

**Department of Veterans Affairs
Meeting of the
Advisory Committee on Women Veterans (ACWV)
August 7-9, 2019**

The Advisory Committee on Women Veterans (ACWV) met at the Department of Veterans Affairs Central Office (VACO), 810 Vermont Avenue NW, Washington, D.C. 20240. Octavia Harris, Chair, presiding.

VA ACWV Members Present:

CMDCM Octavia Harris, USN, Ret., Chair
LTC Lisa Kirk, MDANG, Ret., Vice Chair for Health
COL Betty Yarbrough, USA, Ret., Vice Chair for Benefits
LTC Kate Germano, USMC, Ret.
CWO Moses McIntosh, USA, Ret.
Yareli Mendoza, USAF Veteran
CMDCM Linda Handley, USN, Ret.
COL Wanda Wright, USAF, Ret.

VA ACWV Members Excused:

Kailyn Bobb, USAF Veteran
CDR Janet West, USN
LTCOL Shannon McLaughlin, MA ARNG

Ex-Officio Members Present:

Colonel Toya Davis, Defense Advisory Committee on Women in the Services (DACOWITS), Department of Defense
Laurine Carson, Compensation Service, Veterans Benefits Administration (VBA); outgoing VBA ex-officio member
Lawrencia Pierce, Insurance Service, VBA; incoming VBA ex-officio member
Dr. Nancy Glowacki, Veterans Employment and Training Service, Department of Labor (DOL)

Ex-Officio Member Excused:

Dr. Patricia Hayes, Women's Health Services, Veterans Health Administration (VHA)

VA ACWV Advisor Present:

Faith Walden, Program Analyst, Office of Finance and Planning, National Cemetery Administration (NCA)

VA ACWV Advisor Excused:

CAPT Michelle Braun, Nephrology Nurse Practitioner, National Institutes of Health

Center for Women Veterans (CWV):

Jacquelyn Hayes-Byrd, ACWV Designated Federal Officer (DFO)
Anna Crenshaw

Shannon L. Middleton
Linda Wellman

Other VA Staff:

Scott Posti, VBA
Antoinette Rivera, VBA
Leslie Williams, VBA
Ileana Ferrari, Office of Policy and Planning
Shurhonda Love, Office of Mental Health, VHA
Jocelyn Moses, VBA

Public Guests:

Stephanie Jones, Committee on Veterans Affairs, U.S. House of Representatives
Tammy Barlet, The American Legion
Roscoe Butler, Paralyzed Veterans of America
Bernice Chu, National Academies
Patricia Craig, Washington DC VA Medical Center (DCVAMC) Veterans Mental Health
Advisory Council
Jessica Danaux, Atlas Research
Abby Griffith, Atlas Research
Sara Mabe, NVLSP
Ellen Milhiser, Synopsis
Dan Monteith, Genomic Health
Abby Rosenberg, Atlas Research
Blake Reichmuth, NASEM
Cassie Ricci, GE Healthcare
Shawn M. Ross, Indigo Consortium
Barrington B. Ross, Indigo Consortium
Cathy Santos, National Alliance of Women Veterans, Inc.
Porsche Williams, DCVAMC Mental Health Advisory Council
Marilyn Wyche, Women Veterans Resource Center

Wednesday, August 7, 2019

The Advisory Committee on Women Veterans (ACWV) met in Room C-7, VACO, 810 Vermont Avenue NW, Washington, D.C., at 8:30 a.m., Command Master Chief Octavia Harris (U.S. Navy, Retired), Chair, presiding.

Open Meeting/Committee Discussion, Command Master Chief Octavia Harris (U.S. Navy, Retired), Chair, Advisory Committee on Women's Veterans (ACWV)

The Chair called the meeting to order at 8:33 a.m. The ACWV is a Congressionally mandated, Federal advisory committee, which was chartered to advise the Secretary on VA's policies and programs for women Veterans in VHA, VBA, and NCA, and to provide a report of recommendations to Congress on a bi-yearly basis.

The Committee members, ex-officio members, advisor, VA staff, and public guests

introduced themselves. The Designated Federal Officer (DFO) delivered welcome remarks and touched base with the Committee, regarding upcoming vacancies. Over 50 people are interested in joining the Committee and the Veterans believe the Committee is on the right track.

Update on Veterans Benefits Administration's Initiatives; The Honorable Paul Lawrence, Under Secretary for Benefits, VBA

The Chair introduced Under Secretary for Benefits Paul Lawrence, who provided an overview of updates from VBA. According to VA Secretary Wilkie, VA is undergoing the greatest period of transformation since Omar Bradley's time. The Under Secretary referenced several new legislative tools which have enabled this transformation. The Accountability Act gives VA the ability to deal with habitually bad performers who provide customer service to Veterans. The MISSION Act gives Veterans a choice, so that they can be served in a way they want. The Appeals Modernization Act enables the VA to handle appeals much faster, cutting processing time from three-to-seven years down to 125 days under two of the three lanes maintained by the VBA. The Forever GI Bill provides a great deal of flexibility and benefits to Veterans, including a STEM scholarship that provides additional time and funding for Veterans' education, and the VetTech apprenticeship for Veterans who want to enter the high tech industry.

Last fall the VA experienced some issues implementing the housing allowance provision of the Forever GI Bill. By August of 2018 the Agency was supposed to have implemented 30 sections of the law. Twenty-eight were correctly implemented, while two were not; therefore, the Secretary directed a reset regarding those provisions to be correctly implemented by December 1, 2019. In the original GI Bill of 1944, the housing allowance was 43 words; the new provision is over 43,000 words, and this complicates the implementation of the new provision. Spring of 2020 will be when the new housing allowance will be fully implemented, and, per the Secretary's commitment, VBA will recalculate everybody's benefits as if the law had been in place on August 1, 2018, per the promise. This period of recalculation will be called True-Up, in which VBA will make whole those Veterans who were affected. There will be more communication on this going forward.

The Secretary recently hosted a meeting with new Congressmen and women who are Veterans, asking them their aspirational goals while in Congress. Virtually all of them wrote that they wanted to increase the benefits under the GI Bill.

The Under Secretary spent time talking about the Blue Water Navy Vietnam Veterans Act of 2017 and the implementation of H.R. 299 which will go into effect on January 1st, at which time VBA will begin granting benefits. However, VBA is currently processing claims and doing the development work; therefore, if a Veteran thinks they're eligible then they should file a claim now. There is a notion that VBA will wait until January 1st to process claims and this is not true; stakeholders such as the Disabled American Veterans perceived the Secretary's comments on the matter as vindictive, and this is a misunderstanding. The recent Procopio decision from the Federal appeals court, in which the Court found that the intent of Congress was to extend benefits under the

Agent Orange Act to Veterans who served within 12 nautical miles of the shore of Vietnam, also contributed to the delay in implementation because the legal interpretation of the issue was complicated. Since late December when it became clear how the implementation of the law would move forward, the VBA has been working with the Navy and the National Archives to scan and access all ship logs related to Servicemembers in the Blue Water Navy during Vietnam.

Other questions that were raised involved survivor's benefits, specifically regarding what happens if the Veteran passes between now and the period of time needed to implement the law. The Under Secretary and his deputy, Margarita Devlin, met with Doctors Stone and Lieberman, the executives in charge of VHA, to understand the question of Blue Water Navy Veterans who need healthcare now. The Under Secretary explained that certain people who are only eligible for care under Medicare part D may go to a medical facility and be granted humanitarian access to emergency care. The Under Secretary is currently working with the VSOs to implement this service. Additionally, the Secretary has gone forth with a request to Congress for about \$1 billion over the ten year period it will take to process Blue Water claims at an estimated volume of 500,000 claims. Similar to the Camp Lejeune situation it will require communication to contact the service members who were affected; such outreach will require more technology.

The Under Secretary hosts a quarterly webcast centered around the results of VBA by business line. The Agency is processing its work faster and more of it. Toward this end the Agency held an Independence Day claims challenge for the 8,000-employee claims processing team. The team was challenged to process nine weeks of work in eight weeks in exchange for a one day grant of leave on the Friday of the July 4th weekend. Based on a goal of 255,000 claims, the team processed about 270,000, quality remained high, and no other work was skipped or under-delivered. The challenge was so successful that more business units wanted to participate; therefore, VBA will run a Labor Day challenge for five or six of the business lines. About 14 percent more work was performed during the challenge period.

The Under Secretary appreciated the ACWV's perspective on gender differences and the unique experience of female Veterans. The Secretary has been mindful in talking about how the force is changing and how Veterans are changing. The National Guard had similar points to make about how members move in and out of benefits eligibility, and the Under Secretary said that VBA would offer to form a small group of leaders to understand specific things that challenge the Agency's benefits process, the idea being to immediately fix issues that become clear from a broad perspective and then pinpoint areas that require further study in order to arrive at results faster.

Ms. Yarbrough raised the question of gender bias in the awarding of claims, and recommended the leadership group take a look at that. The Under Secretary agreed in principle but warned that investigating gender difference in claims may not be the best practice to reach results.

Ms. Wright asked the Under Secretary about the Committee's recommendation regarding the women Veteran program coordinator in the VAROs holding ancillary duties that make it difficult for them to work on Veteran women specific issues. The Under Secretary agreed that this would be an issue for the leadership group to investigate, see if it's widespread, and then figure out what it means.

Ms. Mendoza, a doctoral candidate studying higher education among women Veterans, raised a concern regarding the Break Pay issue. Under the GI Bill, benefit availability for Veterans enrolled in higher education based on a traditional semester system disproportionately affect women Veterans because they are more likely to be single, divorced, or single parents, and are unlikely to be enrolled in the summer. Therefore Ms. Mendoza suggested looking at Break Pay again as something that may be at the forefront of the GI benefits package. The Under Secretary stated that the Agency will continue to evaluate the equity between benefits available for for-profit versus non-profit institutions.

Ethics Briefing, Carol Borden, VA Staff Attorney/Deputy Ethics Official, Office of General Counsel

Ms. Borden is a member of the ethics specialty team, a virtual team comprised of 12 attorneys. She has served in the JAG Corp overseas and has heard a lot of distrust of the VA by women Veterans in the field.

Ethics training is a statutory requirement for all FACA members. Ethics advice is important in setting expectations and standards of conduct for public servants. These include, for example, standards of ethical conduct for Federal employees, which apply to advisory committee members 24/7.

One big reason that seeking ethics advice is important is because a member can rely upon it in good faith, even when it is wrong. That being said, members must disclose everything, whether or not it may pose a conflict of interest; advice of ethics counsel is only as reliable as the facts available. The ethics rules will apply to all members, whether sitting in their official capacity or in their personal capacity.

The members of ACWV are not required to file financial disclosure reports; however, it is best practice for members to disclose the financial assets of their spouse, dependent kids, and connections to outside organizations and employers. The ethics official will look for whether there is something in the charter that would give them reason to believe that there may be a conflict of interest. For this reason, it is important for members to self-police. For example, if a member is working on a matter that touches them personally, then a red flag should be going off. One of the ways these cases can be addressed is through the waiver process via the Office of Government Ethics. Other ethics rules and laws include the Hatch Act, which deals with the political activity of advisory committee members in their official and personal capacity; the law is designed to give special government employees a little bit more breadth than career Federal employees.

Title 18 United States Code (U.S.C.) section 208 is a criminal statute concerning conflict of interest. It is designed to prevent Federal employees from lining their own pockets because of the public service. In order for the statute to be triggered, the entire definition must be met: it is a crime to participate personally or substantially as a government officer or employee in a particular matter that will directly or predictably affect your financial interest or a financial interest imputed to you. In order for conduct to trigger the statute, there must be personal and substantial participation by the member; it must involve a particular matter, and there must be some predictability that it is going to have a financial impact. Imputed interest treats the interests of certain covered persons and parties as if they were one's own, including one's spouse, minor kids, or general partner. The ethics regulations deal with appearances and matters, which may not be necessarily finance-based. There is an exception for particular matters of general applicability for government employees, meaning that in the universe of all matters there are matters that affect a discrete and identifiable class. These are matters of general applicability, and members may participate in such matters, providing that they will not be financially affected. However, if they are a consultant, this exception will not apply to them.

Appearances matter. If a member's involvement in a matter will cause a reasonable person who is not familiar with the ethics rules to question their integrity, then that matter should be disclosed or addressed to the ethics official; this is the "reasonable person standard." Such situations involve accepting a gift under the \$20 gift value. Members cannot participate in a specific party matter where a person with whom they have a "covered relationship" is, or represents, a party. Specific party matters include a contract or a grant in which a specific party will be financially affected. A "covered relationship" involves all persons whose interests are imputed to the member under the criminal conflict of interest laws and regulations.

Prohibited compensation, as addressed under Title 18 U.S.C. 209 and 201, states that no member may be paid by an outside source for their service on the committee. In other words, do not take a bribe. Title 18 U.S.C. 203 and 205 are criminal conflict of interest statutes that address working for parties that have a financial interest in specific party matters of the committee. Title 18 U.S.C. 207 addresses the lifetime ban against advisory committee members working for or representing outside parties to the committee regarding specific party matters of the committee. They can work behind the scenes on such matters, but cannot be a representative.

The overarching theme of standards of conduct is that public service is a public trust. Within the standards of ethical Conduct, there are 14 principles which boil down to: do not use your position on the committee for your own private gain or that of a person imputed to you, and do not give unauthorized preferential treatment to any entity that you associate with in the performance of your official duties. The "misuse of position" standard dictates members not to misuse their official title or position; members cannot speak on behalf of the committee. Members may teach, speak, and write about public information related to the business of the committee, but may not receive compensation for it. The exception to this no-compensation rule is for teachers and professors

receiving a salary.

Most people think they know not to take a gift, but gifts can be presented in a lot of different ways, for example, in exchange for one's service on a committee, a vote, or pushing a particular committee agenda.

Members may not accept gifts given to them because of their official position on the committee or given to them by a prohibited source, including any entity seeking official action by the VA, seeking to do business with the VA, who could be substantially affected by the work of the committee, or any entity in which a majority of the members are prohibited sources. The exception to the gift rule is a de minimis gift valued at \$20 or less per prohibited source, but no more than \$50 from the same prohibited source in the same calendar year. The ethics gift rules now require employees to ask themselves the question before accepting a permissible gift: what would a reasonable person think if I were to accept this gift; would they question the integrity of the program; if the answer is yes then the employee is encouraged not to accept the gift.

There is no charitable fundraising allowed on Federal property, outside of the Combined Federal Campaign. The Office of Special Counsel is the office involved with monitoring that.

Because ACWV members do not file disclosure reports, Ms. Borden recommended that they review the agenda before each meeting and ask themselves if anything could affect them financially. If so, they should talk to the DFO.

Ms. Wright asked for examples of people breaking the ethics rules and Ms. Borden responded that the Office of Government Ethics releases a yearly list of cases investigated by the Department of Justice.

Update on Women's Health Initiatives, Dr. Sally Haskell, Deputy Chief Consultant, Director of Comprehensive Women's Health, Women's Health Services, Patient Care Services, Veterans Health Administration (VHA)

There has been a rapid growth and increasing number of women in the military. Over 15 percent of active duty and 18 percent of National Guard and reservists are women. This growth of women in the military has brought many women into VA care. Thirty percent of the increase in Veterans served between fiscal year (FY) 14 and FY 18 was due to women Veterans. Women still make up 8.3 percent of the population of VHA users, but the growth is remarkably rapid. From 2014 to 2018, VHA has provided care to over 625,000 unique women Veterans. In 2018 there were over 500,000 women in active VA care. This has presented some challenges in the VA health care system, which VHA is working hard to meet. The largest percentage of women Veterans are aged 45 to 65, but there is a growing peak of young women Veterans as well as a declining number of World War II Veterans.

VHA's principal Deputy Under Secretary, Dr. Lieberman, has charged an integrated project team (IPT) to research harassment and culture change, and look at gaps in

women's health care at VA. After hearing of sexual harassment research, he resolved that harassment of women Veterans had no place in VA. He later established this workgroup to target the problem. The IPT will also look at gaps in care and capacity, resources and budget, as well as standardization of care across the system. Women's Health Services is working with the Office of Healthcare Transformation (OHT) within VHA, to assess the current state, develop an ideal state, and come up with an operational plan projected to be completed by November.

VHA hosted a three-day National mini-residency in Florida to update providers' skills in women's health. Training topic focused on gender-specific care, including providing contraception, treating menopause, training in the performance of pelvic exams and Pap smears. Six thousand providers in VA have gone through the program, after which they are qualified as a designated women's health primary care provider. VHA is also working through a contractor to provide a rural health mini-residency that has already trained 230 primary care providers, both virtually through VA's TMS online training system, and on-site through hands-on training at the rural community-based clinics.

The care coordination initiative is one of the areas of care in which VHA has had some gaps, because women's health teams in primary care require more coordination services than others. Coordination of services for women-specific screening programs, such as mammograms and Pap smears, are very time consuming and important. Providers never want to miss an abnormal Pap or mammogram, so there have to be people in place to coordinate those programs. Maternity care coordinators are required by policy to be in every facility, to coordinate maternity services which are not offered by VA. This specialization of women's health care has resulted in the need to hire women's health care coordinators, but not all sites were doing it. Women's Health Services partnered with the Office of Rural Health, to provide funding to hire women's health care coordinators. The program has funded women's care coordinators at 27 sites.

VHA is partnering with Altas Research to roll out the Evidence-based Quality Improvement (EBQI) program. EBQI is a method of quality improvement that uses a multi-level approach that integrates local practice with system and regional priorities as well as incorporating both leadership and folks on the ground. In the past year, Women's Health Services and a contractor team performed site visits at every health care system across the country -- all 140 -- to look at their women's health program. Based upon these findings, VHA intends to help them build their programs through the EBQI program. Using the site visit data, VHA will identify the 30 lowest performing systems in Women's Health and randomly assign them to receive the EBQI project; VHA and the system will then identify gaps in care and areas for improvement. VHA was able to do seven sites for three years, and the results have been very successful. Going forward VHA will ask sites to request the services of an EBQI visit, in order to engage with systems who would like help in identifying and resolving gaps in care.

There was a study released by Dr. Elizabeth Yano from VA Health Services Research and Development (study CRE 12-026, Yano PI) on the topic of anti-harassment, which

found that over 13 sites saw 24 percent of the women report negative interaction with male Veterans while at VA facilities. This harassment was in some cases so disruptive that it caused them to miss appointments and, in some cases, not want to return to VA. A couple years ago, VHA put together education and awareness training for staff, worked with the women Veterans program manager to ensure consistent implementation across facilities, and have been creating ongoing poster campaigns focusing on harassment. The report has caught the attention of very high levels of leadership, and the acting Under Secretary is very adamant that such harassment cannot continue at VHA.

The Chair remarked upon the End Harassment campaign and said that she looks for those posters whenever she walks into any VA medical center. She said the culture of anti-harassment must start from the top-down, and asked Dr. Haskell how the Administration holds providers accountable when site leadership does not accept the fact that harassment takes place in their facility. Dr. Haskell stressed the importance of engaging leadership at all levels, to ensure a consistent implementation of the culture shift.

Ms. Germano asked about whether the facilities targeted for EBQI work showed overlap between the incidence rate of harassment, complaints, and EBQI metrics. Dr. Haskell responded that the EBQI metrics do not measure harassment as much as women's care coordination. Ms. Germano said that a corollary between harassment and low performance metrics may suggest a bias in the leadership that causes them to overlook poor performance in the workplace.

Dr. Kirk suggested levying a survey directly to the 500,000 empaneled women Veterans in order to collect harassment data. Dr. Haskell referred to the V-signals data collection program, which levied a somewhat similar question regarding whether Veterans felt respected and comfortable at VA. Dr. Kirk stressed the form of the question, which would be designed to identify odd and off-putting experiences for women Veterans. Dr. Kirk also asked whether VHA planned to increase number of women health care coordinators from 27 sites. Dr. Haskell reiterated that maternity care coordinators are required by policy, and while the coordinator position is allowed to be a collateral duty it is preferable to have a dedicated provider who did not have collateral duties beyond those of the women's health service coordinator.

Ms. Yarbrough asked what kind of training is given to Veterans, regarding sexual harassment. Dr. Haskell replied that, outside of focus groups that have been held for male Veterans, there have not been trainings launched directly at their population. It may be possible to include such training in new patient orientation.

Update on Veteran's Legacy Program, Heidi Wiesner, Education Specialist, Veterans Legacy Program, National Cemetery Administration

The Veteran's Legacy Program (VLP) is a part of the National Cemetery Administration's (NCA) Office of Engagement and Memorial Affairs. The core of the program is about developing partnerships that engage students, educators, and the

American public with their local history, through the diversity of Veteran experience in NCA's 136 national cemeteries. The Administration specializes in education outreach, to carry out the mission of memorializing American Veterans. The VLP has a team of three employees dedicated to leveraging partnerships across the country.

One of the strategic goals of the VLP is to elevate the NCA brand recognition. Contrary to popular opinion, Arlington is not the Nation's only cemetery. VLP has worked with university undergraduate and graduate students, to begin research into the stories of Veterans that are interred in their hometowns. A list of VLP partners, as of 2018, includes: the Universities of Central Florida, San Francisco State, Black Hills State, California at Riverside, Denver, Tennessee, George Mason; the National History Day program; the American Battle Monuments Commission; and the World War I (WWI) Centennial Commission. Nearly one thousand Veterans stories have been discovered.

Of the 3.7 million Veterans interred across the 136 national cemeteries, there is an average of 2-3 percent woman Veterans interred. Additionally, more women are serving in the armed forces, which NCA sees as an opportunity for future memorialization efforts. Ms. Wiesner provided a sampling of some of the women Veterans' stories discovered, including a book produced by the California-Riverside partnership containing Veterans biographies researched and written by 8th grade students. Biographies include those of Alene Duerk, Rose Puchalla, and Pauline Cushman. Ms. Wiesner also shared an example of legacy in action, regarding the memorialization of one of the "Hello Girls" Signal Corps telephone operators interred in Golden Gate National Cemetery; the Veteran was not properly recognized for her service in WWI, so NCA had a new headstone cut for her.

The Veterans Legacy Memorial is the VLP's newest product launch in memorialization, using a fully online platform to digitalize the entire cemetery experience across the 3.7 million Veterans interred in National cemeteries.

Ms. Wiesner presented a WWI documentary film produced through a partnership with San Francisco State University. The film highlights the achievements of Nurse Helen Fairchild, a member of the WWI Nurse Corp who died on the front lines from exposure to mustard gas.

Ms. Wiesner introduced Dr. Bryce Carpenter, Program Manager of the Veterans' Legacy Program, who delivered remarks about NCA's strategic plan, particularly on expanding the Administration's digital presence through the Veterans Legacy Memorial. The product launched today, with notification being sent to the House Veterans Affairs Committee (HVAC) and the Senate Veterans Affairs Committee (SVAC). Tomorrow the program will go public with external communications. The goal of the Veterans Legacy Memorial is to create an online digital memorial experience, providing an online digital memorial space for 3.7 million Veterans and over 1 million spouses and dependents. In its first launch, every featured Veteran will have a page presented in a manner that is graphically appealing and encourages the public to engage. Version 2.0 will launch before Veterans' Day season this fall. Next of kin will have elevated administrative

privileges and be able to manage the memorial page for their beloved Veteran. The product aims to give a voice to the families and to the survival communities, in order to make memorialization a social effort by creating a living memorial experience. The Veterans Legacy Memorial can be found on www.va.gov/remember.

VA Women's Health Transition Training Program, Major Alea A. Nadeem, United States Air Force (AF), AF Barrier Analysis Group, Women's Initiative Team Lead, Department of Defense; Dr. Sally Haskell, Deputy Chief Consultant, Director of Comprehensive Women's Health, Women's Health Services, Patient Care Services, VHA; William (Bill) Brinley, Acting Assistant Director, Executive Management Office, Office of Transformation and Economic Development, VBA

The program grew out of a small pilot partnership between VA Women's Health Services and the Air Force. Now the program has approval to transition into a permanent Department of Defense (DoD) program. Dr. Haskell was present to represent Dr. Nancy Maher, the lead from Women's Health Services.

Major Nadeem reported that, when women were transitioning out of the military, there was a lack of health-related debriefing. There was a misconception that only certain Veterans had access to VA care. Air Force leadership, including Mr. Sitterly (who currently works in VA HR), became aware of this problem and cold called VA to propose a program to address the situation. They noticed that there was a difference between male Veterans' and women Veterans' enrollment in VA, where males tend to enroll faster and at higher rates. Additionally, women Veterans have a two times higher suicide rate than their civilian women counterparts. They also had a higher instance of chronic pain and mental health. The program used a lot of Dr. Haskell's research and resolved that developing an education component in the transition process would help to address the disparities in care.

Dr. Haskell addressed the four-hour curriculum that was developed with the assistance of subject matter experts from Air Force and VA in which they train women about what VA is able to provide in terms of women's health care and how to enroll in services. Pre-session training score studies found the baseline perception of women toward VA women healthcare services to be very low. 82 percent hoped to learn more about the available VA health care services.

The objective of the training program is to improve Veterans' accuracy from the baseline 27 percent knowledge of women's health services. The outcome of the training is that perception is changed so that people know that they can go to VA for women specific services, as well as for assistance suicide prevention, homelessness, and military sexual trauma (MST). Eighty-two percent of women expressed that they had the tools to navigate VA's health system. Eighty-eight percent of comments described how the course relieved their perceived anxiety and fear during transition out of the military.

The instructors that teach the course have to be women Veterans and they have to use VA. The program has a \$2 million budget and an 86 percent enrollment rate. It is significant that DoD drove the implementation of the program and guided VA's

involvement. DoD and VA have gotten official approval to turn this into a permanent program through the TAP program. VA will continue to gather data at pilot sites and expand throughout the military. There will be a virtual module and live virtual program through a telehealth modality and a self-taught module is in the future. In 2021 VHA will transition the program over to VBA and it will become an official part of the TAP program. In FY2020 VHA will develop a "hub-and-spoke" implementation plan to help VBA rollout the program in 2021.

The Chair asked about the contracting side of the program, specifically regarding how to ensure that women's health coordinators are women Veterans. Major Nadeem replied that Dr. Maher writes the requirement into the contract.

Dr. Kirk asked whether the program had collected any data on suicide, to which Dr. Haskell replied no. Dr. Kirk also asked whether National Guard and Reservists will have the same kind of access to the program through TAP, and Major Nadeem replied that even they have to transition out per the TAP program in order to receive a DD-214.

Ms. Germano asked how, since the Air Force is a more progressive branch when it comes to how women and minorities are treated, accepted, and included, DoD will overcome service culture differences as they are rolling out the program. Major Nadeem replied that it has been a challenge but that engaging with allies -- women in high ranks and members of the Congressional Women Veterans Task Force -- has been integral to the success of the mission. Ms. Germano also asked whether the VA has enough service providers to accommodate more women. Dr. Haskell responded that the VA is adequately staffed to address the increasing enrollment of women Veterans.

Ms. Wright asked when during the transitional time are these trainings occurring. Major Nadeem replied that it varies by service, but in most cases it can only be taken after the original TAP. Furthermore, woman-specific transition assistance is an optional one-day course.

The DFO remarked that she actually took the class and it was phenomenal. Ms. Wright advocated for offering the live program over the non-live/virtual program.

The Chair introduced Mr. Brinley from the Office of Transformation and Economic Development (TED), the VBA office to which the DoD and VHA are going to be handing the program starting in 2021. Mr. Brinley delivered remarks upon the transition process of the program, engagement with the DoD through the TAP interagency partnership, and making sure the rollout goes seamlessly.

Adjourn, Chair, ACWV

The Chair adjourned the first day of the meeting at 11:46 a.m.

Thursday, August 8, 2019

The Advisory Committee on Women Veterans (ACWV) met in Room C-7, VACO, 810 Vermont Avenue NW, Washington, D.C., at 8:30 a.m., Command Master Chief Octavia Harris (U.S. Navy, Retired), Chair, presiding.

Open Meeting, Command Master Chief Octavia Harris (U.S. Navy, Retired), Chair, Advisory Committee on Women's Veterans (ACWV)

The Chair called the meeting to order at 8:30 a.m.

The Chair allowed Department of Defense ex-officio member Colonel Toya Davis, Military Director of the Defense Advisory Committee on Women in the Services (DACOWITS) to provide brief remarks about how DACOWITS operates. The topics discussed by DACOWITS must be approved each year by the Secretary of Defense (SecDef) or his designated representative, who is currently the acting Under Secretary of Defense for Personnel and Readiness James Stewart. DACOWITS then does a deep dive into those topics throughout the year, via research, briefings, installation visits, and office calls with all the senior leaders of the services to get information on those various topics to see where the gap is. The DACOWITS's next meeting will be 17 and 18 September, wherein it will vote on what recommendations to push forward to the SecDef. DACOWITS will be looking at the topics of parenthood and pregnancy policies; lactation and breastfeeding support, including lactation rooms in installations; the impact of assignments on women who are pregnant or may become pregnant; recruitment and retention (by gender, race, and ethnicity); and exit surveys. The Services accepted the recommendation to create exit surveys, but they are in varying stages of implementation. Other topics include gender integration, especially in the Marine Corp; on 17 September the commanding general of their training session will brief DACOWITS on the January trial run of integrated recruit training. Other topics include: women on ships; childcare resources; fee assistance programs and childcare support; conscious and unconscious bias and how it is impacting promotions and evaluations; and changing the physical fitness test to an age and gender-neutral test. DACOWITS visits an average of two installations per service each year. The report generated by those visits will be posted by the end of the month. The committee has the opportunity to suggest which topics they would like to study, by compiling a package of data and input solicited from the services and agencies. The solicitation is currently open and the suspense to submit topics is the 23rd of August. DACOWITS will look at the topic of domestic violence, as there have been a lot of reported incidents of Servicemember issues with domestic violence.

The Chair introduced Dr. Kirk as the Committee's new Vice Chair for Health. The Chair played a ten-minute video about the memorialization of women Veterans, produced through the Veterans Legacy Program.

FACA 101 Training, Jelessa Burney, Program Specialist, Advisory Committee Management Office, Office of the Secretary

The Federal Advisory Committee Act, passed in 1972, governs the behavior of Federal

advisor committees. At one time, there were over 8,000 advisory committees, but FACA reduced them down to about 1,025 Federal advisory committees. There is also an executive order that aims to reduce that number even more. The act applies to all groups with at least one non-Federal employee established or utilized by an agency obtaining advice or recommendations.

The charter of the ACWV will expire in September and must be raised to the Secretary for renewal. The ACWV must also have a designated Federal officer (DFO); public meetings, with an agenda announced in the Federal Register published 15 days in advance; a balanced membership, and maintenance of their records. The members should each have a copy of the Committee's charter. A Federal advisory committee must hold meetings that are open to the public. Meetings will be closed for certain reasons, including the sharing of proprietary data, if a Veteran is giving a personal story, or if the agency is providing access to classified data or sensitive information. There has been a spike in committees wanting to hold closed meetings, but they cannot do so merely to hold discussion in private. The DFO must be present during the meeting; if the DFO or the alternate DFO is not present, then the meeting would come to a halt. There must be a quorum, defined as 50 percent plus one, in person or via phone for the entirety of the meeting, in order for the committee to do business. If the quorum goes away, then the committee must operate in a different mode, such as a subcommittee. A Committee may advertise in the Federal Register that they will hold an administrative meeting or call to discuss preparatory work; however, whenever recommendations are discussed, the public must be present for transparency.

Members should be familiar with the VA Committee Member Handbook (handbook). The Handbook is currently undergoing review, and a smart template will be added. Members have a maximum two term limit. Before a member rotates off the committee, he or she should recommend a replacement.

When writing recommendations to the government, committees may use the smart template that will be a part of the revised Handbook. Committee members cannot testify as a member speaking on behalf of this committee, but only as a private citizen. If requested to testify, a member should check with the Director of the Advisory Committee Management Jeffrey Moragne and ethics attorney Carol Borden for matters of appearance and conflict of interest. Some of the best practices for members are to master the committee calendar and know the role of the committee and subcommittees. The ACWV has two subcommittees, to address issues related to health and benefits.

Briefing on Individual Long-term Exposure Record (ILER)/Update on 2018 Report of the Advisory Committee on Women Veterans, (Recommendation 4: Capturing Women Veterans In-Service Occupational and Environmental Exposures), Dr. Patricia Hastings, Deputy Chief Consultant, Post Deployment Health Services, VHA

Dr. Hastings delivered the briefing on behalf of Dr. Eric Shuping, who covers the Individual Longitudinal Exposure Record (ILER). The ILER will create a record for every single Servicemember at the time they enter the military, and will continue throughout

their entire service career to note where they have been deployed and the monitoring of environmental conditions present there. There is possible legislation in the House of Representatives called the Service Members Occupational and Environmental Transparency Health Act, or the Oath Act (H.R. 2617), which provides that DoD and VA will work together to monitor exposures of Servicemember to transfer that information over to VA; ILER will be able to facilitate this Act into perpetuity.

Where there have been exposure concerns, such as with burn pits or Agent Orange, Congress has created a registry; however this method is not an objective recording of the data, as it relies on Veterans' best recollection via opting-in to self-reporting. ILER is able to monitor all things Servicemembers are exposed to in their careers. This information will also be able to inform the past. The data prior to 2002 will constitute ILER's legacy registries. The program is in pilot right now; it will go into initial operating capability in September, and all the providers that have used it thus far have been very impressed with it. Claims specialists, epidemiologists, and clinicians all use information similar to that recorded in ILER, and the information will also be available in the electronic health record to support a living, breathing IT program. The current and hopefully last self-reported registries include ionizing radiation, Gulf War, Agent Orange, depleted uranium, toxic embedded fragments, airborne hazard, and open burn pit. ILER will be able to take their place and these will become legacy registries part of ILER. The most recent and real-time data for ILER will be a direct feed from the Defense Manpower Data Center (DMDC), DOD's manpower database, and the Periodic Occupational Environmental Monitoring System (POEMS). This will result in fewer delays in the care, benefits and enhanced medical surveillance for Servicemembers affected by exposure to specific environmental conditions. ILER will achieve full operating capability, in 2023.

Ms. Laurine Carson, outgoing VBA ex-officio member, delivered additional remarks on the ILER program. Vice Chair for Health Dr. Kirk mentioned that DoD's Defense Occupational Environmental Health Readiness System-Industrial Hygiene (DOEHRS-IH) registry will also be populated into the VA system and asked what VBA will do once those records are pulled over, and how practitioners will be able to use the information. Dr. Hastings said that ILER would be able to provide suggestions for care. Ms. Germano asked how community clinicians would be able to access the program. Dr. Hastings said that training about exposures is available for the civilian community and that further educational opportunities are being developed.

The DFO asked about coverage for dependents of Servicemembers who sustain exposure to environmental conditions, such as those found in Camp Lejeune, and Dr. Hastings responded by talking about the Camp Lejeune Family Member Program.

Center for Women Veterans Initiatives/Update on 2018 Report of the Advisory Committee on Women Veterans (Recommendation 7: Enhancing Center for Women Veterans Resources), Jacquelyn Hayes-Byrd, Executive Director, Center for Women Veterans/Designated Federal Officer (DFO), ACWV

The Center for Womens Veterans (CWV) was established in 1994, to monitor VA's

administration of benefits and services for women Veterans. The DFO, who is executive director of CWV, advises the Secretary on all issues involving women and connects women Veterans across VA with the services and benefits that are available to them. CWV works with VBA, NCA, VHA, and the Veterans Experience Office to ensure women's needs are recognized and met. CWV helps women Veterans, by integrating, advocating, connecting, and providing outreach. Many women Veterans do not identify themselves as such, and CWV aims to educate them on services they earned. CWV also creates campaigns to show the contributions of women Veterans, including the Women Veterans Trailblazer initiative and the I Am Not Invisible (IANI) campaign, to redress and increase awareness around the inequity women Veterans experience on a daily basis.

Women Veterans represent approximately two million of the nation's 22 million Veterans, about 10 percent of the population. Although the overall Veterans population is expected to decline in 2040, the women Veterans population is expected to increase to 12.4 percent in 2020. Therefore, CWV's long-term desired outcome is to achieve full equity, access, and satisfaction for women Veterans. The Center's goal is to shape its strategic approach to accommodate those evolving needs and to ensure that VA's programs continue to serve those evolving needs through research and development.

The Women Veterans Task Force that was just appointed by Congresswoman Brownley and Congressman Takano is spearheading advancements for women Veterans as well. The Women Veterans Partners Breakfast honors and outreaches with the non-governmental organizations that work with women Veterans. The Veterans Canteen Services, a part of VA, provides as-needed funding for CWV's initiatives. Over 55 applicants to the soon-to-be vacant committee seats prove that the ACWV is increasing its impact and bringing attention to the affairs of women Veterans.

**Update on 2018 Report of the Advisory Committee on Women Veterans
(Recommendation 3: Reimbursement of Cost for Non-VA Care), Dr. Kameron L. Matthews, Deputy Under Secretary for Health for Community Care, VHA**

Dr. Matthews has been working for the prior year on the MISSION Act (MISSION) implementation. VA has been purchasing care by and through the community care network. Community care is the largest and first focus of MISSION. The act is not about privatization through vendor relationships, but about strengthening VA's health care system and integrating more appropriately with community partners. The Veterans Choice Program (Choice) had its shortcoming and the current MISSION implementation seeks to remedy the policy decisions that were made when the program was implemented.

In light of the welcomed expiration of Choice on June 6, VA has the opportunity to consolidate the many efforts of community care going forward. Key changes in the MISSION Act include an urgent care benefit that is meant to be supplemental to the primary care relationship. There are now more than 5,500 partners in the network managed by TriWest and Optum. One of the biggest items for Veterans was expansion of eligibility from the controversial "30 days and 40 miles" requirement under Choice.

There will be further market assessments going forward, to fine tune eligibility. Under MISSION, new eligibility requirement will be 30 or 60 minutes, not miles, from the primary or specialty service that the Veteran needs. The wait time requirement is now 20 days for primary care and 28 days for specialty care, versus 30 days under Choice. The Secretary has said that he wants to drive efficiency into the system, using more rigorous wait time requirements.

VA has a critical audience of community care partners and providers, because neglectful VA relations will cause vendors to limit care to Veterans. VA has very bad provider payout backlogs and has been a pretty bad communicator with community care providers. VA will improve its referral system, using enhanced IT, communication, and medical record systems administered through a centralized clearing house. VA has purchased a new IT system, the Decision Support Tool, which will automate the authorization and referral management process in addition to employing ten other systems at the same time. MISSION is the result of several years of modernization for community care. There is a co-payment structure included in the urgent care benefit, as well as eligibility requirements that mirror the emergency room bill requirements.

There is still fear and confusion among Veterans, as a result of the poor implementation of Choice. VA is in the process of implementing education and outreach regarding changes in the law.

VA has been attempting to award and deploy new network contracts for several years. Lessons learned from the imperfect 90-day implementation of Choice have resulted in the creation of these new contracts, which include pilot sites in each region instead of immediate nationwide launch. The previous contracts were downright horrible in holding stakeholders accountable; therefore, VA has been diligent and careful in putting together this new managed care contract, to effectively implement its program of building a network and purchasing care. Third-party scheduler-coordinators between VA and the Veteran will be taken out of the relationship and returned to the facility, as it was before Choice. Also, per industry standard, VA's system will be divided along state lines. Regions one, two, and three were awarded to Optum, which is a division of United Health; VA deployed the Region 1 pilot sites in Philadelphia and White River Junction, just last week.

ACWV expressed concerns about the effects of Choice implementation, regarding provider payment and administrative problems in the way VA pays claims. MISSION and the new vendor contracts contain regulations around timely payment. VA's newly purchased auto-adjudication system will facilitate claims processing. Dr. Matthews asserted that, by the end of the calendar year, VA will be out of its current claims payment backlog of 1.6 million claims. VA receives more claims than it is physically able to process, at a rate of 2 million out of 2.1 million claims received per month. The 40 percent of claims received on paper has been reduced to single digits. through a contract to convert those paper claims to electronic.

There has been widespread concern regarding adverse credit reporting that occurs

under Choice, when community care providers bill the Veteran for care for which VA does not pay timely. In response, VA built an adverse credit reporting hotline so that if a Veteran is charged he or she can contact VA. VA will then contact the provider, to prevent the bill from adversely affecting the Veteran's credit history. Since the hotline was set up in 2016, there have been more than 84,000 resolutions. Through these technological and policy changes, the claims backlog will dissipate. VA is approaching MISSION launch, not only as an entire replacement of Choice but as a new and modernized community care program.

Ms. Wright asked if there would always be a rolling backlog of 100,000 claims every month. Dr. Matthews replied that there would, but that those would be timely claims aged less than 30 days. Ms. Wright then asked if there was data available on the gender differences in claims processing. Dr. Matthews replied that there was not and stressed that these claims are being filed by the medical providers and not Veterans. Ms. Wright advocated on behalf of women Veterans who feel they are suffering disproportionately from VA's claims processing backlog.

The Chair remarked that women are being sent out to receive community care more than men, yielding higher rates of utilization and therefore adverse credit effects. Dr. Matthews replied that VA does not track gender demographic data, either through the referral process or at the primary consult level. She further stated that it would likely cost billions of dollars in IT fixes to cross-reference and collect such data.

Ms. Germano asked why it is the Veteran's responsibility to contact the adverse credit reporting hotline, when VA is aware that it is responsible for the claims backlog that causes the billing of Veterans in the first place. Dr. Matthews agreed that the process is burdensome for the Veteran, but that VA cannot afford the workload needed to contact every affected provider who may bill a Veteran for community care; not all Veterans are being billed directly. Ms. Germano continued that further outreach is needed for many Veterans to even become aware of the hotline's existence; VA is compounding this problem and could be implementing programs to better educate Veterans.

Ms. Wright asked whether the statement of work for the providers could include language that the provider will not ever bill a Veteran. Dr. Matthews replied that although that verbiage exists in prior authorizations it does not preclude the provider from billing the Veteran, because they have to be able to bill somebody. Ms. Germano stressed that Veterans, having served, should not have to bear the burden of unwarranted medical billing.

Dr. Kirk asked about Veterans-specific training for community providers. Dr. Matthews replied that the language is in the MISSION Act and that such training includes general military competence, suicide prevention, opioid safety, as well as PTSD, MST, and traumatic brain injuries (TBI). The trainings are being finalized by subject matter experts in VHA and will be provided through online modules; network contractors are also building them into their contracts.

Ms. Yarbrough stressed both subcommittees' concern with adverse billing. Dr. Matthews replied that the crux of the issue is that VA needs to pay its bills on time and get through its backlog. Providers bill Veterans, because their claims are in VA's backlog. If and when MISSION changes are implemented, then that bill will never get to the Veteran.

Volunteer In-home Visitor Program, Prince Taylor, Deputy Director, VA Volunteer Service (VAVS), VHA

The Volunteer In-home Visitor Program, a Veteran companion/caregiver respite program, will significantly reduce or improve Veteran and caregiver wellbeing, through introduction of non-clinical support to address depression-- the most common cause of both Veteran suicide and caregiver burnout. Twenty Veterans a day commit death by suicide, and socially isolated Veterans tend to be more depressed.

The program has been going on for about ten years and offers a unique health care industry service that improves patient/customer experience, by matching Veterans and their caregivers with a VHA volunteer companion. The program aligns with the Secretary's top three priorities of improving customer service, implementing the MISSION Act, and business transformation. The program currently runs in eight facilities across VA and has eight centrally funded coordinators around the country. It provides not only companionship, but geriatric, extended care, and home-based primary care from a home whole health approach. Veterans benefit though less social isolation and the caregivers benefit though being provided a respite of rest and relaxation. According to the coordinators, the most critical factors to the program's success are having a dedicated full time employee (FTE), so that the medical centers would not have to bear the brunt of the entire cost by themselves. Desired outputs include more hours of socialization, reduced emergency room visits, reduced hospitalization, and reduced suicide and suicide attempts, as well as reduced burnout and increased support for the caregivers. VAVS will partner with National Center for Organizational Development (NCOD), to levy effectiveness surveys on the Veteran, volunteer, and care team.

The Chair remarked that she did not know the program was so progressive and Mr. Taylor replied that the Director of Volunteer Services, Sabrina Clark, has said that the program is in the "share" phase of the Develop-Implement-Brand-and-Share (DIBS) process.

Dr. Kirk asked how many women Veterans are being supported by the program and Mr. Taylor replied that it was about 10 percent, based on statistics from New York.

Ms. Wright asked if MISSION will support this program through its caregiver component and Mr. Taylor replied that it is financially uncertain, but that he would like it if VAVS had some control over the FTEs. VAVS needs medical centers to say they want this program.

Ms. Germano observed that the program seems to be one that is compassionate and

driven by service, but that, in a world of constrained budgets, VAVS must provide metrics that demonstrate the nexus between the program's services and return on investment.

Adjourn, Chair, ACWV

The Chair adjourned the second day of the meeting at 12:00 p.m.

Friday, August 9, 2019

The Advisory Committee on Women Veterans (ACWV) met in Room 230, VA Central Office, 810 Vermont Avenue NW, Washington, D.C., at 8:30 a.m., Octavia Harris, Chair, presiding.

Open Meeting, Command Master Chief Octavia Harris (U.S. Navy, Retired), Chair, Advisory Committee on Women's Veterans (ACWV)

The Chair called the meeting to order at 8:30 a.m.

Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendations 3 and 4: Expansion of Reproductive Care), Dr. Alicia Christy, Acting Director, Reproductive Health, Women's Health Services, VHA

Dr. Christy delivered the update on the ACWV's Recommendation 3, to pursue a regulatory change to remove the exclusion of in vitro fertilization (IVF) services for treatment of infertility from the medical benefits package; and Recommendation 4, that VA pursue a regulatory change to remove the exclusion of abortion services in cases of threat to the life of the mother, sexual assault, and incest from the medical benefits package.

Regarding Recommendation 3, the final rule for fertility counseling and treatment for certain Veterans and spouses was published in the Federal Register on March 7, 2019, allowing VA to offer IVF to Veterans with a service connected disability that results in their inability to procreate without the use of fertility treatment, subject to eligibility requirements, including the presence of a service connected condition that caused the infertility, a legal marriage, and sperm or an intact uterus with an ability to produce eggs.

Regarding Recommendation 4, VA has declined the ACWV's recommendation and will not change the medical benefits package regulations to remove the exclusion of abortions and abortion counseling services. VA believes that Congress, as the representatives of the will of the American people, must take the lead on this sensitive and divisive issue. VA will take no further action on the matter without a legal mandate, and will work with the House Veterans Affairs Committee to provide technical assistance on related legislation.

The Chair asked if VA provides contraception to women Veterans, regardless of service connection at no cost. Dr. Christy replied that VA provides contraception, including tubal ligation, to all women Veterans. There is a co-payment for some Veterans, but there is no requirement for service connection in order to receive contraception.

The Committee went into discussion of Recommendations 3 and 4, whereupon the Chair deferred to the Health Subcommittee. Dr. Kirk, Vice Chair for Health, delivered remarks upon VA's decline of ACWV's recommendation. The intent of Recommendation 3 was to extend the letter of the law to encompass fertility- and service-related injury sustained by women as well as men. ACWV was looking for a whole host of exclusions to be lifted to make it a policy that was more amenable to both men and women.

Regarding VA's decline of Recommendation 4, the Chair inquired why the recommendation on VA's abortion policy was rejected when it mirrored DoD's policy. Dr. Kirk remarked upon abortion as emergency care in a matter of life or limb. Ms. Yarbrough remarked upon the difference between DoD and civilian policies. Dr. Kirk raised a matter of general equity in health care provided to male versus women Veterans. Ms. Germano remarked upon health care in cases of military sexual assault and Dr. Kirk added that in such cases as the Navy SEALs case, women Veterans suffer the "double whammy" of being sexually assaulted in the already life-threatening service of one's country. Ms. Pierce remarked upon the rationale provided by VA regarding the need for the Congress to step in and legislatively address the matter of abortion. ACWV must be more specific in its recommendation language, in order to make any progress on this issue. The Chair said she knows U.S. House staffer Andrea Goldstein has the Committee's recommendations.

Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation 1: Treatment of Eating Disorders), Dr. Susan McCutcheon, National Mental Health (MH) Director, Family Service/Women's MH/Military Sexual Trauma, Office of Mental Health, VHA

Dr. McCutcheon just completed facilitating VHA's third Women's Mental Health mini-residency in Dallas, Texas, and is beginning to plan the 2020 Women's Mental Health mini-residency in partnership with DoD. The residency provides training for up to 200 DoD and VA participants.

In reference to Recommendation 1, regarding eating disorders for women Veterans, VHA received guidance and structure of what the ACWV was interested in and developed some action steps that they told the ACWV they would meet in advancing this recommendation.

The first step was to continue the eating disorders workgroup. VHA meets quarterly with their eating disorder subject matter experts in expanding their training. They are currently hiring two new subject matter experts to assist them in their training.

The second step was to develop a needs assessment, which was completed in June 8 of 2016. The interviews were conducted August 31, 2016, and the interviews were transcribed and analyzed in September of 2016. VHA summarized the key findings for Women's Health Services and the Suicide Prevention and Eating Disorders Workgroup and piloted a training team for the multi-disciplinary eating disorders treatment team training. These training teams must have a minimum of three core individuals, including

a therapist such as a psychologist; social worker, or advanced practice nurse; a physician such as a psychiatrist or primary care physician; and a dietician. The training program pilot was completed in July of 2016; the program was implemented in October 2016. VHA obtained feedback in November, and modified the program based on the feedback in March of 2017. VHA surveys the teams quarterly; it has currently trained 43 multi-disciplinary eating disorder treatment teams and continues to do so at an average of two teams per fiscal year. Attrition is a problem with these teams. An online training was developed in response, so the whole team does not have to come back for training. Fifty percent of people treated in the current quarter were diagnosed with binge eating disorder; 28 percent bulimia nervosa; and 16 percent anorexia nervosa. Eighty percent of the teams are providing direct care; 100 percent are providing some form of education and consultation to their colleagues; and 40 percent of the teams are providing telemedicine. Women's mental health is provided through online training for primary care providers. There is now a National eating disorder share point site that includes screening diagnoses, common medical comorbidities, and steps to treatment. VHA believes it has fulfilled the recommendation of the Committee.

Dr. Kirk asked about the identification of women who have eating disorders and whether such training is provided to all primary care physicians (PCPs). Dr. McCutcheon responded that up to half of the Veterans VHA sees are male and therefore PCPs are not required to take the training. Congress mandated that all providers receive training on military sexual trauma, but training for eating disorders is not mandatory.

Ms. Germano asked how many women have participated in the program and the trends in the progression of their treatment. Dr. McCutcheon replied that her office would supply that information. Ms. Germano said that the Committee would put together a request for information (RFI), in order to ascertain hard data on how the intent of the Committee's recommendation is being achieved.

The Chair asked how the MISSION Act would play into the treatment for women diagnosed with bulimia, binge eating or anorexia and their residency options. Dr. McCutcheon replied that they would be offering further educational training sessions. Some Veterans with eating disorders would be appropriate for inpatient care when their condition is very acute, when they have become critical or suicidal.

Briefing on VA's Veterans Justice Outreach Program, Jessica Blue-Howells, Deputy National Coordinator, VA's Veterans Justice Outreach Program (VJP), VHA

The Veterans Justice Program (VJP) is a component of VHA's homelessness prevention under the Homeless Programs Office. Veterans' participation in the criminal justice system is finally declining, however VA does not hold that data. The incarcerating government agency actually holds that data, whether it be the state, Federal Bureau of Prisons, Department of Justice, or the Bureau of Justice Statistics.

VJP is separate from the Homeless Program, because there are specific components involved in working with Veterans who are involved in the criminal justice system. The

first piece of VJP's mission is to identify Veterans who are justice involved, because there is no mandate on law enforcement to include information on someone's military service. VJP has developed data strategies and partnerships aimed at finding Veterans who are in the population. VJP has a community-facing workforce that performs outreach to meet Veterans where they are and the intent of that outreach is to facilitate access to VA services, such as treatment for substance use issues.

Partnerships between VA and criminal justice are imperative, because they do not have a mandate or any type of requirement to allow VA staff within their facilities. The grand vision of the VJP is to help Veterans end their involvement in the justice system altogether. VJP services include Veterans Justice Outreach and Health Care for Reentry Veterans (HCRV), the prison outreach-focused program which started in 2007. The Veterans Justice Outreach has a mandate to serve people who are newer to the criminal justice system.

The Veterans Treatment Court Improvement Act of 2018 requires VA to hire additional staff and updates the authorization for VJP. Even the President acknowledges the updated authorization. Women are a very small component of Veterans who are incarcerated, at a rate of one percent in prisons and three percent in jails, according to the Bureau of Justice Statistics. In the general population of adult women incarcerated, VJP has found more drug and property crimes and lower violent crimes; higher drug use and mental health diagnoses; and more common abuse and trauma backgrounds. Court and jail environments must be much more trauma informed. In the last two fiscal years, VJP has found that about two percent of its overall justice outreach footprint is women Veterans. Staff is proactively able to gain access to women prison facilities. The core component of VJP is to find Veterans engaged in the criminal justice system and get them involved in VA; women did better than men over all in that area.

Ms. Wright asked if the decline in incarcerated Veterans was due to naturally losing Veterans every day in the world versus actual recruiting practices that cause Veterans not to recidivate. Ms. Blue-Howells responded that that data is not known. She continued that the Veterans' treatment court infrastructure is being utilized by more young Veterans, as a result of aging.

Ms. Germano asked if it would be helpful for ACWV to recommend that VA require prisons to allow VA staff access, as well as the mandatory reporting of Veterans status. Ms. Blue-Howells replied that any such legislation would only apply to the Federal Bureau of Prisons because the Federal government cannot compel a Federal entity's entry into state prisons. Ms. Germano asked about the preponderance of mental illness in Veterans before they entered the military. Ms. Blue-Howells replied that there has been some research on that question regarding Vietnam Veterans.

Ms. Wright recommended pushing forward to the State Directors of Veterans Affairs a legislative resolution to support VJO's going into jails.

The Chair asked about benefit programs offered to the dependents of incarcerated

Veterans. Ms. Blue-Howells replied that VBA has had changes in their policy to allow dependents of long-term incarcerated Veterans to apply to receive benefits.

Ms. Glowacki, Department of Labor (DOL) ex-officio member, remarked that DOL has employment services available Nationwide, and incarcerated or formally incarcerated Veterans do qualify for the most intensive case management services. Ms. Blue-Howells said that VJP loves DOL programs and one of the Homeless Veterans Reintegration Program (HVRP) grants went directly to the New York State Department of Corrections.

Dr. Kirk asked about data on men who are incarcerated for crimes against women Veterans. Ms. Blue-Howells replied that there has been some emerging data around family violence that shows that Veterans are more likely than civilians who are incarcerated to have committed a violent sexual crime, particularly against family members or their own children.

Discussion on Status of 2016 and 2018 Report Recommendations

Vice Chair for Health Dr. Kirk volunteered to annotate the Committee's decisions to open or close the 2016 and 2018 recommendations.

The first open recommendation for 2016 was treatment for eating disorders. Ms. Germano recommended leaving it open to receive data on the success rates of women versus men. VA established a comprehensive program in collaboration with community partners but has not provided any measure of success. The Chair noted Committee's request for information.

The next recommendation was expansion of reproductive care. Dr. Kirk moved to close this recommendation and start over with revised language. Without objection, it was so moved.

Regarding 2016 report recommendation 4, that VA pursue regulatory change to remove the exclusion of abortion services, Ms. Germano recommended closing the recommendation and starting again.

Regarding 2016 report recommendation 6, that VA collects and reports any specific data on programs and services and all regular reports: VA concurred that this needs to happen and the Committee said that progress is being made, but that there needs to be continued to focus on the data and metric issue. The Committee made a request for information, because it wants that to be able to extract the data and information it needs from the claims and other sources of metrics on women Veterans.

The recommendation one of the 2018 report was closed.

Regarding recommendation two of the 2018 report, that VA conduct a comprehensive needs assessment of the women Veteran population that encompasses anticipated long terms needs as they age and develop an action plan to ensure identified gaps are filled

including but not limited to staffing, facilities, budgeting, training and community-based resources, VA concurred in principle, and the response is currently that Women's Health Services (WHS) is utilizing national survey and data collection methodology to assess the needs of women Veterans and to plan the growth in aging of the women Veteran population. Ms. Germano suggested that the Committee submit a request for information at a future update. The Chair moved to leave the recommendation open, asking of VA leaders specifically what VA is doing from a holistic VHA-VBA-NCA perspective for the aging population. The DFO concurred and it was moved without objection.

Regarding recommendation three of the 2018 report, that VA identify Veterans who through utilization of non-VA care for eligible services were billed directly for those services, have either paid charges out of pocket and/or have received collection notices and have received adverse impact on their credit: VA concurred in principle and added that since publication of the VA Office of the Inspector General report of 2018, VA has undertaken targeted efforts and outreach to assist Veterans inappropriately billed for authorized community care services. Operations focused on providing timely and more accurate payments to community care providers, the root cause behind these Veteran issues. At present the six recommendations made to the VA in the OIG report have been either addressed or resolved. The Committee moved to leave the recommendation open, because VA is still backlogged 1.6 million claims.

Dr. Kirk delivered the Health Subcommittee's answer to the 2018 RFI number 3: that VA provide the percentage of women impacted by the backlog, the timeline of how VA will pay the backlog of claims to providers that impact Veterans, and data on claims that are older than 90 days. The Committee needs an update on all claims older than 90 days. Furthermore, VA should send a communication to all Veterans potentially impacted that advertises the credit impact hotline phone number in order to be proactive rather than retroactive. Every Veteran that is affected by that 1.6 million provider backlog should be contacted. The Committee moved without objection to leaving the recommendation open.

Regarding recommendation four of the 2018 report, that VA capture and document occupational and other hazardous exposures that women Veterans encounter: VA Post-Deployment Health services agrees and is working on the ILER with DoD. The Vice Chair for Health remarked that the subcommittee wanted to keep the recommendation open and ask for an update at the Committee's spring meeting.

Regarding recommendation five of the 2018 report, that VHA provide resources and training to expand available treatment options as well as research the effectiveness of novel psychotherapeutic and psychopharmacological treatment modalities for clinical practice in the treatment of MST conditions: VA concurs and responded that they are committed to radically transforming healthcare to promote Veteran's whole health and ensure Veteran-centric care. This is a core component to VA's strategic goal to empower Veterans to improve their wellbeing. Ms. Germano remarked that there is nothing that actually addresses whether or not VA is looking to innovate with new

modalities. Ms. Wright made a request for information and the Committee moved without objection to leave the recommendation open.

Regarding recommendation six of the 2018 report, that VHA review the current activities and utilization of women Veterans program managers (WVPM) across the enterprise to identify discrepancies between their intended role as defined in the position description and their actual utilization: VA agrees; the VHA directive for health care professionals is in concurrence for revision. The WVPM position is a full time position without collateral assignments; it is an administrative management position in charge of program development and has direct supervisory reporting to the facility director or chief of staff.

The Chair remarked that this response looks good in principle but on a site-visit basis the WVPM is more than often a nurse who is not keeping up their clinical skills. This is not only a training issue, but a skillset issue, a leadership issue of not knowing who to choose, and a consistency issue across the enterprise. Dr. Kirk suggested the Committee leave the recommendation open in order to request metrics and position descriptions to demonstrate the intent of the program. Ms. Pierce remarked that the program is in the concurrence process, and so the Committee may want to submit a request for the finalized document and then reengage. Ms. Wright suggested the position description include language that mandates that the facility recruit a qualified woman Veteran. Dr. Kirk moved that the Committee request for a copy of the finalized instruction, an update on the inspection checklist around this position, and an RFI on the timeline and the position descriptions. Colonel Davis added that the Committee could also request the draft that is currently in concurrence to see if there is anything they want to add before it is finalized. Without objection it was so moved.

Regarding recommendation seven of the 2018 report, that VA allocate additional resources, funding, and staffing to the Center for Women Veterans to be able to effectively support projected enhancement of Advisory Committee on Women Veterans activities such as increasing the frequency of regular meetings, conducting focus groups, and enabling the Committee to better accomplish its mission: VA concurred in principle and is dedicated to ensuring the Committee has the resources needed to fulfill its congressionally mandated function of advising VA on needs of women Veterans.

The Chair turned to the DFO and asked if VA is going to provide additional funding for staffing, site visits, and travel. The DFO recommended that this request be addressed to the Secretary because the final decision on the budget and the recommendation is stronger if it comes from the body. The Chair suggested the Committee close the recommendation and reword it. Ms. Wright concurred with the Chair's suggestion. The impending growth of women Veterans in the year 2020 also supports the Committee's request.

Colonel Davis remarked that the Committee's recommendation for more funding looked vague and that it should identify specific needs in its recommendation. Ms. Wright suggested making a recommendation for an extra plenary session (making four total meetings) and two more site visits per year; furthermore, the Committee should have

the resources to visit any and all VA facilities which need to be examined, including Guam, Puerto Rico and U.S. territories. The DFO suggested focusing on the sites that most need the attention of the Committee. Ms. Germano recognized that the Committee has not attached any dollar amounts to its request and the Chair suggested requesting a cost snapshot to inform the Committee's recommendation. Ms. Middleton delivered general remarks upon the budget and projection of costs, noting that projections are impacted by location and number of meetings.

Ms. Wright moved to close the recommendation and open a new one with regards to site visits and travel. Dr. Kirk asked if there was any value in the Committee recommending that the Secretary ask Congress for funding specific to the Center for Women Veterans with the intent of allocating more funds for Committee activities. Mr. McIntosh delivered remarks upon the feasibility of cost projection and rationale for the recommendation.

The Chair concurred that she liked the idea of requesting a specific line item dedicated to the CWV. Ms. Pierce suggested the Committee offer a litigation plan and establish data metrics to support the recommendation. Ms. Yarbrough remarked that the Committee seeks to move toward a more hands-on focus-group-oriented approach that relies more on physical visitation to VA facilities than metrics. The Chair moved to close the recommendation and make a new recommendation with more specific language. Without objection it was so moved.

Overview of the Women Veterans Task Force, Andrea Goldstein, Senior Policy Advisor, Women Veterans Task Force, Committee on Veterans' Affairs, U.S. House of Representatives

The Congressionally-mandated Women Veterans Task Force (Task Force) of the House Committee on Veterans' Affairs, chaired by Congresswoman Julia Brownley. She was joined by VA fellow Stephanie Jones.

The Task Force was announced in February of 2019 and launched in May. There are now 74 participating members from the House Veterans Advisory Committee and Committees on Armed Services, Appropriations, Homeland Security, and Small Business. The Task Force has introduced 16 pieces of legislation, since March, including Congresswoman Brownley's Veterans Access to Child Care Act which passed the House in February. The Health for Woman Veterans Act passed the House on July 23, authorizing the DoD/VA transition program. Many other pieces of legislation will become components of the House version of the Deborah Sampson Act which should come out in the fall. The Task Force has written four letters to the Executive Branch and held two hearings specifically pertaining to women Veterans. The Task Force participated in a full VA Committee hearing on suicide prevention and a joint hearing with Armed Services. It holds monthly roundtables and conducts oversight visits.

The Chair asked if there were any trends in the discussion around women Veterans. Ms. Goldstein replied that health is the biggest concern, with particular regard to provider shortages, provider burnout, and environment of care challenges, harassment or denigration of service at facilities, and inconsistency with the implementation of the

Women Veteran Program Manager position. On the benefits side, the schedule of benefits may not be sufficient for conditions like dyspareunia, pelvic floor disorder, and certain musculoskeletal conditions where women are being rated like men.

Homelessness and precarious housing are also concerns among women Veterans. There is some inconsistency in MISSION Act implementation, especially regarding pregnant Veterans. Women who are not enrolled and not service connected who would be eligible for mental health because of military sexual trauma are being turned away and not every facility knows about the policy change.

Dr. Kirk asked about the declination of the Committee's recommendation on abortion services and Ms. Goldstein replied that Congress first needs to legislate the issue of abortion counseling before that of paying for abortions.

The DFO asked about the Task Force's recent one-on-one training. Ms. Goldstein replied that because women Veterans are not as well organized as the big VSOs, the Task Force implemented training to help women Veterans be heard, advocate for themselves and their organization, and identify actionable items.

Ms. Germano remarked that women Veteran issues have been at the forefront of VSOs concerns, but that there seems to be a lot of duplicative effort between VSOs and those on the Hill, with very little collaborative work. Ms. Goldstein replied that VSOs support women Veterans, but they have not really gone into depth about what that means.

The Chair asked if the Task Force works or partners with the Servicewomen and Women Veterans Caucus and Ms. Goldstein replied yes. The caucus manages the active duty side, the Task Force manages everything from transition to becoming a Veteran, and both manage Reserve and Guard. Ms. Wright asked about overall headway among women Veterans' issues and Ms. Goldstein replied that there is a lot of energy surrounding the issue of women Veterans.

Dr. Kirk asked what percentage of the 74 members were men and Ms. Goldstein replied that the majority of Republicans on the Committee are men. Mr. McIntosh asked if the House has a working relationship with VA's Office of Congressional Affairs and Ms. Goldstein replied that they are the House's preferred point of contact.

Meeting Adjourned, Chair, ACWV

The Chair adjourned the meeting at 12:00 p.m.

/s/

CMDCM Octavia Harris, USN, Ret.
Chair, Advisory Committee on Women Veterans

/s/

Jacquelyn Hayes-Byrd
Designated Federal Officer, Advisory Committee on Women Veterans