# DEPARTMENT OF VETERANS AFFAIRS

# Congressionally Mandated Report

# Fiscal Year (FY) 2022 Study on Staffing of Women Veteran Program Managers at Department of Veterans Affairs (VA) Medical Centers and Training of Staff

**September 2021**

## Table of Contents

## 1. Introduction

The Veterans Health Administration (VHA) Office of Women's Health (OWH) is charged with developing, evaluating and when necessary, improving the quality and accessibility of gender-specific benefits and services VHA provides to women Veterans**. VHA has projected that the number of women Veterans will increase from 11% today to 15% of all Veterans by 2030.**[1] As a means to meet this challenge, Congress enacted title V of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act*, P.L. 116-315. Hereafter, title V shall be referred to as the "Deborah Sampson Act." The law provides OWH the opportunity to build upon their extensive knowledge of what women Veterans, and the programs that support them, need. Pursuant to the requirements of the law, OWH will report to Congress on many components involved in the provision of care to women Veterans, including but not limited to access to care, staffing of women's health programs, use of health care, treatment options and training adequacy.

### 1.1. Statutory Requirement

As required by the Deborah Sampson Act, P.L. 116-315 § 5204, OWH conducted a study on the staffing and training of Women Veterans Program Managers (WVPM) at Department of Veterans Affairs (VA) Medical Centers (VAMC) and the feasibility of creating a Women Veterans Program Ombudsmen. The purpose of this report is to provide the study findings on:

1) If the program is appropriately staffed at each VAMC;
2) Whether each VAMC is staffed with a WVPM; and
3) Whether it would be feasible and advisable to have a Women Veterans Program Ombudsman at each VAMC.

In addition, this report addresses the requirement in section 5204(c) of the Deborah Sampson Act that the Secretary shall ensure that all WVPMs and Women Veteran Program Ombudsmen receive the proper training to carry out their duties.

All findings are based on data from fiscal year (FY) 2020 and interviews of key VHA leaders conducted in April and May 2021.

### 1.2. Background

The current Veteran population consists of over 19,500,000 women and men who have borne the battle for the United States. Women Veterans are the fastest growing population of Veterans, currently accounting for 11% of the total population. Today, there are more than 2,045,000 living women Veterans.

To accommodate the rapid growth of women Veterans, VA has continued its efforts to ensure the needs of women Veterans are met and that they are able to access high-quality health care. This includes comprehensive primary care, gynecology care, maternity care, specialty care and mental health services. VHA established the

[1] U.S. Department of Veterans Affairs, VetPop2018 National Data, August 2020, located at https://www.data.va.gov/dataset/VetPop2018-National-Data-1L/jd85-8kjv.

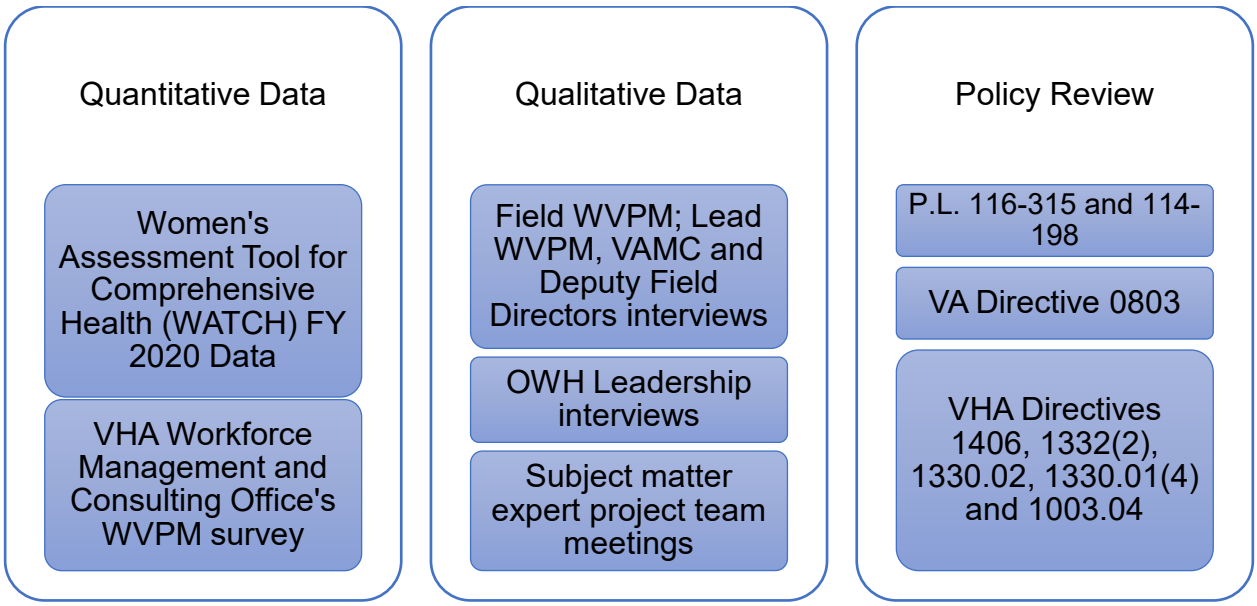
Women's Health Program to decrease barriers to health care services and programs for women Veterans. WVPMs fulfill the role of advocating for women Veteran's health care needs and providing leadership and oversight to ensure they receive timely, equitable and high-quality services in a safe and sensitive environment.

As required by VHA policy established in VHA Directive 1330.02*, Women Veterans Program Manager*, a WVPM is appointed to each Veterans Integrated Services Network (VISN) and VAMC in the VHA health care system (HCS). Lead WVPMs are appointed to VISNs and are responsible for VISN-wide oversight of the VHA Women's Health Program, education and outreach to women Veterans and providing training and mentorship to WVPMs at the facilities within their VISN. Lead WVPMs are required to perform their duties as Lead WVPMs part-time at a 50% full-time equivalent. At the facility level, WVPMs are in a leadership and managerial position, responsible for developing and implementing all aspects of the Women's Health Program, including for oversight of the women's health environment of care and services provided for all service lines, strategic planning, chairing the Women Veterans Health Committee, timely diagnostic services, and conducting outreach for women Veterans as well as working in partnership with other special population programs. Facility WVPMs are required to fulfill WVPM responsibilities full-time without collateral duties.

### 1.3. Study Framework and Data Sources

As a key component of the study framework, a data resources matrix is leveraged using qualitative and quantitative data collection methods, including cross referencing statutory and VHA national policies. A holistic approach utilizing many data inputs was necessary to understand the complexity of the VHA Women's Health Program and nuances specific to it. Figure 1 (below) highlights and summarizes the data sources included in the analysis designed to examine WVPM staffing and training and the feasibility of a Women Veterans Program Ombudsman.

**Figure 1. Data Sources**



### 1.3.1. Quantitative Data

**Women's Assessment Tool for Comprehensive Health**

Data from the Women's Assessment Tool for Comprehensive Health (WATCH) for FY 2020 was reviewed after being aggregated for reporting. The WATCH report is annually administered as an online survey completed by WVPMs and summarizes characteristics of the VHA Women's Health Program at the HCS level.

**VHA Workforce Management and Consulting (WMC) Office's WVPM Surveys**

The team reviewed data from a survey developed by VHA's WMC Office to assess policy adherence disseminated to all WVPMs (hereafter referred to as the "Workforce Management and Consulting Office WVPM Survey"). The survey instrument collected 118 responses, representing 85% of WVPMs Nationwide. An integrated project team (IPT) of WVPM subject matter experts was formed to assist in the development of this survey. The IPT also provided subject matter expertise and input required to adequately assess the survey and WVPM staffing needs. The survey was available for voluntary WVPM response for 7 calendar days, and the specific questions asked are provided in Appendix A.

Similarly, OWH released a survey to all Lead WVPMs, inquiring about their VISN's compliance with VHA Directive 1330.02 that they maintain a minimum of a 50% Full-Time Employee (FTE) for Lead WVPM responsibilities (hereafter referred to as the "OWH Lead WVPM Survey"). The survey instrument collected 18 responses representing all 18 VISNs Nationwide.

### 1.3.2. Qualitative Data

**Interviews**

Interviews were conducted with WVPMs representing rural and urban women Veteran populations at the facility, VISN and national levels with OWH senior leadership. These interviews represented 6 WVPM interviews from 7 VISNs, with 14 interviewees (7 Lead WVPMs and 8 Facility WVPMs) on the dates below:

- May 07, 2021
- May 11, 2021
- May 12, 2021
- May 17, 2021
- May 20, 2021

The purpose of these interviews was to evaluate WVPM staffing, training and the advisability of a Women Veterans Program Ombudsman. In addition, the IPT of WVPM experts met on three separate occasions to discuss the impact on WVPMs, interactions with Patient Advocates and any authority the Ombudsman position may hold.

Interview questions and an associated script were built to streamline responses and support the codifying of qualitative data. Following the interviews, responses were populated into an output mapping spreadsheet. Dropdown selections were provided to quantify simple "yes" and "no" responses. All other qualitative data were reviewed and

categorized based on key themes. The key themes focused on recurring experiences, ideas and recommendations the interviewees reported that reflect their strengths, weaknesses, opportunities for growth, pain points and best practices. The interview questions are provided in Appendix B.

**Training Resources**

Training resources were collected and reviewed from the OWH intranet site for employees, interviews with deputy field directors of the WVPM Program and throughout field interviews. The resources include orientation checklists, data management tutorials, formal mentorship programs, business case examples, position descriptions, protocol guides and position responsibility activities. In addition, WVPMs attend conferences, such as the Annual Women's Health Field Leaders Training, monthly calls for national training and required VA Talent Management System (TMS) trainings (see Section 3.2)

In addition, WVPMs were asked about their experiences with onboarding and opportunities for training throughout their tenure.

### 1.3.3. Policy Review

Statutory requirements and VHA national policies were reviewed to highlight policy compliance and adequacy. Specifically, *P.L. 114-198*, *VHA Directive 1330.02,* and *VHA Directive 1003.04, VHA Patient Advocacy* were relevant to the WVPM staffing assessment. These policies outline the positions, responsibilities, and reporting structure for the Women Veterans Program, including WVPMs, Women's Health Medical Directors, VISN Directors, Clinical Liaisons and Patient Advocates.

## 2. Study on the Use of the Women Veterans Program Managers (WVPM) Program

This section is organized based on the initial questions posed in section 5204 of the Deborah Sampson Act regarding staffing adequacy and the addition of the Ombudsman role and training. The responses to the questions leverage the data sources including interviews, WATCH data, the WMC Office WVPM Survey, training resources and relevant policies.

### 2.1. Is the WVPM Program appropriately staffed at each VAMC?

**The analysis of reported data from WATCH confirms the regulatory requirements for Facility WVPMs have been predominately fulfilled, at 98% complete** (See Figure 2 below). While 98% of all facilities are compliant with the regulatory requirements, the program itself is not appropriately staffed. Additional findings collected from interviews and WATCH data submission support the need for increased compliance to VHA policy requirements outlined in VHA Directive 1330.02 regarding how much time is required for WVPM responsibilities and to whom the WVPM reports. Specifically, Facility WVPMs expressed the need for one FTE with no collateral duties to effectively fulfill their duties and for the program to be appropriately staffed.

### Lead WVPMs

In addition, the OWH Lead WVPM Survey responses indicate that 16 of the 18 VISNs, or 89%, report maintaining a 50% FTE for the Lead WVPM role. While many sites have fulfilled their policy requirements, interviews have supported the notion that the complexity and scope of the role, workload and increasing demand require one FTE to effectively fulfill the Lead WVPM role. Similar to Facility WVPMs, Lead WVPMs have met their minimal staffing requirements per VHA policy; however, due to collateral duties and workload, Lead WVPMs are also inappropriately staffed to effectively fulfill their program responsibilities.

WVPMs maintain sufficient access to training resources through VA's TMS, National WVPM training conferences, monthly meeting presentations, internal OWH electronic libraries and by engaging colleagues through mentorships. However, due to immediate program needs, some WVPMs reported less time for onboarding and regular training, and experienced barriers in accessing and fully utilizing these resources.

## 2.2. Is each VAMC staffed with a WVPM?

The majority of HCS adhere to the requirement for VAMCs to appoint a full-time WVPM, as prescribed in VHA Directive 1330.02. **The annual WATCH data for FY 2020 reports 136 out of 139 HCS have at least 1 full-time WVPM onsite.** Figure 2 (below) provides the specific staffing numbers for Facility WVPMs for FY 2020. VHA Directive 1330.02 also specifies Facility WVPM positions are full-time, thus requiring individuals appointed to the position maintain no collateral duties (tasks carried out by an employee beyond their full-time position requirements). However, WATCH data reports 49% of all WVPMs have collateral duties, taking time away from their WVPM responsibilities.

While staffing of WVPMs is largely in compliance with VHA policy, data from the WMC Office's WVPM Survey indicates only 85% of facilities comply with the requirement for WVPMs to report directly to the Facility Director or Chief of Staff (COS). WVPMs at facilities not in compliance with this mandate report to positions such as Assistant Chiefs of Staff and Directors of Clinical Service Lines, such as Nursing, Ambulatory Care, Primary Care and Social Work.

OWH works directly with VA facilities to monitor and improve compliance to policy regarding WVPM staffing and to decrease need for collateral duties (such as care coordination responsibilities). Women's Health Innovation and Staffing Enhancement funding is being prioritized for VHA facilities with needs to enhance support for WVPMs and to assist them with hiring additional staff to perform care coordination duties.

**Figure 2. WATCH Data FY 2020, VHA Health Care Systems WVPM Staffing**

| WVPM Employment Status | Total HCS | Percentage of HCS |
|---|---|---|
| ***Full-Time WVPMs*** | | |
| One WVPM | 130 | 93.5% |
| Two WVPMs | 3 | 2.2% |

| | | |
|---|---|---|
| ***Subtotal:*** | *133* | *95.7%* |
| ***WVPM Acting/Interim*** | | |
| Part-Time | 1 | 0.7% |
| Full-Time | 3 | 2.2% |
| ***Subtotal:*** | *4* | *2.9%* |
| ***Other*** | | |
| Part-Time WVPM | 1 | 0.7% |
| Position Not Filled | 1 | 0.7% |

### 2.3. Would it be feasible and advisable to have a WVPM Program Ombudsman at each VAMC?

The typical role of Federal Ombudsmen and Ombudsmen serving in traditional health care settings involves being an advocate on behalf of a designated patient and/or Veteran population. In reviewing all relevant policies, VHA concludes that **establishing Women Veterans Program Ombudsmen would duplicate requirements already established in VHA policy for the positions of WVPM and Patient Advocate.** A Women Veterans Program Ombudsman would also be less thorough than the role of VHA Patient Advocates mandated under the Comprehensive Addiction and Recovery Act (CARA), P.L. 114-198, and the implementation of the Office of Patient Advocacy and its partners. OWH convened three IPT sessions to discuss the review of WVPM staffing models and the potential need for an Ombudsman. Following these sessions, the IPT agreed that the Ombudsman role was already fulfilled by the WVPM and their coordination with Patient Advocates.

Significantly, VHA Directive 1330.02 mandates WVPMs serve as advocates for women Veterans by working closely with VHA Offices of Veterans Experience and Patient Advocacy to facilitate problem resolution and women Veteran satisfaction. VHA's Office of Patient Advocacy was established in June 2017, as directed by CARA, P.L. 114-198, section 924. Patient Advocates within VHA ensure advocacy on behalf of Veterans receiving and seeking care at VHA facilities. They are also responsible for the reporting requirements under P.L. 114-198, section 924, as well as collaborating with other key VHA employees within programs and services that impact the experience of Veterans and providing them with training in patient advocacy and reporting.

VHA ensures a Patient Advocate is available at every VHA site of care for all Veterans. VHA policy utilizes two models of patient advocacy, decentralized and centralized, based on facility patient population and staffing levels. Patient advocates at VHA facilities utilizing a decentralized model of patient advocacy are required to designate a key employee within every service or care line to serve as the liaison between Veterans within that program or service line and the resolution outcomes as part of a decentralized model of patient advocacy. Patient advocates at VHA facilities, utilizing a centralized model of patient advocacy, are responsible for individually addressing all

patient complaints. As a part of this multi-tiered approach, Facility WVPMs and Patient Advocates successfully fulfill the role of an Ombudsman at each VHA site of care. The IPT therefore agreed an Ombudsman would be both duplicative and insufficient.

## 3. Report on the Use of the WVPM Program

Throughout the qualitative interviews and review of reported data, including the WATCH data, the WMC Office WVPM survey and the OWH Lead WVPM survey, additional findings were made that complement the responses to the questions (See Section 2. Study on the Use of the WVPM Program) with contextual support. The additional findings provided below are organized into two larger categories of Policy Adherence and Organizational Culture, which are the largest indicators for WVPM success.

### 3.1. Policy Adherence

**Staffing**

Each VAMC within an HCS must staff a full-time WVPM to comply with VHA Directive 1330.02. Per the WATCH data collected for FY 2020, 136 of the 139 HCS have fulfilled this requirement, with 1 site reporting a part-time WVPM and one site reporting a vacancy. In addition, responses to the OWH Lead WVPM Survey indicate that 16 of 18 VISNs fulfill the requirement to staff a minimum of a 50% FTE for the Lead WVPM role per VHA Directive 1330.02.

**Responsibilities and Collateral Duties**

Per VHA Directive 1330.02, the position of a WVPM is responsible for all women's health position requirements and adherence to women's health-related policies. The policy does not specify or discuss the role existing or operating beyond an individual basis or with support of administrative staff. At the VAMC level, leadership must comply with the requirement to protect full-time hours for Facility WVPMs, while VISNs are required to comply with protecting 20 hours a week for Lead WVPMs to conduct duties associated with the position. Figure 3 (below) provides an overview of all the responsibilities outlined in VHA Directive 1330.02 for WVPMs with specifications that vary between Lead and Facility WVPMs.

**Figure 3. Position Responsibilities for Lead and Facility WVPM**

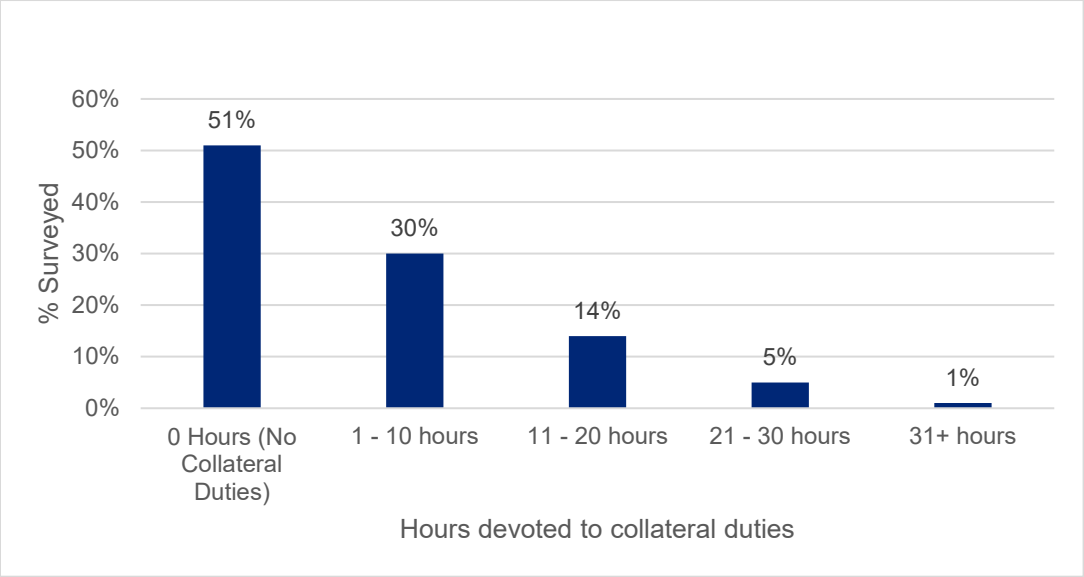
| Responsibilities for All WVPMs | Responsibilities Specific to Lead WVPMs | Responsibilities Specific to Facility WVPMs |
|---|---|---|
| Conduct clinical workload required to maintain licensure. | Identify disparities and necessary interventions related to access and quality of services for Women Veterans Programs within VISN. | Lead the overall delivery of care for women Veterans. |

| Responsibilities for All WVPMs | Responsibilities Specific to Lead WVPMs | Responsibilities Specific to Facility WVPMs |
|---|---|---|
| Consult VISN and facility leadership on issues faced by women Veterans. | Initiate epidemiological and prevalence studies to improve health promotion of women Veterans. | Serve as Chair of facility Women Veterans Health Committee. |
| Develop and execute a comprehensive strategic plan for their Women Veterans Program(s). | Mentor Facility WVPMs and provide new WVPMs with orientation. | Advocate for women Veterans in collaboration with the Patient Advocate and Veterans Experience Offices. |
| Properly implement VHA policies related to women Veterans and revise local policies, as necessary, to meet community needs. | Lead monthly calls with VISN facilities WVPMs and Women's Health Medical Directors. | Lead facility in cultural transformation to ensure a safe, secure and respected environment of care for women Veterans. |
| Develop and coordinate training about women Veterans based on locally-identified gaps in employee knowledge. | Consult on environment of care matters related to women's health for VISN. | Advocate for program to receive the fiscal and resource necessary to support needs of women Veterans from facility leadership. |
| Conduct community outreach to engage with local women Veterans and increase public awareness of gender-specific VHA services. | Represent the interest of women Veterans in VISN committees. | Participate in reviews to identify environment of care deficiencies and opportunities for new construction and renovations as appropriate for women Veterans. |
| Lead, and coordinate access to equitable, high-quality services that meet the need of Veterans served within their Women Veterans Program(s). | Advocate for the needs of Facility WVPMs and other champions of women's health. | Partner with coordinators and program managers for special populations to ensure the needs of women Veterans are fully cared for. |
| | Develop a VISN women's health data dashboard. | Review contracts related to women's health to ensure they meet the requirements of VHA women's health policies. |

| Responsibilities for All WVPMs | Responsibilities Specific to Lead WVPMs | Responsibilities Specific to Facility WVPMs |
|---|---|---|
| | | Ensure women Veterans using community care receive services in a timely manner. |
| | | Collaborate with facility leadership to ensure gender-specific diagnostic services are available with processes in place for timely care coordination. |
| | | Ensure all clinics within the facility provide comprehensive care to women Veterans through collaboration with specialty care, emergent care and urgent care clinics. |

During WVPM interviews, many reported collateral duty assignments. Facility WVPMs stated their collateral duties are not germane and/or complementary to their responsibilities as a WVPM and require extensive time for administrative tasks outside of their professional expertise in clinical care and gender-specific services. In addition, all WVPMs confirmed they worked beyond 40 hours a week, at least some of the time, to complete the requirements of their position. Figure 4 (below) represents the percentage of weekly hours WVPMs reported that they devote to collateral duties (e.g., maternity, cervical and mammography care coordination and clinic practice management).

**Figure 4. Time WVPMs Spent on Collateral Duties**




VISNs are only required to protect a minimum of a 50% FTE of Lead WVPM hours for WVPM duties. However, many Lead WVPMs report more than 70% of their work hours are required to complete the minimum requirements of Lead WVPM work and feel unsatisfied with the efficiency or quality of their work. Every Lead WVPM interviewed expressed that the role should be a full-time FTE with administrative support staff. **Lead WVPMs receiving administrative support from the VISN experienced increased success in growing their VHA women's health programs, supporting the Facility WVPMs within their VISNs and interfacing with leadership on strategic planning initiatives.**

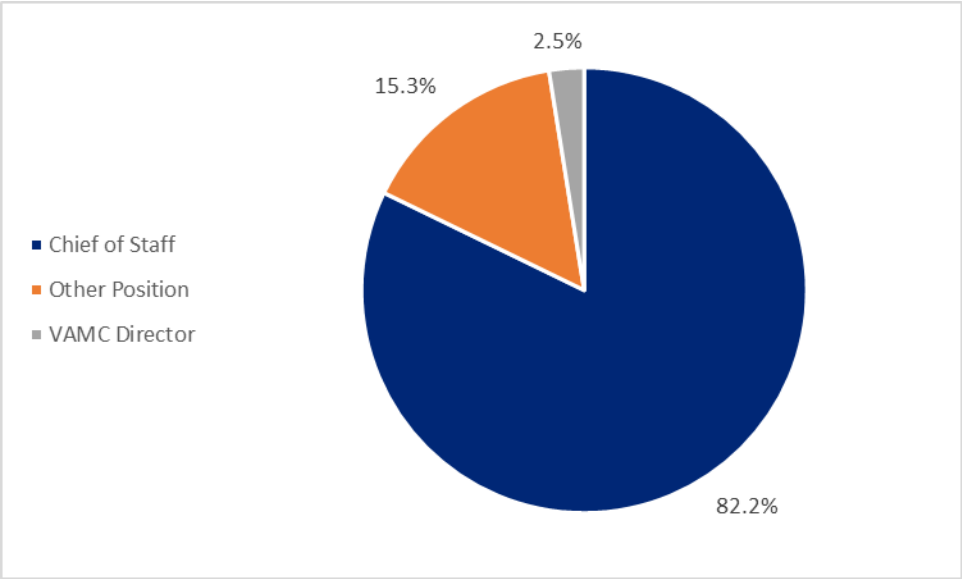
As found with Facility WVPMs, it has been reported in interviews that the Lead WVPM position should be a full-time FTE without collateral duties**.** This was supported with descriptions of the complexity of Lead WVPM duties to meet the growing women Veteran population's health care needs. Lead WVPM collateral duties often include leading other special population programs. As a result of the requirement specified in VHA Directive 1330.02 that all Lead WVPMs have a clinical designation, Lead WVPMs require protected time to maintain their clinical licenses. Some Lead WVPMs cited difficulty finding time to maintain their clinical licensure requirements. **All Lead WVPMs confirmed they have frequently worked beyond 40 hours a week to complete the requirements of their position.**

### Direct Reporting

As noted above, VHA Directive 1330.02 requires Facility WVPMs report to the Facility Director or Chief of Staff. While this structure was built to ensure consistent support and a streamlined approach to program management, data from the WATCH report and the Workforce Management and Consulting Office WVPM Survey show a substantial number of HCS are not compliant with national policy. Survey data of 118 WVPM participants report only 85% of survey respondents report to their Facility Director or

Chief of Staff. Figure 5 (below) illustrates the primary leaders to whom WVPMs report.

**Figure 5. WVPM Direct Reporting Structure Responses**




## 3.2. Organizational Culture

### Training

Extensive training resources are available on VA's TMS training website for employees. The WVPM TMS resources are listed below:

- Women Veterans Program Manager Orientation (Course #37561)
- Women Veterans Program Manager Orientation: Maternity Care Coordination (Course # 38141)
- Women Veterans Program Manager Orientation: Data (Course #39456)
- Women Veterans Program Manager Orientation: Emergency Department (Course #41030)
- Women Veterans Program Manager Orientation: Strategic Planning (Course #41918)
- Women Veterans Program Manager Orientation: Mental Health Services (Course #43104)
- Lead Women Veterans Program Manager Orientation (Course #37070)
- Women Veteran Program Manager EOC Recording (Course #43754)

WVPMs are also provided monthly opportunities for support and national best practice training. Lead WVPMs are expected to provide Facility WVPMs with consistent mentorship and opportunities for additional education and training. All new Facility WVPMs are also assigned a tenured Facility WVPM mentor to support them during the onboarding process. A key takeaway from interviews conducted with WVPMs is the positive impact mentorships and shadowing have on new WVPMs learning the position and their confidence in successfully fulfilling the position requirements. Albeit uncommon, WVPMs who were able to shadow a mentor within the WVPM program

during their onboarding and orientation period cited this as the most effective training and meaningful professional development in their skillset and professional program network.

Many WVPMs reported onboarding after the position had already been vacant, thus leaving them without the ability to have a period of transition with their predecessor. It was also reported during interviews that the immediate demands of the position created a difficult environment to undergo training, requiring most WVPMs to conduct their training at home and/or after hours. This proves particularly problematic for WVPMs without any previous work experience within VA.

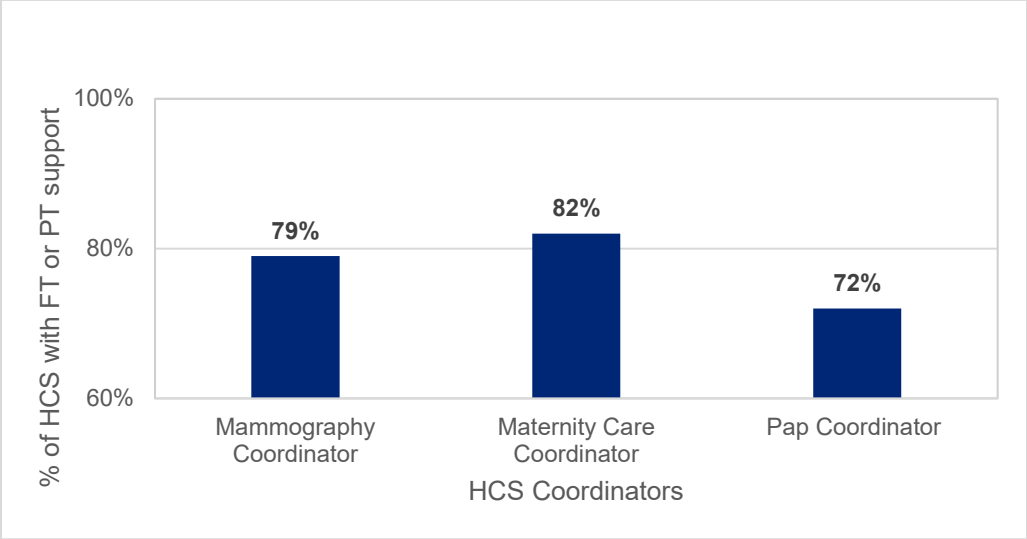
**Facility Support**

The prioritization and support of facility leadership is often directly associated with the success of women's health programs. One measurement of this is WVPM participation in committees. Pursuant to VHA Directive 1330.02, Lead WVPMs are required to participate in VISN-level committees to represent the interests of women Veterans. Facility WVPMs are required to serve on executive leadership committees, clinical boards and any other committees with the potential to impact women Veterans. While most WVPMs report being members of clinical committees, participation in executive leadership committees and issuance of voting rights is inconsistent. Lead WVPMs experience the greatest inconsistency regarding committee memberships and have significantly fewer voting rights than Facility WVPMs.

Caring for women Veterans is the responsibility of all VHA providers and staff. As such, it is important that all service lines have the capability to provide competent care to women Veterans, rather than sending all care coordination involving women Veterans to a WVPM. VHA Directive 1330.02 requires that WVPMs are responsible for collaborating with facility leadership on culture transformation to create a safe, secure and respectful environment for women Veterans to receive care in addition to many other requirements involving leadership coordination. WVPM interviews indicated an opportunity for improvement with increased facility leadership support, stakeholder buy-in and participation in women's health steering committees. In addition, WVPMs also reported an opportunity for improvement with participation as a voting member to executive leadership committees that allow for structured input on strategic directions.

WVPMs and Lead WVPMs reported a need for administrative and/or care coordination support staff. As reported above, many WVPMs spend a large portion of their time performing collateral duties like maternity, cervical and mammography care coordination. Per the WATCH data, only 79% of sites reported having full-time or part-time care coordination support for mammography care coordination, 82% for maternity care and 72% for cervical care, respectively. Figure 6 (below) details these responses.

**Figure 6. Full-time or part-time administrative support for mammography care coordination, maternity care and cervical care**




While some sites have reported that they have been able to bring on staff since the receipt of Women's Health Innovations and Staffing Enhancements (WHISE) funding, some have been unable to garner leadership support to continue funding post-award. However, **WVPMs report consistent and diligent support from VISN and national leadership for women Veterans health care**.

## 4. Conclusion

In accordance with section 5204 of the Deborah Sampson Act, OWH conducted a study on the staffing and training of WVPMs at VAMCs and based on WATCH data, confirms the regulatory requirements for Facility WVPMs have been predominately fulfilled at 98% complete. In addition, annual WATCH data for FY 2020 reports 136 of the 139 HCS have at least one full-time WVPM onsite. The OWH Lead WVPM Survey results also report that 16 of the 18 VISNs have at least one Lead WVPM with 50% FTE or more. Further, the study determined that establishing Women Veterans Program Ombudsmen would duplicate requirements already established in VHA policy for the positions of WVPM and Patient Advocate.

Additional findings from the study include that it is important that VHA policy supports additional time for the Lead WVPM position; improve policy compliance that full-time WVPMs are not assigned collateral positions; and that the role of mentors and opportunities for shadowing are integral for new WVPMs learning the position and their confidence in successfully fulfilling position requirements.

## 5. Reference Documents

1. P.L. 116-315.
2. P.L. 114-198.
3. VA Directive 0803, *Women Veterans Program*, dated March 1, 2013.
4. VHA Directive 1003.04, *Patient Advocacy Program*, dated February 7, 2018.
5. VHA Directive 1330.01(4), *Health Care Services for Women Veterans*,

dated February 15, 2017, amended January 8, 2021.
6. VHA Directive 1330.02, *Women Veterans Program Manager*, dated August 10, 2018.
7. Women's Assessment Tool for Comprehensive Health, Fiscal Year 2020.
8. Report to Congress: Locations Where Women Veterans Are Using Health Care from the Department of Veterans Affairs, February 2021.

Department of Veterans Affairs
September 2021

## Appendix A. Workforce Management and Consulting Office Survey

1. To which position does the Women Veterans Program Manager report:
   - VAMC Director;
   - Chief of Staff; or
   - Other position.

2. What percentage of time does the Women Veterans Program Manager spend on the Women Veterans Program Manager role?
   - A. 100% with no collateral duties
   - B. Less than 100% due to collateral duties

   If “B” is selected, select all that apply of collateral duties performed outside of the Women Veterans Program Manager.
   - Mammogram coordinator
   - Pap coordinator
   - Maternity coordinator
   - Military Sexual Trauma Coordinator
   - Intimate Partner Violence Coordinator
   - Lesbian, Gay, Bisexual and Transgender (LGBT) Coordinator
   - Clinical work (greater than one session per week as needed to maintain licensure)
   - Clinical supervision such as Clinic Nurse Manager
   - Other: _____

3. What percentage of time is spent on collateral duties outside the Women Veterans Program Manager role? (Drop Down of Percentage from 10-50).

## Appendix B. Lead WVPM Interview Questions

1. How long have you been in your role as Lead WVPM?
    a. Was it a role you sought out?

2. How many FTEs/Hours per week do you spend conducting WVPM duties?
    a. Is 0.1-0.5 FTE for a WVPM enough?
    b. Are your other responsibilities outside of being WVPM related or complimentary to Women Veterans?

3. Are you able to provide a breakdown, or estimate, of your WVPM duties/responsibilities hours/percentages for requirements from your VISN, facilities within your VISN and Central Office?
    a. Are you able to complete all these responsibilities within your required FTEs/hours?
        i. If yes, do you feel quality suffers?
        ii. If no, do you feel you could efficiently complete all the responsibilities if your WVPM role was 1.0 FTE?

4. Do you feel you adequately support Facility WVPMs within your VISN?
    a. If no, how so? What changes would allow you to provide adequate support?

5. Do you feel national and VISN leadership fully support your VISN WVPM position?
    a. If no, why not? What could leadership do to better support the role?

6. Do you have voting membership to executive leadership and committees (CAM, CFO, etc.)?
    a. If no, has it always been that way?
    b. If some, who?
    c. How would it improve your ability to perform your responsibilities if you had better access?

7. Do you feel the initial training you received as Lead WVPM was sufficient?
    a. If no, how so/why?
    b. Have you received any additional WVPM or women Veteran-specific training since you started?
    c. Have you had any of the standardized executive leadership trainings?
        i. Have you had other leadership training?

    d. Do you have any additional training or education related recommendations that would benefit Lead WVPMs?

8. Are there any other program offices or roles, such as coordinators or liaisons, outside WVPM that you feel would/should be able to effectively take lead on some of the responsibilities that may fall on you? *Examples could be within the caregiver support program, community care coordinators, homeless programs, etc.*
    a. If yes, would you provide examples and explain why?

9. Do you have any other thoughts or recommendations related to this survey that we have not asked?

**Facility WVPM Interview Questions**

1. How long have you been in your role as WVPM?
    a. Was it a role you sought out?

2. How many FTEs/hours per week do you spend conducting WVPM duties?
    a. Is 1.0 FTE for a WVPM enough?
    b. Are your other responsibilities outside of being WVPM related or complimentary to Women Veterans?

3. Are you able to provide a breakdown, or estimate, of your WVPM duties/responsibilities hours/percentages for requirements from your facility?
    a. Are you able to complete all these responsibilities within your required FTEs/hours?
        i. If yes, do you feel quality suffers?

4. Do you feel you adequately supported by the Lead WVPM within your VISN?
    a. If no, how so? What changes would allow you to provide adequate support?

5. Do you feel National and VISN leadership fully support your VISN WVPM position?
    a. If no, why not? What could leadership do to better support the role?

6. Do you have voting membership to executive leadership and committees (CAMs, CFO etc.)?
    a. If no, has it always been that way?
    b. If some, who?
    c. How would it improve your ability to perform your responsibilities if you had better access?

7. Do you feel the initial training you received as WVPM was sufficient?
    a. If no, how so/why?
    b. Have you received any additional WVPM or women Veteran specific training since you started?
    c. Have you had any of the standardized executive leadership trainings?
        i. Have you had other leadership training?
    d. Do you have any additional training or education related recommendations that would benefit WVPMs?

8. Are there any other program offices or roles, such as coordinators or liaisons, outside WVPM that you feel would/should be able to effectively take lead on some of the responsibilities that may fall on you? *Examples could be within the caregiver support program, community care coordinators, homeless programs, etc.*
    a. If yes, would you provide examples and explain why?

9. Do you have any other thoughts or recommendations related to this survey that we have not asked?

**Deputy Field Directors Interview Questions**

1. Please describe your role and how you interact with WVPMs and Lead WVPMs.
    a. How much interaction do you have with the each WVPM?
        i. Is there a role that needs more guidance than the other?

2. What is the training structure currently in place for both Lead and Facility WVPMs?
    a. Are there specific training requirements (e.g., compliance trainings) in place for each?
    b. What training tools are used consistently?

3. How long is the training material/how long does it take to complete the training for each role?
    a. Is there a different level of training for someone completely new to the VA?
    b. How does orientation training differ from other trainings?

4. How often is the training material updated?
    a. How are updates communicated?
    b. What is the process for making changes to the training?

5. Do DFDs monitor what the VISNs and facilities are doing, in terms of local requirement for training and orientation?

    a. If so, is there a requirement for the field to keep them updated on it?

6. What other training opportunities are available to the WVPMs?
    a. How often do WVPMs volunteer for further training/education?

7. Do you have any best practices for onboarding/training etc.?

8. Can you identify any gaps in the training structure or content?
    a. We have heard mentoring and practical training is integral to the success of a WVPM - is there a way to incorporate mentorship and practical training into the current training?
    b. Would you support a mandated 1 week of shadowing for new WVPMs?

9. What else can OWH do to support you in your role and the WVPM?