
P. Evangeline Jamison, USA
Shirley Jaynes, USAF
RADM Fran McKee, USN, Retired
BG Diann Hale O'Connor, NC, USAF, Retired
COL Renee Rubin, USAFR, Retired
CSM Douglas Russell, USA, Retired
SGM Thomas Ryan, USA, Retired
Mary Stout, USA
COL Eloise Strand, USA, Retired
Mary Stremlow, USMC
Precilla Wilkewitz, USA

1991-1992

MG Mary E. Clarke, USA, Retired, Chair
Elizabeth R. Carr, USAF
Doris Gross, USN
P. Evangeline Jamison, USA
Shirley Jaynes, USAF
RADM Fran McKee, USN, Retired
Shirley Ann Waltz Menard, Ph.D., RN, USA
COL Diane Ordes, USAF, Retired
John Thomas Queenan, M.D.
COL Renee Rubin, USAFR, Retired
SGM Thomas Ryan, USA, Retired
Precilla Wilkewitz., USA

1993-1994

Shirley Ann Waltz Menard, Ph.D., RN, USA, Chair
Patricia A. Bracciale, USA
Carolyn Becraft
COL Mary Boyd, USAF, Retired
Elizabeth R. Carr, USAF
Susan Durham, RN, M.P.H, USA
BG Clara L. Adams-Ender, USA, Retired
Marsha Four, USA
COL Lois Johns, Ph.D., USA, Retired
MAJ Karen Johnson, J.D., USA, Retired
RADM Mary Nielubowicz, USN, NC, Retired
COL Diane Ordes, USAF, Retired
John Queenen, M.D
CSM Douglas Russell, USA, Retired
MAJ Linda Spoonster Schwartz, USAF, NC, Retired
BG Connie Slewitzke, USA, Retired

1995-1996

BG Clara Adams-Ender, USA, Retired
Patricia A. Bracciale, USA
COL Christine M. Cook, ARNG
CMDR Constance Evans, USPHS, Retired
COL Lois Johns, RN, Ph.D., USA, Retired
Karen Kaye Johnson
Janette M. McSparren, USN
RADM Mary Nielubowicz, USN, Retired
COL Karen A. Ray, RN, MSN, USA, Retired
CSM, Douglas Russell, USA, Retired
MAJ Linda S. Schwartz, RN, MSN, D.P.H., USAF, Retired
BG Constance L. Slewitzke, USA, Retired

1997-1998

MAJ Linda S. Schwartz, RN, MSN, D.P.H., USAF, Retired, Chair
COL Lois Johns, RN, Ph.D., USA, Retired, Co-Chair
BG Clara Adams-Ender, RN, MSN, USA, Retired
Veronica A'zera
Sherry Blede, ANG
COL Christine M. Cook, ARNG
Bertha Cruz Hall, USAF
CMDR Constance G. Evans, USPHS, Retired
Joy Ilem
CAPT Loy Manning, USN, Retired
Janette M. McSparren, USN
COL Karen L. Ray, RN, MSN, USA, Retired
CSM, Douglas Russell, USA, Retired
BG Constance L. Slewitzke, USA, Retired

1999-2000

MAJ Linda S. Schwartz, RN, MSN, D.P.H., USAF, Retired, Chair
Veronica A'zera
Sherry Blede
COL Christine M. Cook, ARNG
Bertha Cruz Hall, USAF
CMDR Constance G. Evans, USPHS, Retired
MG Marcelite J. Harris, USAF, Retired
Joy Ilem
COL Lois Johns, RN, Ph.D., USA, Retired
LTC Consuelo C. Kickbusch, USA, Retired
CAPT Lory Manning, USN, Retired
Janette M. McSparren, USN
COL Karen L. Ray, RN, MSN, USA, Retired
CSM, Douglas Russell, USA, Retired

2001-2002

COL Karen L. Ray, RN, MPH, MA, USA, Retired, Chair
CMDR Constance G. Evans, USPHS, Retired, Co-Chair
Marsha Tansey Four, USA
Bertha Cruz Hall, USAF
SFC Gwen M. Diehl, USA, Retired
MG Marcelite J. Harris, USAF, Retired
Edward E. Hartman, USA
LTC Consuelo C. Kickbusch, USA, Retired
LTC Kathy LaSauce, USAF, Retired
MAJ M. Joy Mann, USAFR
CAPT Lory Manning, USN, Retired
COL Michele (Mitzi) Manning, USMC, Retired
COL Kathleen A. Morrissey, RN, BSN, USA
CDR Joan E. O'Connor, USNR, Retired
Sheryl Schmidt, USAF
MSgt Lewis E. Schulz II, USAF, Retired
CMSgt Luc M. Shoals, ANG

2003-2004

Marsha Tansey Four, USA, Chair
SFC Gwen M. Diehl, USA, Retired
Cynthia J. Falzone, USA
Bertha Cruz Hall, USAF
Edward E. Hartman, USA
Donna Hoffmeier
LTC Kathleen LaSauce, USAF, Retired
MAJ M. Joy Mann, USAFR
CAPT Lory Manning, USN, Retired
COL Michelle (Mitzi) Manning, USMC, Retired
COL Kathleen A. Morrissey, RN, BSN, USA, Retired
Carlene Narcho, USA
CDR Joan E. O'Connor, USN, Retired
Lorna Papke-Dupouy, USMC
CAPT Emily Sanford, USN, Retired
Sheryl Schmidt, USAF

MSgt Lewis E. Schulz II, USAF, Retired
The Honorable Winsome Earle Sears, USMC
The Honorable Sara A. Sellers, CMSgt, USAF, Retired
CMSgt Luc M. Shoals, ANG, Retired

2005-2006

Marsha Tansey Four, USA, Chair
SFC Gwen M. Diehl, USA, Retired
Cynthia J. Falzone, USA
Edward E. Hartman, USA
CPO Kathleen Janoski, USN, Retired
CDR Joan E. Kelley, USN, Retired
1SG Pamela J. B. Luce, USA, Retired
COL Kathleen A. Morrissey, RN, BSN, USA, Retired
COL Jacqueline Morgan, M.D., M.P.H, USAF, Retired
Carlene Narcho, USA, Retired
Lorna Papke-Dupouy, USMC
COL Shirley Ann Quarles, R.N., Ed.D., USAR
Lupe Saldaña, USMC
CAPT Emily Sanford, USN, Retired
The Honorable Winsome Earle Sears, USMC
The Honorable Sara A. Sellers, CMSgt., USAF, Retired
CMSgt Luc M. Shoals, ANG, Retired
Virgil L. Walker, ANG

2007-2008

COL Shirley Ann Quarles, R.N., Ed.D., USAR, Chair
CDR René Campos, USN, Retired
CMSgt Helena Carapellatti, USAF, Retired
1SG Pamela J.B. Cypert (Luce), USA, Retired
SFC Gwen M. Diehl, USA, Retired
Velma Hart, USAR
CPO Kathleen Janoski, USN, Retired
Marlene Kramel, USA
The Honorable Mary Antoinette Lawrie, USAF
The Honorable Brenda Moore, Ph.D., USA
COL Jacqueline Morgan, M.D., M.P.H, USAF, Retired
TSgt Barbara Pittman, USAF, Retired
Lupe Saldaña, USMC
CMSgt Sara Seller, USAF, Retired
Celia Szelwach, USA
Joanna Truitt
Virgil L. Walker, ANG
MGySgt Rosmarie Weber, USMC, Retired

Appendix E

Advisory Committee Site Visits A Cumulative Record

1987	St. Petersburg Beach, FL
1989	Minneapolis, MN
1993	San Antonio, TX
1994	Albuquerque, NM
1997	Los Angeles, CA
1998	Chicago, IL
1999	Seattle, WA
2001	Boston, MA
2002	Tampa, FL
2003	Phoenix, AZ
2005	East Orange and Lyons, NJ
2006	North Chicago, IL
2007	Palo Alto, CA

Appendix F

Summary of Site Visits for 2007-2008

The Advisory Committee on Women Veterans generally conducts a site visit each year to a VA health care facility that has an active program for women veterans. The site visit provides an opportunity for Committee members to compare the information that they receive from briefings by VA officials with actual practices in the field. The site visit for 2008 was replaced with the 2008 National Summit on Women Veterans' Issues, held in Washington, D.C.

Palo Alto, CA:

The Advisory Committee on Women Veterans conducted a site visit during June 4-8, 2007, to the VA Palo Alto Health Care System (VAPAHCS). The Committee received briefings and updates from key leadership of the VAPAHCS, key leadership of the Veterans Integrated Service Network 21 (Sierra Pacific Network), California State Department of Veterans Affairs, Oakland VA Regional Office, VA National Cemetery Service, Redwood City Peninsula Veterans Center, VAPAHCS's community-based outpatient clinics (CBOCs), VAPAHCS Women's Health Center, resident training, academic affairs/research, quality assurance, surgical services, polytrauma center, veterans service organizations, nursing services, and inpatient acute psychiatry building plans for privacy issues. The Committee toured VAPAHCS's polytrauma area, Medical Surgical Intensive Care Unit (MSICU), laboratory, hospice, and pharmacy. In addition, the Committee toured the Redwood City Peninsula Veterans Center and the Golden Gate National Cemetery. The Committee spent 1 day at the Menlo Park Division of the VAPAHCS. Members received briefings and updates on the women's mental health program, inpatient posttraumatic stress disorder (PTSD) program, drug addiction programs, crisis intervention, OIF Help Center, chaplain services for women veterans, and the health resources initiatives for veterans everywhere (THRIVE). The Committee toured Menlo Park's resource center for women veterans, domiciliary, and substance abuse inpatient unit. The site visit concluded with an open forum and town hall meeting, followed by an exit briefing by VAPAHCS leadership.

Washington, DC:

Members of the Advisory Committee on Women Veterans (Committee) served as facilitators for the quadrennial National Summit on Women Veterans' Issues (Summit), held June 20-22, 2008, in Washington, DC. Over 400 women veterans, active duty members, guard and reserve, congressional staffers, veteran advocates, and exhibitors attended the 3-day event. Congresswomen Susan Davis from California attended the viewing of the Lioness documentary and workshop sessions, and met with many of the participants. The purpose of the Summit was to examine the issues and recommendations from the 2004 Summit, review VA's progress on these issues, provide information on current issues, and develop recommendations and a plan for continuous progress on women veterans' issues. There were eleven workshop sessions. VA leadership provided updates on VA's services and benefits since the 2004 Summit and sessions on women veterans' health care and mental health, DoD/VA OEF/OIF initiatives for returning veterans, DACOWITS, research, employment, and homeless programs. The Committee Chair served as moderator for the town hall meeting, while the Committee members and VA subject matter experts responded to questions from women veterans.

Appendix G

Briefings to the Advisory Committee on Women Veterans (2006-2008)

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

Office of the Secretary and Center for Women Veterans (CWV)

- The Honorable R. James Nicholson, Secretary, Department of Veterans Affairs, October 2006, February 2007.
- The Honorable Gordon Mansfield, Acting Secretary, Department of Veterans Affairs of Veterans Affairs, brief comments and update on the Department, October 2007.
- The Honorable Gordon Mansfield, Deputy Secretary, Department of Veterans Affairs of Veterans Affairs, brief comments and remarks on the Department, February 2008.
- Dr. Irene Trowell-Harris, Director, Center for Women Veterans, update on the 2006 Advisory Committee on Women Veterans (Committee) Report, November 2006, February 2007, October 2007, February 2008, June 2008.
- Dr. Betty Moseley Brown, Associate Director, Center for Women Veterans, update on Center for Women Veterans and activities, November 2006, February 2007, October 2007, February 2008.
- Tom Bowman, Deputy Chief of Staff, priority issues related to women veterans, November 06.
- Dr. Betty Moseley Brown, Associate Director, Center for Women Veterans, update on the 2008 Summit planning, the 2006 Committee Report recommendation matrix, discussion of recent meetings, media interviews, and update on Committee membership, February 2007, November 2007, March 2008.
- Dr. Irene Trowell-Harris, Director, Center for Women Veterans, training on the process for 2008 Committee Report timeline, June 08.
- Dr. Betty Moseley Brown, Associate Director, Center for Women Veterans, training on role of Committee members at 2008 National Summit on Women Veterans' Issues, June 2008.
- Training with Employee Education Service on the 2008 National Summit on Women Veterans' Issues, June 2008.

Veterans Benefits Administration (VBA)

- Thomas Pamperin, Assistant Director for Policy, Compensation and Pension Service, update on key VBA issues and recommendations in the 2006 Committee Report, October 2006.
- Bradley G. Mayes, Director, Compensation and Pension Service, update on key VBA issues, February 2007.
- The Honorable Daniel Cooper, Under Secretary for Benefits, overview of VBA initiatives, October 2007.
- Keith Pedigo, Assistant Deputy Under Secretary for Policy and Program Management, overview of VBA initiatives, February 2008.

Veterans Health Administration (VHA)

- Carole L. Turner, Director, Women Veterans Health Program, update on recommendations 3-5, 14-15, and 17-19 from the 2006 Committee Report, and discussion with panel members Dr. Lawrence R. Deyton, Chief Public Health and Environmental Hazards Officer, and Sara McVicker, Primary Care Service Line, November 2006.
- Dr. Barbara Sigford, National Program Director, Physical Medicine and Rehabilitation, Minneapolis VAMC, briefing on polytrauma, November 2006.
- Dr. Patricia M. Hayes, Acting Director for VHA Women Veterans Health Program, introduction to Committee, February 2007.
- Deputy Field Directors, along with Lead Women Veterans Program Manager, Dr. Patty Hayes, overview of Women Veterans Program Manager duties, key issues in each region that are affecting women veterans, February 2007.
- Meri Mallard, Deputy Field Director, Women Veterans Health Program, discussion of matrix of recommended site visits, February 2007.
- Dr. Michael J. Kussman, Principal Deputy Under Secretary for Health, overview of VHA initiatives, October 2006, February 2007, October 2007, February 2008.
- Dr. Linda Kinsinger, Director, National Center for Health Promotion and Disease Prevention, HealthierUS Veterans Initiative, November 2006.
- Dr. Amy Street, National Center for PTSD, combat post-traumatic stress disorder (PTSD) programs for women veterans, November 2006.
- Terry McCullough, Supervisory Senior Fee Program Specialist and Sandra Mize, Fee Policy Specialist, VA Health Administration Center, briefing on Fee Basis Program, November 2006.
- Ralph Charlip, FACHE, FAAMA, Director, VA Health Administration Center, update on status of Fee Service Program, March 2007.
- Dr. Susan McCutcheon, Program Manager for Special Projects for Mental Health Strategic Health Group, overview of VA Mental Health Program, November 2006, October 2007.
- Dr. Robert Gresen, Associate Chief Consultant (Milwaukee VAMC), briefing on new Psychosocial Rehabilitation and Recovery Services Program, March 2007.
- Dr. Rachel Kimerling, National Center for PTSD, VA Palo Alto Health Care System, briefing on domestic violence, March 2007.
- Dr. Patricia Hayes, Acting Director, Women Veterans Health Strategic Health Care Group (WVHSHG), overview of WVHSHG and status of recommendations 3, 4, 15, 17, & 18, October 2007.
- Dr. Susan McCutcheon, Director, Family Services, Women's Mental Health and Military Sexual Trauma, Office of Mental Health Services, overview of mental health issues and recommendation 20, October 2007.
- Dr. Patricia Hayes, Acting Chief Consultant, WVHSHG, update on recommendations 2 and 16, February 2008.
- Dr. Sumitra Muralidhar, Scientific Program Manager, VHA, briefing: genomic medicine, October 2007.

Center for Minority Veterans

- Lucretia McClenney, Director, Center for Minority Veterans, overview on Center for Minority Veterans, March 2007.

Team Lioness Documentary

- Briefing - Team Lioness documentary, Directors: Meg McLagan and Daria Sommers with Jamie Schor, Captain Anastasia Breslow, U.S. Army, Ranie Ruthig, and Rebecca Nava, June 2008.

National Cemetery Administration (NCA)

- Richard A. Wannemacher, Acting Under Secretary for Memorial Affairs, overview of the National Cemetery Administration, October 2007.

Services for Women Who Are Homeless

- Lisa Pape, Director, Residential Treatment Programs, VHA Homeless and Residential Rehabilitation, update on VA homeless programs and initiatives, November 2006.
- Pete Dougherty, Director of Homeless Program, homeless program/incarcerated veterans, re-entry initiative, February 2007.
- Pete Dougherty, Director of Homeless Programs and Mary Rooney, briefing on 2006 Homeless Report, VA homeless programs and initiatives related to women veterans, October 2007.

Legislative Initiatives and Hill Site Visits

- Christine Hill, Assistant Secretary for Congressional and Legislative Affairs, legislative issues affecting women veterans, October 2007.
- Charles Likel, Legislative Advisor, Office of Congressional and Legislative Affairs, briefing on congressional and legislative affairs and update on recommendation 5 from 2006 Report, November 2006.
- Site visit to Capitol Hill, meet with staffers from House and Senate Veterans' Affairs Committees, February 2006, February 2007

Research and Surveys

- Dr. Shirley Meehan, Acting Director, Health Services Research and Development (HSR&D), VA research on women's health issues, update on strategic plan, status of recommendations 12-13 in the 2006 Report, November 2006.
- Dr. Donna Washington, Primary Care and Women's Health Staff Physician, VA Greater Los Angeles Healthcare System (GLAHS), HSR&D Center of Excellence, update on women veterans' research, November 2006.
- Dr. Joseph Francis, Deputy Chief, Research and Development Officer, VHA, update on recommendation 12 and overview of women veterans' research, February 2008.
- Dr. Elizabeth Yano, GLAHS, Sepulveda Campus, update on women veterans research, October 2007.

Defense Advisory Committee on Women in the Services (DACOWITS)

- COL Denise Dailey, Military Director DACOWITS, key issues from the 2006 and 2007 DACOWITS reports, November 2006, October 2007.

VA/DoD

- Dr. Marianne Mathewson-Chapman, Chief, Outreach to Guard/Reserve, Office of Seamless Transition, update on seamless transition, November 2006.

Office of General Counsel

- Jonathan Gurland, Office of General Counsel, ethics issues, March 2007, October 2007.

Center for Veterans Enterprise

- Gail Wegner, Deputy Director, Center for Veterans Enterprise, overview of the Center for Veterans Enterprise and women veterans issues, November 2006, October 2007.

Veterans Disability Benefits Commission

- Ray Wilburn, Contractor, briefing on the Veterans Disability Benefits Commission's final report, October 2007.

APPENDIX H

DEPARTMENT OF VETERANS AFFAIRS CHARTER OF THE ADVISORY COMMITTEE ON WOMEN VETERANS

A. OFFICIAL DESIGNATION: Advisory Committee on Women Veterans

B. OJECTIVES AND SCOPE OF ACTIVITY: The Committee provides advice to the Secretary on the needs of women veterans with respect to health care, rehabilitation benefits, compensation, outreach, and other relevant programs administered by the Department of Veterans Affairs (VA).

C. PERIOD OF TIME NECESSARY FOR THE COMMITTEE TO CARRY OUT ITS PURPOSE(S): There is a continuing need for the Advisory Committee on Women Veterans to assist the Secretary in carrying out the responsibilities under section 542 of title 38, United States Code. Authorized by law for an indefinite period, the Committee has no termination date.

D. OFFICIAL TO WHOM THE COMMITTEE REPORTS: The Advisory Committee on Women Veterans reports to the Secretary through the Director, Center for Women Veterans.

E. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT TO THE COMMITTEE: The Center for Women Veterans is responsible for providing support to the Advisory Committee on Women Veterans.

F. DUTIES OF THE COMMITTEE: In carrying out its primary responsibility of providing advice to the Secretary of Veterans Affairs, the Committee will (1) assess the needs of women veterans and the benefits and programs provided by VA to meet those needs, (2) review reports and studies pertaining to programs and activities that affect women veterans, and (3) provide to the Secretary such recommendations (including recommendations for administrative and legislative action) as the Committee considers appropriate.

By statute, the Committee shall consist of members appointed by the Secretary from the general public, including representatives of women veterans and individuals who are recognized authorities in fields pertinent to the needs of women veterans including the gender specific health-care needs of women. The Secretary shall determine the number and terms of service of members of the Committee, except that a term of service of any such member may not exceed 3 years. The Secretary may reappoint any such member for additional terms of service.

The Committee will be comprised of approximately 14 members. Several members may be Regular Government Employees, but the majority of the Committee's membership will be Special Government Employees.

G. ESTIMATED ANNUAL OPERATING COSTS IN DOLLARS AND STAFF-YEARS:
The annual operating costs for the Committee are \$176,000 and .75 staff-years. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulation for any travel made in connection with their duties as members of the Committee.

H. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Committee is expected to meet at least three times annually. The Designated Federal Officer (DFO), a full time VA employee, will approve the schedule of Committee meetings. The DFO or a designee will be present at all meetings, and each meeting will be conducted in accordance with an agenda approved by the DFO. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.

I. COMMITTEE TERMINATION DATE: None

J. DATE CHARTER IS FILED:

Approved:  Date: 9/19/07
R. James Nicholson
Secretary of Veterans Affairs

Appendix I

Center for Women Veterans Mission and Goals



MISSION

The mission of the Center for Women Veterans is to ensure that women veterans receive benefits and services on par with male veterans; that VA programs are responsive to gender-specific needs of women veterans; outreach is performed to improve women veterans' awareness of services, benefits and eligibility criteria; and that women veterans are treated with dignity and respect.

The Director, Center for Women Veterans, acts as the primary advisor to the Secretary of Veterans Affairs on all matters related to policies, legislation, programs, issues, and initiatives affecting women veterans.

GOALS

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

- Identify policies, practices, programs, and related activities that are unresponsive or insensitive to the needs of women veterans and recommend changes, revisions or new initiatives designed to address these deficiencies.
- Foster communication between all elements of VA on these findings and ensuring that the women veterans' community that women veterans' issues are incorporated into VA's strategic plan.
- Promote and provide educational activities on women's veterans' issues for VA personnel and other appropriate individuals.
- Encourage collaborative and develop collaborative relationships with other Federal, state, and community agencies to coordinate activities on issues related to women veterans.
- Coordinate outreach activities that enhance women veterans' awareness of new VA services and benefits.
- Promote research activities on women veterans' issues.
- Fulfilling all other functions of the Center as outlined by Congress in Public Law 103-446.