2012 Report

Strategies for Serving Our Women Veterans

Department of Veterans Affairs

Women Veterans Task Force

Draft for Public Comment • May 1, 2012

"We, at VA, must be visionary and agile enough to anticipate and adjust not only to the coming increase in women Veterans, but also to the accompanying complexity and longevity of treatment needs they will bring with them."

Secretary Shinseki, July 16, 2011

Preface

This draft strategy report was developed by the Women Veterans Task Force (WVTF) of the Department of Veterans Affairs (VA). The task force, which was called for by Secretary Shinseki in July 2011, is chaired by the VA Chief of Staff with the three Under Secretaries serving as a governing board.

In preparation for the task force's effort, background on the "as is" state of services and benefits for women Veterans was documented in the fall of 2011 by a working group with representatives from all VA administrations. The WVTF, which commenced work in February 2012, consists of subject matter experts from across VA, representing the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA), and VA headquarters (VACO). Full membership of the WVTF is shown in Appendix A.

This draft report is an interim deliverable, representing the work of the WVTF emerging from a four-day offsite in March. Public comments on this draft are welcome through June 14, 2012 and should be submitted through the Federal Register Web site www.regulations.gov.

Following the comment phase, a revised strategy report will be developed presenting the task force's recommendations for continuously improving services for women Veterans across the entire Department. In addition to the strategy report, the task force will develop an action plan for implementing the recommended strategies, specifying costs, work plans, performance measures, organizational accountabilities, and associated risks. The action plan will update and inform VA's approach to women's issues within the health care, benefits, and cemetery administrations, and will guide the agency in planning and implementation of programming, budgeting, education and training. The task force is posting the draft strategy plan/report for public comment at an early stage in order to elicit the creative thinking and expert opinions of a wide range of stakeholders.

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Introduction

The Department of Veterans Affairs (VA) is committed to transformation, with the aim of becoming an increasingly Veteran-centric, results-oriented, and forward-looking organization. In line with this commitment, Secretary Shinseki called for the formation of a Women Veterans Task Force (WVTF) in July 2011, to be charged with developing a comprehensive VA action plan for resolving gaps in how our organization serves women Veterans. As an interim deliverable, the WVTF developed this draft strategy report to solicit stakeholder feedback on its initial findings and recommendations. Based on public comments to this draft, the WVTF will finalize its recommendations and develop a detailed action plan for implementation.

The urgency of this effort is acute, given the rapid growth of the women Veteran population. Consider these facts, which Secretary Shinseki cited in announcing the formation of the WVTF:

- Fully 14 percent of active duty and 18 percent of National Guard and Reserves forces are now women. In contrast, the percentage of women in uniform was just 2 percent in 1950.
- The nature of warfare places women in hostile battle space in ever-increasing numbers, with ever-increasing opportunity for direct-fire combat with armed enemies.
- Women are sustaining injuries similar to their male counterparts, both in severity and complexity.

Women are now the fastest growing cohort within the Veteran community. In 2011, about 1.8 million or 8 percent of the 22.2 million Veterans were women.[1] The male Veteran population is projected to decrease from 20.2 million men in 2010 to 16.7 million by 2020. In contrast, the number of women Veterans will increase from 1.8 million in 2011 to 2 million in 2020, at which time women will make up 10.7 percent of the total Veteran population.

The population of women Veterans has grown steadily over the last decade because of the increasing number and proportion of women entering and leaving the military, the more favorable survival rate of women compared to men at any given age, and the younger age distribution of women Veterans compared to male Veterans. In 2010, the estimated median age of female Veterans was 48, compared to 62 for male Veterans.

1 Department of Veterans Affairs, VetPop07, at http://www.va.gov/vetdata/

Note: The 2010 American Community Survey reported that 1.6 million or 7 percent of the 21.8 million Veterans were women. *VetPop07* figures are projections based on Census data through 2006.

Building on Our Accomplishments

Providing high-quality care and benefits for America's Veterans is at the heart of VA core values. ***"Because I CARE, I will"*** articulates who we are at VA: professionals who seek to embody the values of **I**ntegrity, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence in our service to Veterans. It calls us to action across VA, recognizing that living these values requires continuous improvement, based on a resolve to identify weaknesses and rigorously correct them.

When it comes to the treatment of women Veterans, we at VA have been working diligently to deliver on our ***I CARE*** values. Our efforts at continuous improvement are informed by a series of reports issued over the past 25 years by the Secretary's Advisory Committee on Women Veterans, the Government Accountability Office (GAO), Congress, and internal VA groups that have identified gaps in access to and delivery of services and benefits for women Veterans. The history of recommendations and VA responses is summarized in Appendix B. Despite considerable progress over the years, gaps do remain and VA continues to strive to identify and resolve them.

Fortunately, we have a strong foundation to build on. Efforts under way across VA pertaining to delivery of services and benefits to women Veterans include:

- Collaborative outreach efforts led by the **Center for Women Veterans** (CWV) to build awareness among women Veterans of the benefits and services provided by VA, and to champion cultural transformation within VA.
- Initiatives led by the **Women Veterans Health Strategic Health Care Group** (WVHSHG) within VHA that have resulted in implementation of comprehensive primary care for women Veterans, training of VA providers in basic and advanced women's health care, launching of the Women's Health Evaluation Initiative, revision of the VHA Handbook 1330.01: Health Care Services for Women Veterans, installation of full-time Women Veterans Program Managers (WVPMs) at VA facilities nationwide, enhancement of mental health and homeless services for women Veterans through collaboration across program offices, and ramped-up communications to and about women Veterans.
- The development by the **Office of Mental Health Services** of an Military Sexual Trauma (MST) Support Team and MST program; and the implementation of national MST training for primary care and mental health providers.
- The designation by VBA of **Women Veterans Coordinators** (WVCs) to outreach to women Veterans, to promote the use of VA benefits by women Veterans and to assist women Veterans in developing claims, especially those claims involving issues of a sensitive nature such as MST. As of August, 2010, VBA reported having a total of 73 WVCs nationwide. All regional offices (ROs) have at least one individual designated to serve as the WVC and larger

offices have two or three employees assigned to the task. WVCs are also located in national call centers and out-based locations.

Another resource is the Secretary's Advisory Committee on Women Veterans (ACWV), established in 1983, which has reporting requirements to the Secretary and to Congress. The Committee's role is to provide 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 VA. The ACWV develops recommendations to address unmet needs that have implications for the entire women Veterans population, based on information presented during briefings at Committee meetings and site visits.

Thanks to all of these initiatives, measurable gains were achieved in recent years. For example:

- **More women are now aware of and benefiting from VA services than ever before.** The first VA-commissioned survey of women Veterans in 1985 revealed that 57 percent of women Veterans did not know they were eligible for VA services or benefits. By 2009, about 30 percent of women Veterans surveyed did not think they were eligible for VA benefits. While this number is still unacceptably high, it does represent a marked improvement in awareness levels.
- **VA outperforms the private sector in breast and cervical cancer screenings.** In 2008, 87 percent of women Veteran patients received breast cancer screenings and 92 percent received cervical cancer screenings compared to commercial health care, which scored 69 percent and 82 percent, respectively.[2]

Current Status of Women Veterans

VA has made significant progress in serving women Veterans, but work remains to be done. Not all of our systems are equipped to address the comprehensive needs of women Veterans or to provide certain services and benefits for which women Veterans have a greater need relative to their male counterparts. Many women Veterans still do not know about or think they are eligible for services. Some gender-based health disparities continue to exist. Data collection gaps hamper our understanding of women Veterans' needs and their utilization of VA benefits and services. We can do better in providing an inviting and secure environment of care, matching capacity to women's health care needs and demands, and ensuring that high-quality services are rendered in a respectful and sensitive manner. It is the desire to achieve systemic improvements in addressing such issues that prompted formation of the WVTF by Secretary Shinseki.

[2] State of Health Care Quality Report, 2008, www.ncqa.org

In health care, in particular, the VA has the opportunity to become a national model for service delivery that successfully addresses gender-specific needs. Recent research indicates that health programs that are gender-responsive — taking gender issues into account in health policy, planning, practice, and research — are not only more effective in reducing health inequities, but also exhibit greater efficiency.[3]

Available data reveal several characteristics of women Veterans that should be considered in ensuring gender-responsive services and benefits:

Higher physical and mental health needs.[4] A higher proportion of female Veterans (22 percent) are diagnosed with mental health problems than male veterans.[5] The most common diagnoses among women Veterans seeking care are PTSD, hypertension, depression, high cholesterol, low back pain, gynecologic problems, and diabetes. Studies show that 31 percent of women Veterans have both medical and mental health conditions compared with 24 percent of male Veterans. Among women Veterans with diabetes, 45 percent have a serious mental illness or substance use disorder. In FY 2009 and FY 2010, PTSD, hypertension, and depression were the top three diagnostic categories for women Veterans treated by VHA.[6]

Higher incidence of Military Sexual Trauma (MST). One in five women Veterans who use VA for health care screen positive for MST. [7]Women who enter the military at younger ages and those of enlisted rank appear to be at increased risk for MST. In addition, women who have had sexual assaults prior to military service report higher incidences of MST.[8] MST has been associated with increased risk of depression, PTSD and substance use. Females experiencing MST are more than four times more likely to have PTSD and are at six-fold increased risk for having three or more mental health conditions. In FY 2011, the most recent year for which data are available, 19.4 percent of OEF/OIF/OND female Veterans reported a history of MST

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3 Guidelines for the analysis of gender and health. Liverpool School of Tropical Medicine, Gender and Health Group

4 Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans. Women Veterans Health Strategic Health Care Group. November 2008

5 VA Office of Inspector General, "General Combat Stress in Women Receiving VA Healthcare and Disability Benefits."

6 Women Veterans Health Workload Report. October 2010

7 The definition of MST used by the VA is given by U.S. Code (1720D of Title 38): "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training." MST includes any sexual activity where someone is involved against his or her will—he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or implied faster promotions or better treatment in exchange for sex), may have been unable to consent to sexual activities (for example, when intoxicated), or may have been physically forced into sexual activities. MST includes unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; and threatening and unwelcome sexual advances.

8 A. Suris and L. Lind, "Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans," *Trauma Violence Abuse* Vol. 9, No. 4 (October 2008) pp. 250-269.

when screened by a VA healthcare provider compared with 0.9 percent of OEF/OIF/OND male Veterans. Rates of MST reported among all Veterans screened at the VA were 23.0 percent for females and 1.2 percent for males for FY 2011.[9]

Lower access and enrollment of VA health care. The number of women Veterans using VA has increased 83 percent in the past decade, from about 160,000 to over 292,000 between FY 2000 and FY 2009, compared with a 50 percent increase in men.[10] Lifetime female health care expenses are a third higher than male expenses.[11] Although the number of women Veterans using VHA has increased over time, it is important to note that women Veterans are still approximately 30 percent less likely to enroll in VHA than men.

Gender-based disparities in healthcare quality. Health care quality scores related to contributors to cardiovascular disease risk (management of high blood pressure, high cholesterol, and diabetes) were worse for women Veterans when compared to male Veterans.[12] There are also disparities between men and women in preventive care statistics. Fewer women Veterans received colorectal cancer screening, depression screening, and immunizations (pneumococcal and influenza) compared to male Veterans. Pharmacy data indicate that women in VA are more likely to be prescribed inappropriate drugs than men.[13] Although gender-based disparities in health care exist in the private sector as well, VA is in an excellent position to understand why the gaps occur and to implement systems of care that can close them.

Higher rates of homelessness. Secretary Shinseki made a commitment to ending homelessness among our nation's Veterans by 2015. In December 2011, VA and the Department of Housing and Urban Development announced that homelessness among Veterans decreased by 12 percent between January 2010 and January 2011.[14] While the overall number of homeless Veterans is declining, the number of homeless women Veterans is increasing. Women Veterans are the fastest growing segment of the homeless population and are at higher risk of homelessness than their male counterparts.[15] Female Veterans also are more than twice as likely to be

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9 Military Sexual Trauma Support Team (2012). Military Sexual Trauma (MST) Screening Report, Fiscal Year 2011. Washington DC: Department of Veteran Affairs, Patient Care Services, Office of Mental Health Services.

10 Frayne SM, et al. Sourcebook: Women Veterans in the Veterans Health Administration. Volume 1. Sociodemographic Characteristics and Use of VHA Care. Women's Health Evaluation Initiative, Women Veterans Health Strategic Health Care Group, VHA. December 2010.

11 Alemayehu B & Warner K. The lifetime distribution of healthcare costs. Health Service Research, June 2004.

12 Wright SM, Lucatorto MA, Yano EM. An analysis of the quality of care provided to men and women in the VA health care system.

13 Systematic Review of Women Veterans Health research 2004-2008, October 2010. VA Health Services Research and Development Service.

14 These homeless statistics are drawn from a survey taken each January, known as a "Point-in-Time" counts. The January 2011 survey found 67,495 homeless veterans, down from 76,329 one year earlier.

15 "Homelessness Among Women Veterans," presented at 2011 National Training Summit on Women Veterans by Stacey Vasquez.

homeless when compared to female non-Veterans in the United States and female Veterans living in poverty are more than three times more likely to be homeless than female non-Veterans in poverty.[16] Younger Veterans (18–29 years) were at higher risk for homelessness, with young, female black Veterans at the greatest risk.

Need for access to child care. The Secretary's Advisory Committee on Women Veterans recommended in its 2010 report that VA provide childcare options for eligible Veterans, utilizing public and private partnerships, in order to facilitate their access to quality health care services. Under the Caregivers and Veterans Omnibus Health Services Act of 2010 (PL 111-163), Congress required VA to implement a two-year childcare pilot in no fewer than three separate Veteran Integrated Service Networks (VISN). The law requires that the pilot program assess the feasibility and advisability of providing assistance for childcare to qualified veterans receiving VA care. Since many Veterans, particularly women Veterans, are the primary caretakers for young children, it is hoped these childcare centers will make it easier for such Veterans to utilize VA. In a survey, VA found that nearly a third of Veterans were interested in childcare services and more than 10 percent had to cancel or reschedule VA appointments due to lack of childcare. The intent is to diminish barriers for Veterans who have difficulty keeping appointments due to child care obligations. The law limits the provision of childcare assistance to these pilot programs, and eligibility is defined as being for qualified Veterans receiving VA health care services on an outpatient basis at a VA facility.

Higher level of service-connected disability ratings. In FY 2009, among users of VA health care, a higher proportion of women Veterans had service-connected (SC) disability ratings than men (55 percent versus 41 percent). Of these, 26 percent of women and 19 percent of men had a disability rating higher than 50 percent. The fact that more than half of women Veterans now carry an SC disability rating and that many are young holds implications for the future as they will be eligible for compensation and VHA care for many years.[17]

Higher demand for education benefits among OEF/OIF/OND women Veterans. According to the 2010 National Survey of Veterans, overall 35.2 percent of women Veterans used VA education benefits, which was comparable to the 36 percent of male Veterans who used such benefits. However, 50.6 percent of females serving in OEF/OIF/OND were likely to report using benefits compared to 37.2 percent of males in OEF/OIF/OND.

Underrepresentation in memorial services. The Advisory Committee on Women Veterans (ACWV) cited concerns that women Veterans may be underrepresented

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16 Culhane DP. Prevalence and Risk of Homelessness among US Veterans: A Multisite Investigation. August 2011. Available at: http://works.bepress.com/dennis_culhane/107

17 Frayne SM, et al. Sourcebook: Women Veterans in the Veterans Health Administration. Volume 1. Sociodemographic Characteristics and Use of VHA Care. December 2010. Pp. 11-12

among those interred in National and State Veterans' cemeteries. From 2001 to 2010, 10.0 percent of male Veterans received burial in a national cemetery, compared to 8.8 percent of women Veterans. For Veterans not interred in National cemeteries, there is a significant disparity between the percentage of women who receive headstones or markers (14.2 percent) compared to men (46.8 percent).

Defining Priority Themes

In recognition of the growing numbers and needs of women Veterans, Secretary Shinseki called for a Women Veterans Task Force in July at the 2011 National Training Summit on Women Veterans. The goal of the Task Force is to develop a comprehensive VA action plan that will focus on key issues facing women Veterans and the specific actions needed to resolve them. The action plan will update and inform VA's approach to women's issues within the health care, benefits and cemetery administrations, and will guide the agency in everything from planning to implementation of programming, budgeting, education and training. The task force is to develop the action plan for implementation in coordination with VA's Advisory Committee on Women Veterans (ACWV).

To provide the Women Veterans Task Force a foundation for their work, a VA workgroup was formed to develop a better understanding of VA's current efforts to serve women Veterans and collect gender-specific data on women Veterans. While initiatives directed towards women Veterans exist in every VA administration and service line, they may not be coordinated. A broad survey of VA's gaps in services and current efforts to meet these needs was conducted to inform the way forward for the task force.

The workgroup involved subject matter experts (SMEs) from all the major service lines to ensure that all major VA programs targeted to women Veterans were included. Administration leads were asked to appoint an appropriate SME designee to participate on the workgroup. Next, SMEs who were members of the workgroup were asked to submit answers to a list of priority issues facing women Veterans.

The identified issues or needs of women Veterans, as reported by SMEs, included the following:

- Underutilization of services
- Lack of awareness of benefits or eligibility
- Personal privacy and environment of care
- Fragmentation and gaps in health care
- Access to mental health care services
- Access to gender-specific specialty care (OB/GYN)
- Gender-based health disparities
- Underrepresentation in research; lack of data
- Unemployment
- Homelessness
- Need for child care
- Military sexual trauma (MST) and related issues (i.e. PTSD coverage, employment, etc)
- Domestic violence

The initial list of priority issues was presented for a roundtable discussion on November 4, 2011.

Participants then discussed how VA has worked to address issues for women Veterans over the years. Concerns over these efforts could be grouped into several themes as well:

- Outreach to women Veterans
- Coordination across the department, duplication of services, and need for a department-wide strategy to address women Veterans
- Roles and responsibilities of Women Veterans Program Managers (VHA), Women Veterans Coordinators (VBA), the Center for Women Veterans (CWV), and the Advisory Committee on Women Veterans
- Need for department-wide planning and programming to meet increased demand from the future population of women Veterans.

At the conclusion of the November 4 roundtable, participants prioritized the issues as:

- Capacity and coordination of services
- Women Veterans' experience of care and environment of care
- Employment and training
- Data collection and evaluation of services

Evaluation of these themes by the working group informed the efforts of the WVTF during its four-day workshop in March 2012.

Addressing Two Overriding Questions

Despite the very real progress in recent years and the concerted efforts under way throughout VA, gaps persist in our services and benefits to women Veterans. Given the projected continued growth in the women Veteran population, it is imperative that we make systemic changes within VA to better understand and address their unique service and treatment needs.

Two overriding questions have shaped the work of the WVTF:

- ***What is the nature of gaps that persist; and***
- ***What do we need to do differently across VA to eliminate them?***

In evaluating these questions, the WVTF surveyed the 25-year history of VA efforts to better serve women Veterans and began to gather available data on "as is" conditions across our service lines. To date, the initiatives undertaken pertaining to women Veterans have been conducted almost exclusively within the individual VA administrations or offices. Data pertinent to women Veterans are not always shared and correlated across VA organizational boundaries. As a result, some questions about women Veteran's unique needs and their level of awareness of, access to, and satisfaction with VA services and benefits remain unanswered.

Initial Conclusions

The WVTF concluded that transforming VA to meet the needs of the growing cohort of women Veterans will require:

- **Leadership support and championing of a comprehensive, collaborative cross-VA strategy** for continuously improving service and benefits delivery to women Veterans, based on evidence, ongoing data collection and evaluation, performance measures, and significant input from stakeholders. The WVTF recommends that four priority themes (defined below) be the focus of the first action plan, and that care be taken to leverage, rather than duplicate, work related to these themes that is being actively undertaken in other VA forums, including the Women Veterans Health Strategic Health Care Group (WVHSHG), the VA/Department of Defense (DoD) Employment Task Force, the DoD/VA Integrated Mental Health Strategy, the VHA National Leadership Council's Veteran Experience Committee, and the VA Homelessness Program.
- **Enhancing organizational accountability, collaboration, and transparency.** Despite leadership support, significant efforts made to date, and passionate internal and external stakeholders, VA activities to improve services and outreach to women Veterans are fragmented. Recommendations to enhance the effective delivery, accountability, resource management, and sustainability of services and benefits for women Veterans will include developing a department-wide integrated plan for meeting the needs of

women Veterans; analyzing current organizational design, relationships and internal accountability measures and mechanisms; identifying organizational and business process enablers and barriers throughout VA; identifying opportunities for improvement; and formalizing the roles, responsibilities, accountability, and reporting mechanisms across the VA organizations engaged in addressing the unique needs of women Veterans.

The WVTF recommends that the initial cross-VA action plan for women Veterans address the four priority themes identified by the working group in fall 2011:

- **Capacity and Coordination of Services.** This theme addresses the development of systems to ensure appropriate health care staffing projections for primary care, mental health care, and relevant specialty care to meet the current and projected needs of women Veterans; and the enhancement of efforts to coordinate provision of care and services across VA and between VA and other federal, state, and community-based organizations. The action plan should address specific subpopulations of women Veterans, including racial and ethnic minority groups, rural Veterans, OIF/OEF/OND, and homeless women Veterans.
- **Environment of Care and Experience.** This theme focuses on ensuring 100 percent resolution of identified gaps in the Environment of Care (EOC) for women at VA facilities, including addressing guidelines to safeguard the dignity, respect, and security of women Veterans in inpatient, outpatient, and residential VHA environments. The EOC is made up of three basic elements: (1) the building space, including how it is arranged and the special features that protect patients, visitors, and staff; (2) equipment used to support patient care or to safely operate the building space; and (3) people, including those who work within the hospital, patients, and anyone else who enters the environment, all of whom have a role in minimizing risks.[18] This theme also addresses the need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a Veteran herself, but a male Veteran's wife, mother, or daughter. Women Veterans often report feeling that their service in the military is not recognized or respected. [19]
- **Employment and Training.** This theme addresses improving employment rates among women Veterans who have faced unique challenges in transitioning to civilian employment. The plan of action in this area should complement current efforts to address Veteran unemployment. Whenever possible, efforts to improve the transition process for women should be informed by research that evaluates whether women Veterans are

[18] http://www/utmb.edu/envcare/

[19] Foster LK, Vince S. California's Women Veterans: The challenges and needs of those who served. California Research Bureau. CRB 09-009. August 2009.

maximizing services such as vocational rehabilitation, compensated work therapy for Veterans with disabilities, and intervention assistance (e.g., tutoring) for those eligible for a VA education benefit; and that measures long-term impact of education and training received through the VA or Department of Labor programs.

- **Data Collection and Evaluation of Services.** The task force believes that continuous improvements in services and benefits must be data-driven and evidence-based, and must rely on robust feedback from customers and stakeholders. These continuous improvements must capitalize on existing expertise and available data and evaluation initiatives. Challenges will include developing the methodologies and systems for collecting and evaluating appropriate data, sharing data across organizational boundaries, and providing the needed analysis to drive informed strategies and policy decisions.

The following sections of this strategy report introduce each of the four themes to be addressed in a cross-VA action plan on women Veterans. Each section includes preliminary goals and objectives as the framework for the action plan. The report concludes with a section on the organizational accountability, collaboration, and transparency that will be needed to ensure successful implementation of the new strategic direction regarding women Veterans.

Capacity and Coordination of Services

Problem Statement

Due to the projected increase in demand, VA will need to increase its capacity to provide consistent and coordinated access to comprehensive services and benefits that meet the unique needs of women Veterans, driving action to achieve the optimal resource mix at the appropriate locations to meet this dynamic demand.

- Women Veterans represent 8 percent of the total Veteran population and are projected to reach 10.7 percent by 2020.
- Enrolled women Veterans represent 6.7 percent of the total enrolled Veterans population.
- Approximately 55 percent OEF/OIF/OND women Veterans currently use VA.

Goal 1	Objectives
Provide timely services and benefits that meet the needs of the growing population of women Veterans (utilizing WVHSHG mission strategic plan as a model).	**1.1:** Assess existing VA workforce to determine ability to meet the expected increased demand.
	1.2: Ensure every site of care has a trained and proficient workforce to meet the needs of women Veterans.
	1.3: VHA, VBA, and NCA will ensure they have sufficient ability to accommodate women Veterans who request access to staff of specific gender.

Goal 1 and objectives address the need to appropriately match VA workforce capacity to the increased demand for services by women Veterans, to ensure proficiency of the workforce, and to accommodate requests for staff of specific gender.

Goal 2	Objectives
VA (VHA, VBA, NCA) will collaborate in the coordination of services and benefits that achieve optimal outcomes for women Veterans.	**2.1:** VA will use eBenefits as a platform to provide a central pathway for comprehensive VA benefits and services information that permits women Veterans to craft a Customized Individual Plan (CIP).
	2.2: VA will develop an integrated process for every woman Veteran who requests services and/or benefits to ensure that she is provided the opportunity to create a CIP that addresses her specific needs.

Goal 2 and objectives take on the needs of women Veterans by providing individualized care and alternate means of interacting with VA.

Goal 3	Objective
Enhance the coordination and integration of outreach targeting all women Veterans.	**3.1:** Develop and deploy a One-VA comprehensive (uniform) women Veterans services and benefits package for outreach
	3.2: Strengthen partnerships with Veterans Service Organizations (VSOs) and other stakeholders (federal, state, county, and local) to enhance outreach and education to women Veterans.

Goal 3 and objectives seek to create a clearly defined, accessible, united core of VA benefits and services for women Veterans and to communicate this through a collaborative outreach program.

Outcomes

1. Women Veterans and their families find it easier to access the right benefits and health care while meeting their expectations for quality, timeliness and responsiveness
2. Increased enrollment by women Veterans
3. Increased use of benefits and services by women Veterans.

Environment of Care and Experience

Problem Statement

Gaps exist in personal privacy, dignity, security, and respect that impact the overall women Veterans' experience in VA.

Given the current population needs and forecasted increase in the number of women Veterans eligible for VA services, care, and benefits, it is critical that these gaps are addressed immediately.

Goal 1	Objectives
VA will create a women Veteran-centric environment that exceeds VA standards for personal privacy, dignity, security, and respect, in a manner consistent with applicable law. This goal will be accomplished in collaboration with the VA construction office.	1.1: Eliminate or address remaining VHA-identified facility deficiencies by 2013.
	1.2: Assess VBA and NCA structures for personal privacy, dignity, security, and respect compliance.
	1.3: Design physical environments that take into consideration the changing women Veteran demographics and new concepts in Veteran-centeredness.
	1.4: Design alternate modalities (e.g., virtual, tele-medicine, kiosks, etc.) that take into consideration the changing women Veteran demographics and new concepts in Veteran-centeredness.

Goal 1 recognizes the need to eliminate or address through interim measures the remaining environment-of-care deficiencies at VHA facilities and to identify and remedy any environmental deficiencies at VBA and NCA facilities. In addition, it considers means for ensuring that future facilities and alternate modalities of care delivery are appropriately designed.

Goal 2	Objectives
VA will create a women Veteran-centric environment that exceeds their expectations for services and benefits.	2.1: Invest in innovative and creative means to reach all employees (messaging, video), and ensure inclusiveness of women Veterans in all relevant training programs, developing new training materials as required. Cultural transformation efforts with regard to women Veterans should go hand-in-hand with the global efforts around VA's Veteran-Centric transformation.
	2.2: Increase the total number of women Veterans who are aware of VA benefits and services and the steps they must take to access them.

	2.3: Exceed process and client satisfaction measures for eligibility determination, application, approval, and enrollment for all benefits and services that VA offers and measures.

Goal 2 reflects importance of increasing women Veterans' awareness of VA benefits and services, and of equipping all VA staff to interact respectfully and effectively with women Veterans.

Employment and Training

Problem Statement

Women Veterans continue to face unique challenges in the area of employment. In 2011, the annual average unemployment rate for women Veterans was 9.1 percent compared with 8.2 percent for non-Veteran women. Among 18-24 year-olds, the unemployment rate for women Veterans was 36.1 percent compared to 14.5 percent for their non-Veteran counterparts. [20]

There is a lower percentage of women Veterans with a Bachelor's degree than non-Veteran women:

- Among women aged 17-24, 4 percent versus 10 percent
- Among women aged 25-34, 24 percent versus 35 percent (2009)[21]

There is insufficient integration and collaboration within VA and among external resources in the area of employment and career development/workforce training for women Veterans.

Goal 1	Objectives
Increase employment and retention of women Veterans by leveraging public and private sector resources and improving synergy, integration, and collaboration.	1.1: Identify existing employment-related programs and perform gap analysis.
	1.2: Identify issues specific to women Veterans that impact their employment such as Military Sexual Trauma (MST), mental health ,homelessness, childcare, dependent care, etc.
	1.3: Develop and implement a comprehensive women Veterans' employment plan.

Goal 1 seeks to assess available Federal, state, and non-profit programs related to employment and job retention and to better leverage these programs to improve employment levels of women Veterans.

[20] *Employment Situation of Veterans* 2011; Briefing by Bureau of Labor Statistics, March 19, 2012.

[21] America's Women Veterans; Military Service History and VA Benefit Utilization Services, VA National Center for Veterans Analysis and Statistics, November 23, 2011.

Goal 2	Objectives
2: Enhance marketability and professional development of women Veterans through career development/ workforce training.	2.1: Increase capacity of women Veterans to market their skills and advance their careers.
	2.2: Enhance internal VA capacity to effectively deliver career development/ workforce training resource information, and reintegrate women Veterans in the workplace.

Goal 2 addresses the need for on-going career planning and development women Veterans, which includes navigation to appropriate Federal, state, and local education and training resources.

Data Collection and Evaluation of Services

Problem Statement

One challenge VA faces in meeting the ongoing and emerging needs of women Veterans is the lack of sufficient and actionable data used to deliver quality benefits and services.

Goal 1	Objectives
1: Collect high-quality, gender-specific data to meet stakeholder needs.	1.1: Conduct an initial assessment of stakeholder data needs by the end of FY12.
	1.2: Develop a coordinated approach for enterprise-wide data collection, management, and analysis processes by end of FY12.

Goal 1 addresses the need for an effective approach to enterprise-wide collection, sharing, management, and analysis of gender-specific data. Key actions will include identifying the data required to answer relevant policy and planning questions, and to measure achievements in meeting women Veterans' needs.

Goal 2	Objectives
2: Use data to evaluate services to address women Veterans' needs.	2.1: Evaluate the needs and measures of success of women Veteran programs, services, and benefits and the effectiveness of the VA-wide outreach effort specifically to women Veterans by the end of FY12.
	2.2: Evaluate the needs and satisfaction of Women Veteran programs, services, and benefits in terms of capacity, access, quality, cost, and utilization by the end of FY13.

Goal 2 addresses how data will be used, measured, and continuously improved, the effectiveness of outreach to women Veterans, and their satisfaction with VA programs, services, and benefits.

Organizational Accountability, Collaboration, and Transparency

There has been a considerable investment in enhancing VA's programs, benefits, and services for women Veterans but there remain policies, practices, programs, and related activities that are not yet fully responsive or sensitive to the needs of women Veterans. There is leadership support, significant efforts, and passionate internal and external stakeholders; however, these activities remain fragmented.

Throughout VA a variety of organizations perform women Veteran related policy development, official information dissemination, internal and external communications, outreach to the public, internal and external training and provide direct delivery of service to women Veterans. These activities are not always effectively communicated or coordinated across the Department.

We must enhance the effective delivery, accountability, resource management and sustainability of services and benefits for women Veterans.

Key Efforts

- Develop a department-wide integrated action plan for meeting the needs of women Veterans. (This document is the outline of that plan.)
- Analyze the current organizational design, relationships and internal accountability measures and mechanisms. Identify organizational and business process enablers and barriers throughout VA, and identify opportunities for improvement.
- Formalize the roles, responsibilities, accountability and reporting mechanisms across the VA organizations that are engaged in addressing the unique needs of women Veterans.

Conclusion

At VA, we are committed to providing high-quality services and benefits to America's Veterans. Meeting this commitment requires ongoing adaptation and transformation. As Secretary Shinseki explained, "This transformation is demanded by new times, new technologies, new demographic realities, and new commitments to today's Veterans. It requires a comprehensive review of the fundamentals in every line of operation the Department performs." In this spirit, Secretary Shinseki has charged the Women Veterans Task Force with developing a comprehensive VA action plan in how our organization serves women Veterans, a timely effort given the rapid growth in the women Veteran population. This draft strategy report represents the first phase in the development of such a comprehensive action plan. Public comments are being sought at this early stage to ensure that the expertise and experience of our diverse stakeholders and partners can inform the ultimate plan. We believe that the strong support demonstrated by VA leadership, together with the commitment of our stakeholders, will equip VA with the ingredients for success in addressing the unique care and service needs of our women Veterans.

Appendix A

Members of the Women Veterans Task Force, Categorized by Working Group

Capacity and Coordination of Services

Karen Malebranche, Executive Director, Interagency Health Affairs (VHA); Co-Chair
Michela Zbogar Chief Medical Officer (VHA, VISN 8); Co-Chair
Julie Carie, VSO Liaison (VBA, BAS)
Serena Chu, Program Analyst (VHA, Rural Health)
Stacy Garrett-Ray, Deputy Director, Comprehensive Women's Health (VHA, WVHSHG)
Amy Marcotte, Team Lead (VHA, Vet Centers)
Jeanette Mendy, Health Systems Specialist (VHA, IHA)
Stephanie Robinson, Program Analyst (OPIA, HVIO)
Richard Stark, Director, Primary Care Clinic Operations (VHA, Primary Care)
Sally Haskell, Acting Director, Comprehensive Women's Health (VHA, WVHSHG)

Data Collection and Evaluation of Services

Shana Brown, Assistant Director, San Diego RO (VBA); Co-Chair
Christi Greenwell, Assistant Director (VBA, BAS); Co-Chair
Murielle Beene, Acting Deputy Director for Health Infomatics (VHA)
Tom Garin, Program Analyst for OPP (VA)
Kate Hoit, New Media Specialist (VHA)
Candace Ifabiyi, Program Analyst for OPP (VHA)
Michelle Lucatorto, Program Manager (VHA)
Cathy Rick, Chief Nursing Officer (VHA)
Kenneth Wagner, Director for OPP (VA)
Faith Walden, Program Analyst (NCA)
Elizabeth Yano, Co-Director, Center for Excellence (VHA)
Laurie Zephyrin, Director, Reproductive Health (VHA)

Environment of Care and Experience

Aubrey Weekes, Director, Environmental Program Service (VHA); Co-Chair
Abdoulie Jammeh, Bay Pines VAMC Assistant Chief, Environment Management Service (VHA); Co-Chair
Sonja Batten, Deputy Chief Consultant for Specialty Mental Health (VHA)
Vonda Broom, Deputy Director, Environmental Programs Service (VHA)
Anna Crenshaw, Chief, Client Services Outreach (VBA, BAS)
Elizabeth Helm-Frazier, Program Assistant, Office of Strategic Planning (VBA)
Kate Hoit, New Media Specialist (OPIA)
Connie LaRosa, Deputy Field Director, WVHSHG (VHA)
Billie Randolph, Deputy Chief Prosthetics Officer (VHA)

Employment and Training

Georgia Coffey, Deputy Assistant Secretary for Diversity and Inclusion (VA); Co-Chair
Joan Ricard, Director, El Paso VA Health Care System (VHA); Co-Chair
Cathy Abshire, Program Manager, VHA Homeless Programs (VHA)
Chanel Bankston-Carter, Program Management Officer (VESO)
Stephanie Birdwell, Director, Office of Tribal Government Relations (OPIA)
Sharon Crowder, LCSW, CPRP, Office of Mental Health Operations and Office of Operations and Management (VHA)
Bridget Griffin, Program Analyst (VBA, BAS)
Betty Moseley-Brown, Associate Director (CWV)
Annette Taylor, Education Specialist (VALU)
Angela Wilcher, Program Analyst (VBA, VRE)

Planning for the Future

Lillie Jackson, Assistant Director, Buffalo RO; Co-Chair
Susan Sullivan, Director of Strategic Planning, (VACO); Co-Chair
Deborah Amdur, Chief Consultant, Case Management & Social Work (VHA)
Lauren Bailey, Acting Deputy Director, Online Communications (OPIA)
Ruth Fanning, Director, Vocational Rehabilitation and Employment (VBA)
Robin Ficke, Legislative Staff, Compensation Service
Sarah Goddard
Patricia Hayes, Chief Consultant (VHA, WVHSHG)
Catherine Trombley, Communications Specialist (VBA)
Carrie Tuning, Learning Consultant (VALU)
Stacey Vasquez, Deputy Director, (OPIA, HVIO)
Stephanie Willis, Strategic Management Group (HRA)

Appendix B

History of VA Efforts to Improve Services and Benefits for Women Veterans

Women have served in U.S. military efforts since the American Revolution, and were first granted a formal role in the armed forces with the creation of the Army Nurse Corps in 1901.[22] The U.S. Code does not make a distinction between male and female Veterans. However, the reality is that women have not always had equal access to all Veterans' benefits. Beginning in the 1980s and 1990s, as more information became available about gender disparities in VA care and benefits for women Veterans, VA took a number of action, some mandated by Congress, to ensure better access to services and benefits for women Veterans. Milestones in the evolution of VA services to women Veterans are highlighted below.

VA for Women Veterans Timeline – VA has come a long way

1972: Public Law 92-540 clarifies that the term "wife" includes the husband of any female Veteran, and the term "widow" includes the widower of any female Veteran.

1980: Women comprise less than 2 percent of the Veteran population; 1980 Census finds 1.2 million women served in the Armed Forces.

1982: GAO report reveals lack of access to psychiatric care because facilities cannot accommodate women. Also, women Veterans received little to no gynecological care.

1983: Secretary's Advisory Committee on Women Veterans is established with reporting requirements to the VA Administrator and to Congress on needs of women Veterans and recommendations for action.

1984: First report of the Advisory Committee identifies 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.

1985: First VA-commissioned survey of women Veterans reveals that 57 percent of women did not know they were eligible for VA services or benefits. Also, women Veterans reported twice the rates of cancer compared to women in the general population, with gynecologic cancers being most common.

1986: Advisory Committee recommendations to improve outreach spur creation of women Veterans coordinator positions at VBA regional offices and at VA medical centers.

1988: First office to address women's health issues is created within the Veterans Health Administration.

1992: Sixty percent of VA medical facilities have women clinics offering gynecologic care as well as preventive health and counseling services. All domiciliaries are able to admit women. P.L.102-585 authorizes counseling for sexual trauma that occurred while on active duty. Four comprehensive women Veteran Health Centers established, expanded to eight in 1993.

1994: National training program for women Veteran coordinators. Some full-time coordinator positions added at VA medical centers and VBA regional centers. Congress establishes the Center for Women Veterans through P.L.103-446. The Center director reports directly to the VA Secretary and ensures VA programs are responsive to the needs of women Veterans.

Compensation and Pension Service Advisory Committee on Women's Issues is created within VBA to review policy and procedures regarding benefits delivery for women Veterans.

[22] Willenz JA (1983). Women Veterans: American's Forgotten Heroines. New York: The Continuum Publishing Company, p.15

VA for Women Veterans Timeline – VA has come a long way (continued)

GAO reports VA has had great success in improving privacy protections for women Veterans in VA facilities. VA completed more than 130 projects to improve facilities and spent more than $672 million.

In 1996, P. L.104-262, authorized the provision of both inpatient and outpatient care to eligible Veterans. In implementing this authority, VA defined a medical benefits package that is available to Veterans enrolled in VA's health care system. The package includes comprehensive prenatal, intra-partum and post-partum care to eligible women Veterans.

By 1997, partly through improved outreach, outpatient and inpatient visits among women Veterans increased more than 50 percent from 1994 to1997 and the number of women receiving gender-specific services (Pap smears, mammograms, reproductive health care) increased more than 40 percent from more than 85,000 to over 121,000 women.

In 2000, VA supports demonstration programs at 11 locations across the country specifically for homeless women Veterans.

2000: Congress authorizes special monthly compensation for women Veterans with a service-connected mastectomy and provides benefits for children with birth defects born to Vietnam Veteran women.

2008: Advisory Committee recommends that the position of women Veterans program manager (WVPM) be established as a permanent full-time management position in all VA medical centers. Secretary request that VAMCs establish WVPM as a full-time position by no later than December 1, 2008. There are currently over 140 WVPMs. There are 57 designated women Veteran coordinators to help with benefits services in the VBA Regional Offices.

The 2010 ACWV report recommends a full-time WVC in Regional Offices with a female Veteran population (catchment area) greater than 40,000.

GAO reports in 2009 and 2010 find that basic gender-specific services, including pelvic exams, were available at nearly all facilities visited and that the majority of facilities also offered access to one or more female providers.

2008: VHA reports that VA performs better than private sector on gender-specific measures of breast and cervical cancer screening.

2009: National Survey of Women Veterans indicates outreach efforts have enhanced understanding, but still indicate potential for improvement. About 30 percent of women surveyed did not think they were eligible for VA benefits, almost half the percentage who thought they were ineligible in 1985.

2010: Advisory Committee recommends in its 2010 report that VA provide childcare options for eligible women Veterans, utilizing public and private partnerships, in order to facilitate access to quality health care services. Free drop-in childcare pilots open to Veterans eligible for VA care while at VA appointments are being implemented at three VA medical centers: Buffalo, NY; Northport, NY; and Puget Sound, WA.

2011: Veterans Health Administration establishes a National Call Center for Women Veterans.