Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans
Virtual Site Visit: VA Caribbean Healthcare System (VACHS)
Veterans Integrated Service Network (VISN) 8: VA Sunshine Healthcare Network
August 29-September 1, 2022

The Advisory Committee on Women Veterans (ACWV) conducted a virtual site visit with the VA Caribbean Healthcare System (VACHS) and Veterans Integrated Service Network 8 (VISN 8) via video-teleconference. COL Betty Yarbrough, USA, Ret., Chair, presiding.

ACWV Members Present:
COL Betty Yarbrough, USA, Ret., Chair
Delise Coleman, USMC Veteran
COL Wistaria Joseph, USAF, Ret.
CAPT Dr. Cynthia Macri, USN, Ret.
MG Marianne Mathewson-Chapman, USA, Ret.
CW2 Moses McIntosh, Jr., USA, Ret.
LTC Shannon McLaughlin, Massachusetts Army National Guard, Vice Chair for Benefits Subcommittee
Sandra Miller, USN Veteran
MSG Lachrisha Parker, USAR, Ret.
COL Wanda Wright, USAF, Ret.

ACWV Ex-Officio Members Present:
Dr. Patricia Hayes, Women's Health Services (WHS), Veterans Health Administration (VHA)

ACWV Advisor Present:
Faith Hopkins, Office of Finance and Planning, National Cemetery Administration (NCA)

Center for Women Veterans (CWV) Staff Present:
Lourdes Tiglao, CWV Director/Designated Federal Officer (DFO)
Elizabeth Estabrooks, Deputy Director/ Alternate DFO
Shannon Middleton, Committee Manager/ Alternate DFO
Julia Kelly
Missina Schallus

Other VA Staff:
Jelessa M. Burney, Advisory Committee Management Office (ACMO)
Danielle Cataldo, VISN 8, VHA
Natalie Hubble, Puerto Rico National Cemetery, NCA
Dr. Carrie Kairys, WHS, VHA
Iris Morales, Puerto Rico National Cemetery, NCA

Joy Rivera- Bermudez, San Juan Regional Office, Veterans Benefits Administration (VBA)
Deshaun Sewell, VBA

Public Guests:
Christine Allen
Adrian Atizado
Rene Campos
Mary Cevera
Luis Collazo-Rodriguez
Grace Cruz
Omayra Cruz Rodriguez
Alisa Delgado
Angelis Ferreia-Flores
Rosa Gonozalez
Hilda (Guest)
Joann (Guest)
Jari Moreno-Sanchez
Stephanie Pagan
Charlin Rodz
Itsamarie Santiago Castro
Judith Silvia
Meggan Thomas
Roberto Vega-Rivera
Helena Villanueva

Monday, August 29, 2022

Open Meeting/Introductions of Advisory Committee on Women Veterans (ACWV)
Betty Yarbrough, Chair, ACWV
The Chair called the first day of the ACWV meeting to order at 10:00 a.m. The committee members, ex-officio members, advisors and CWV staff introduced themselves.

Welcome
Carlos R. Escobar, Executive Director, VA Caribbean Health Care System
Welcomed the committee and gave brief comments about his staff's dedication to providing quality care for women Veterans.

Purpose for Site Visit
Lourdes Tiglao, Director, Center for Women Veterans/Designated Federal Officer, ACWV
Ms. Tiglao stated that the purpose for the site visit is to provide an opportunity for the Committee members to compare the information received from VA Central Office (VACO) briefings with the activity in the field, as well as for the members to hear about the treatment programs and provision of benefits and services that are in place for

women Veterans in VISN 8, Puerto Rico and the Virgin Islands especially. The presentations will address how program services and benefits relate to women Veterans. VACHS's senior leaders will have the opportunity to discuss special interests to share with the Secretary or address concerns regarding the welfare of women Veterans. It is an opportunity for them to demonstrate how they address challenges for women Veterans in accessing VA benefits and services. She concluded with a snapshot of the previous ACWV conducted over the course of the committee's history. She also noted that this is the committee's first site visit with a facility in the territories.

Overview of VISN 8 Facilities/Programs/Demographics
Dr. Chona Macalindong, Acting Chief Medical Officer VISN 8
Dr. Macalindong noted that VISN 8 is the largest VISN in the nation, serving about 10 percent of all active users of VA health care. The VISN stretches from south Georgia, all of Florida, all the way to Puerto Rico and the US Virgin Islands. It includes seven health care systems (HCS): VA Caribbean Healthcare System, with San Juan VA as the flagship medical center; Miami VA Healthcare System, with Bruce Carter is the flagship hospital; West Palm Beach VA Medical Center; VA Orlando Healthcare System, with their main facility at Lake Nona; James A. Haley Veterans' Hospital and Systems; C.W. Bill Young VA Medical Center; and North Florida/South Georgia Veterans Healthcare System, which spans the northernmost South Georgia. South Georgia. North Florida/South Georgia Veterans Healthcare System has two hospitals, the Malcolm Randall VA Medical Center, where they have the higher complexity care and the Lake City VA Medical Center, which is more like a community hospital with a large community living center (CLC) facility.

They serve about 1.5 million Veterans and deliver highly complex surgical and medical services at all seven HCSs except for West Palm Beach, which is a 1C with a slightly lower number of procedures. The goal is to provide the highest quality VA health care and foster a learning organization.

All seven healthcare systems offer an expansive set of health care services, including diagnostic services, geriatrics and extended care, mental health, prevention and screening, primary care, rehabilitation and specialty care. There are several sites with spinal cord injury services and one polytrauma referral center. In 2019, there was a large number of services from outpatient emergency department (ED) visits; there was a dip in 2020 because of COVID. In 2021, the visits started ramping up again.

VISN 8 is also engaged in professional training programs. Several of their healthcare systems are strongly affiliated with state universities. They are fully accredited by the Joint Commission. Six of the seven systems have completed their triennial site visit with Joint Commission and are just awaiting the final report.

VISN 8 was a leader in telehealth and was proactive in preparing the system for virtual health. Even in fiscal year (FY) 2019, they assessed for training, and issuing equipment to all facilities to be ready for emergencies. They converted a lot of their workload to virtual care, increasing the virtual care workload by 1,280 percent during the pandemic.

They ramped up their COVID-19 workload with vaccinations to Veterans and the community. They provided mission assignments to the community, including vaccination and COVID care to state Veterans' homes and partnering with community hospitals for admissions into VA hospitals.

Eighty-five percent of the Veterans they serve are male and 15 percent are female. The number of women Veterans increases every year. In terms of the unique women Veterans, VISN 8 is overall up 14.5 percent in FY 2022, as of July, compared to FY 2020. The biggest increase is in the Orlando Healthcare System, where there is a nearly 23 percent increase in women Veterans, followed by James A. Haley. Overall, everyone is up more than 10 percent.

Regarding the overall age distribution of the Veterans served, the largest age bracket is 55 to 74 years old but most of the Veterans served are about 84 years old. In terms of the era of service, the majority are currently the Persian Gulf Vietnam-era era Veterans. Post-9/11 and Vietnam era make up the majority of the eras. VISN 8 is expected an increase and even more enrollees in Veterans served, given the impact of the PACT Act in terms of serving the presumptive conditions and the expanded benefits.

VISN 8 engages with community partners. Bay Pines has a very large geographic spread and a national cemetery and the VBA. The CLC achieved the highest overall rating. Bay Pines established a memorandum of understanding with the Moffitt Cancer Center in 2021 to allow Bay Pine oncology physicians access to the Moffitt Center clinical pathways. Bay Pines is a model for collaboration with the Community Veterans Engagement Board. Haley VA expanded accreditation elements for its programs and was awarded the Healthcare Equity Index Leadership Status, which is a national LGBQT+ benchmarking tool to evaluate healthcare policy and practice for equity and inclusion for the tenth year in a row.

Miami VAHCS is also accredited by the Joint Commission, the Ascellon (for the CLC), mental health residential programs, and the Spinal Cord System of Care. Its homeless program continues to be a leader in providing outreach and services to Veterans. Miami-Dade County is recognized as the largest metro area to have ended Veteran homelessness.

North Florida/South Georgia is a leader in quality and patient satisfaction, with 35 innovation grants funded in fiscal year 2021. It developed 48 COVID-19 best practices that were implemented across VA. Its research program is strong, and it is recognized for its telehealth and creative arts program. The Malcom Randall CLC is recognized as an age-friendly healthcare system, implementing geriatric care best practices in a manner consistent with evidence-based practices.

Orlando is the fastest-growing system. There is a lot of interest in receiving care at the new Lake Nona facility and they have already outgrown it. They are looking to offload some services at Lake Nona to another facility or to Lake Baldwin, to make room for more inpatient care. The Daytona Beach VA multispecialty clinic is in progress with

target completion in fall 2023. There are also other construction projects. VACHS is the premier healthcare facility in Puerto Rico, and even in COVID when it had to do virtual care, they did not stop delivering quality care. It was reaccredited in 2021 for compensated work therapy, vocational rehabilitation, Commission on Accreditation of Rehabilitation Facilities (or CARF) homeless program and blind rehabilitation. West Palm Beach is a leader in suicide prevention with several accredited programs. It is a leader in the Health Care Equity Index. It engaged community partners during COVID-19 to help homeless Veterans receive housing in local hotels. It has a new accredited geriatric fellowship program.

VISN 8 is a leader in virtual care through the Clinical Contact Center, where Veterans can call and have virtual urgent care delivered to their devices or in their home. During COVID, Veterans did not have to come into medical centers to get some of the care they needed as long as they were not very sick. There is also the Clinical Resource Hub that is the arm for gap coverage. If a facility needs interim help with staffing, the Clinical Resource Hub provides interim help.

Orlando has the fastest-growing Veterans population, including women Veterans, because of the growing metro area. It is near a major hub for airports and there is a lot of employment. Real Estate is cheaper, compared to south Florida or Tampa. It is also diverse compared to other areas in Florida.

The Chair opened the floor to the Committee for questions and comments. Ms. Wright asks for an explanation of the issue of travel between the islands for care. Dr. Macalindong states transportation is an issue because it is a large VISN and there are a lot of rural locations. That is true in Puerto Rico and Florida. There are transportation services VA is testing for key population areas, like rideshare programs. Virtual care is also available. Digital Divide Consult can provide portable laptops for virtual care and communication. It requires a consultation with a social worker and those who qualify receive a laptop with built-in internet coverage. Cognitive behavioral therapy and telehealth is available through a community-based outpatient clinic (CBOC). Community Care is also available.

Dr. Macri asks about tracking Veterans in remote nursing facilities, so they can be accounted for in case of hurricanes. Dr. Macalindong stated that VACHS has a strong outreach program and has an organized way to track everyone, particularly the vulnerable populations, in case of emergencies. They also consider the quality of care in the community, so they try to arrange for the best option for the Veteran in question regarding whether to travel. Mr. Escobar noted that the clinic in Vieques is not closed and has a provider that potentially comes twice a week. They are tracking Veterans, including women, who are homebound because they are beginning to realize that they are expanding home-based primary care. The pandemic revealed the need to move to non-institutional access to care. They already have a unique program in remote areas because they contract charter flights for Veterans who come from St. Croix and St. Thomas. They are also discussing having local government pay for empty spaces so the Veterans who do not qualify for benefit travel can gain the benefit of taking the

charter flight. They also arranged with the Transportation Security Administration and the port authorities to bypass security, so there is concierge service for Veterans to get to the airport. They are looking for options for managing women Veterans who are pregnant where flying is not an option.

Overview of VISN 8 Women Veterans Services
Lisa Martel, Acting Lead Women Veterans Program Manager (WVPM), VISN 8/WVPM, VA Orlando Healthcare System.

Ms. Martel presented on behalf of Michelle Zielenski, VISN 8's Lead WVPM. VISN 8 has seven WVPMs; one at each site. Some of the WVPMs have assistants, due to the depth of the facilities' program. There are six women's health medical directors. The Bay Pines HCS is actively seeking to fill its women's health medical director vacancy.

All VISN 8's sites have a Model 3 clinic, which is a comprehensive women's clinic co-located with primary care and gynecology (GYN). There are also specialty providers embedded in the clinic, which have their own entrances, check-in areas and waiting areas. All the sites offer in-house mammography and gynecological care. All sites have an active in vitro fertilization- IVF interdisciplinary team. All sites have an Intimate Partner Violence Assistance Program (IPVAP) and Strength at Home Program. The Bay Pines HCS is currently seeking an IPVAP coordinator. Orlando has a regional Strength at Home trainer. The Strength at Home program is a trauma-informed and evidence-based group program for Veterans who struggle with conflicts in relationships. Five sites are part of the Women's Health Research Network (WHRN): Miami, Bay Pines, Tampa, San Juan and North Florida/South Georgia. All have done harassment feedback projects. Other sites have done similar projects on their own but not as part of WHRN.

In 2020, VISN 8 facilities received $4,409,642 from Women's Health Innovation and Staffing Enhancements (WHISE) funds that helped to expand Women's Health programs. They were approved for 48 women's health-specific funding positions. All sites also have a Women's Health Navigator, responsible for tracking breast and cervical cancer screenings. Five sites have full-time maternity care coordinators. West Palm Beach and San Juan have maternity care coordinators who are also the nurse care coordinator.

Strategic planning for this coming up year includes: continuing to create and promote a sensitive environment to continue cultural transformation to improve health care delivery to women Veterans; developing a specific psychological well-being program, including the Whole Health Program that is expanding specifically to serve women Veterans; developing, implementing and ensuring a proficient workforce through training, education and assessment on women's health; expanding the Maternity Care Program and education on VA productive health services, including IVF services; and developing sensitivity and skill training to address the specific needs of the LGBTQ and transgender Veterans.

The male Veteran enrollment's market penetration for VISN 8 is 52.2 percent. The women Veteran market penetration is 53.8 percent. They have been doing focus groups for the last year and a half to focus on the needs of women Veterans. They get regular feedback on their programs and services. Women Veterans indicate that virtual care is helpful to women in most disciplines, especially women who have small children or work during the day. Women Veterans would like information to be shared better about the services VA offers. They also say that the Whole Health services are very well received. They are also pleased with the VA culture shift, the efforts VA made over the last several years to educate the staff about women being Veterans.

VISN 8 has the fourth-highest enrollment of women Veterans in the country. In 2018 it was 62,595 and in May 2022 it was a little over 74,000--an 18.2 percent increase in the women Veteran's enrollment population. In VISN 8, Gainesville has 19,000 and Orlando has 15,000. Orlando averages 1,000 new women Veterans each year.

From July in FY 2020 to July in FY 2022, there was a 14.5 percent increase in number of unique women Veterans receiving services in VISN 8. The largest age groups represented are 35, 45 and 55. This demonstrates the importance of tracking and services for maternity care and breast cancer as well as cervical cancer screening. About 36,000 of these Veterans need care coordination.

VISN 8's women's health programming employs a one-stop shop model. It ensures that women are assigned to primary care physicians who can provide general medical care and all their well women care. Providers and nurses participate in women's health mini-residencies that are very specific to women's health needs; training allows them to work on their GYN skills (doing Pap smears and mammograms), performing breast exams. They also learn about military sexual trauma and other women Veterans-specific types of areas of need. Gainesville, West Palm Beach, San Juan and Orlando hosted at least one local mini residency in FY 2022, where over 162 providers and nurses were trained.

Evidence shows that women assigned to a women's health primary care provider are more satisfied on the six components of VA Survey of Healthcare Experiences of Patients (SHEP) scores and they show improved quality of care and reduced attrition by 50 percent. That supports VISN 8's efforts to provide women Veterans with high-quality equitable care that is on par with male Veterans, to receive care in a safe and healing environment where they get seamless coordination of their care that is specific to women.

Some of VISN 8's women's Health best practices include: conducting a one day standdown on a Saturday for women to come in and get pap smears, which accommodated working moms; offering extended hours for mammography and women's primary care providers, so women Veterans can get all of their comprehensive care at once; and having nurse navigators/care coordinators work directly with primary care team to identify patients overdue for mammography and pap smears to help the team come into compliance with making sure their patients are getting their mammography and Pap smears done.

In general, VISN 8's trust scores look good. However, younger Veterans--both male and female--tend to have less trust in VA. Data from July 2022 indicate that they need to do a better job of reaching out to younger women Veterans. Respect scores indicate that the VISN is doing well overall but indicate a lower percentage with regard to younger Veterans.

For wait times, they are close or even doing better for mental health and primary care for women than men. For new patient wait times compared to established patient wait times, there is a difference that needs work. They will examine this to review staffing shortages and primary care panel capacity and plan accordingly.

One challenge is ensuring that IVF providers are available through the OPTUM network. San Juan did not have an IVF provider until this year. Women's health measures and staffing shortages go hand in hand. VISN 8 is committed to hiring women's health providers and doing mini residencies. There are challenges with the human resources process affecting their ability to get people in timely and to assign women to women's primary care providers. All sites have a backlog of overdue screenings, so they are working on the backlog and doing best practices and identifying new best practices to share among the sites.

The goals for women's health programming are maternity care expansion, incorporating women's health clinical pharmacists, creating more women's health-specific programming, and continuing to strategically plan and prepare for projected growth in women's health programs. There is a new round of funding, WHISE 3.0, and they are applying for quite a few positions VISN-wide again.

The one-day standdown is a best practice from Orlando. They were trying to make a dent in the number of women needing to receive care. The women said it was helpful. Other sites are planning to replicate the best practices. They are looking into the possibility of working with radiology to do the pap and mammogram at the same time.

The Chair opened the floor to the Committee for questions and comments. For the first question, the Chair inquired how many of the 48 funded positions are filled. In response, Ms. Martel said she believed that they were all filled. They received a new round of funding which will help with getting quite a few positions VISN-wide and have shown tremendous assistance inbuilding the programming.

Ms. Parker asked about how often they hold the one-day standdown event and if it was the first time the standdown was done with the single health care provided for that area. Ms. Martel indicated that it was the first time and noted that it was a best practice from Orlando. They are looking for ideas that would help make a dent in the number of women to be served. It was a lot of work on the front end, just to call them and get them scheduled. They surveyed the women coming in to see if the event was helpful and something they would like to see again. The participants responded that it was very helpful.

In Orlando, they were planning to do one at the sites where there has been a need. Some of the other sites in the VISN are planning to hold standdown events too. They plan to continue having them and may look for ways to coordinate other services, to enable them to offer several services at the same time. For instance, they would consider including radiology so they could offer women Veterans Pap smears and mammograms during the event.

Ms. Parker also asked if the standdowns are held at the medical center or if a mobile facility. Ms. Martel said that it is held at the medical center. It was held at the Model 3 clinic in Lake Nona medical Center but will be hosting one in the Daytona outpatient clinic. The goal is really to try to offer it at their home site and there are really dedicated women's health primary care providers who are willing to participate. They were able to do procedures during the standdown, such as removing and replacing IUDs.

Overview of VACHS and Strategic Partnerships
VACHS Executive Leadership Team:
Carlos R. Escobar, Executive Director, VA Caribbean Health Care System
Dr William Acevedo, Chief of Staff, VACHS
Dr Maria Reyes-Rabanillo, Deputy Chief of Staff, VACHS

In Mr. Escobar's overview, he explains that VACHS is a 1A health care facility—referring to the level of complexity of care they can provide; it is the highest level of ranking that a health system can bestow. VACHS trains future healthcare providers and is active in research. They are looking to expand into healthcare disparities by gender, culture, age, and sex. VACHS continually strives to be a highly reliable organization with a strong commitment to excellence, patient safety and the highest level of care. They incorporated women Veterans as part of the patient experience board. They get women Veteran input and they have a safety culture inspired by the spirit of trust they are seeking to generate in their staff and inviting them to bring innovation to the table.

The main academic center is in San Juan. There are multispecialty clinics in Mayaguez and Ponce. The other ones are smaller clinics focusing on rural health care. Ceiba and Vieques are strongly affiliated and their latest program for home-based primary care expansion will enable them to address needed services including post-maternal care, caregivers, or a network of supporting providers when the Veteran cannot come to the clinic. The biggest challenge is transportation. Puerto Rico is mountainous in the center; in Utuado, it takes 45 minutes to go from a Veteran's vicinity to the clinic in the center of town. Vieques and Ceiba are predominantly accessed by a shuttle ferry boat, and they have arranged to transport the Veterans from Vieques to Ceiba rather than to Fajardo.

After Hurricane Maria, there was a diaspora of about 10,000 Veterans. The market assessment identifies about 103,000 and about 4000 in the Virgin Islands. The number of actively registered has continued to increase and as of late it is about 66,230. VACHS has a market penetration of about 92 percent. The challenge is ensuring the

HCS has a cadre of providers in an area where the US Virgin Islands and Puerto Rico have a diaspora of providers. They are significantly medically underserved and that is a reality that Veterans recognize. It is a challenge, and it is not the same as being in West Palm Beach or Miami. The University of Puerto Rico just announced the loss of its main medical school accreditation.

In terms of emergency management commitment, they arranged to make their warehouse, leased at the international airport, a point of receiving as well as an evacuation site. A military C-130 can approach all the way to this area. Medical mobile units, satellite uplink units, portable generators, volunteers and staff, and vulnerable populations have been identified. Lessons learned from Maria prompted them to include continued preparation and readiness in their preparation. They need to be aware of where Veterans are in the middle of a disaster and how they are registered, especially since this would probably be the time when Veterans experience significant co-morbidities with mental health.

Dr. Reyes-Rabanillo noted that with the migration to the mainland, VACHS is seeing that those that are remaining are aging significantly. Close to 70 percent of the Veterans population is Vietnam era.

With the PACT Act and new diagnostic codes, it is important to look at the whole service corps and consider expanding, preparing, and securing the number of providers for them. There are no accredited nursing homes in Puerto Rico and the Veterans population continues to decrease. VACHS anticipates that the PACT Act will bring Veterans that are not registered, thereby increasing the numbers. There is limited access to specialty and community care, bringing some issues with the recruitment and retention of providers. The providers' market pay has lagged significantly behind the average market in Florida and Georgia, so the providers stay two or three years and then leave.

There are several aging components of the medical campus, and they are landlocked; to expand the integrated primary care model--which incorporates pharmacies, psychologists, psychiatrists and nutrition support with primary care providers, as well as expanding specialty care services--they will need to establish a second campus. VACHS has proactively presented a proposal to address concerns.

There are close to 10,000 Veterans and a whole component of women Veterans in the Dominican Republic making efforts to move into Puerto Rico for specialized services. VACHS needs to look at how to coordinate with foreign healthcare services and ensure those Veterans are not left behind. Leadership learned from pilots who have done medical evacuations that they were unable to bring them to Puerto Rico due to issues with port authorities. VACHS is working to resolve this challenge, as they have done with the US Virgin Islands.

Dr. Acevedo states that during Hurricane Irma, one of the hospitals in the US Virgin Islands was out of service, the ceiling ripped off and they had to assist their sister

island. Maria, which occurred just a few months later, had a huge impact on the infrastructure in Puerto Rico. Many people had no electricity. VACHS was the only hospital that was completely unaffected, due to the redundancy of generators and water reserve. In Puerto Rico, there were more than 4,000 deaths from lack of medical accessibility and lack of electricity, but they were able to manage the Veterans population effectively with strong outreach to rural populations. They were able to contact them before the hurricane and made the effort to contact them in person after the hurricane because there were no phones. The next emergency was a huge number of earthquakes where people's homes were destroyed. VACHS also reached those Veterans during that disaster. Then there was the COVID emergency, so they have been in emergencies constantly for the last five years.

The population in Puerto Rico is leaving to go to Orlando, so many Veterans in Orlando are from Puerto Rico and the US Virgin Islands. They have the highest market penetration in the nation, and they are proud of the women Veteran population. In Puerto Rico, it is about 73 percent market penetration. VACHS attributes this to the amount of respect they receive when they come to VA for care.

Dr. Reyes-Rabanillo notes that future construction projects include a domiciliary 40-bed unit for mental health and Veterans with addiction problems expected to be completed by next year. It will provide treatment for PTSD, substance use, homelessness, and serious mental illness. They plan to have a space designated for women Veterans in case of need. They constructed a new state-of-the-art CBOC clinic, proposed to open in February 2023. They are also expanding their emergency department to increase the number of beds and area and planning to build a new parking structure by next year. VACHS will have a Fisher House for Veterans to stay in, starting in FY 2024. Lodging was an issue for Veterans, and this will assist them. The Fisher House will support specialty for the women Veterans. They will also build another CLC; because the existing one does not meet the codes; they have to demolish it.

The Chair thanked the panel for their extensive presentation and opened the floor to the Committee for questions and comments.

Ms. Coleman wanted to know how many of the 40 beds in the domiciliary would be designated for women Veterans and if they are going to be in a wing that gives them privacy and security. Dr. Reyes-Rabanillo responded, saying that the domiciliary will provide treatment for PTSD, substance use disorder, homeless population, and serious mentally ill conditions. They have four floors, and they plan to have a space secure for the female population in case of need.

Mr. Escobar added that the Fisher House will support specialty for the women Veterans coming to the medical center. They are exploring opportunities with Fort Hood's Darnall Hospital to rotate health care personnel through the campus to help us fulfill two components: mission readiness of DoD health care providers as well as assisting VA with reaching out on areas of expertise. For example, Darnall Hospital is very well-known for providing excellent maternity care and obstetrics. Fort Buchanan, the only

remaining Army base in Puerto Rico, happens to be a multi-service force, to include the Navy, Air Force, Coast Guard; reserves and active duty; and Puerto Rico National Guard. Being multi-disciplinary, there are active discussion of collaborative opportunities to serve the women currently enrolled in U.S. Virgin Islands and Puerto Rico and those who will come after separation.

The AIR Commission indicated an expected increase of between 17 to 20 percent; more than 5 percent growth in any given year is a lot. They will need to really get creative and engage DoD partners to understand how the active-duty female personnel evolves as they transition to VA care.

The same discussion is taking place with TRICARE, as it is facing the same challenges with providers. That is the reason VACHS is looking to innovative strategies to ensure that Veterans and active-duty personnel in the region have secure access in their future needs as we work through that. Being one of the pending pilot sites to work with the integration of DoD and VA medical records, they are hopeful that this integration will allow them to provide better care.

Ms. Joseph noted that the market penetration for women in Puerto Rico was 73 percent and inquired about the percentage of market penetration of women Veterans in the Virgin Islands. Agnes Santiago, women Veterans program manager, said it is 73 percent in Puerto Rico and 58 percent in U.S. Virgin Islands, for an overall of 71 percent.

Mr. Escobar added that in St. Thomas, they have a contracted provider managing the clinic that the Veterans love and have expressed requests for the facility to secure him. The consistent feedback received in town hall meetings is that they want a permanent primary care provider that understands them. The provider's wife, who is a gynecologist, is also among the other providers that comprise the Community Care Network.

Dr. Acevedo also added that they were able to recruit a physician for the St. Croix clinic who will start in October (2022).

Overview of VACHS's Women's Health Program/Primary Care
Agnes Santiago-Cotto, Women Veteran Program Manager, VACHS
Dr. Ivette Rivera-Rodriguez, Women's Health Medical Champion, VACHS
Dr. Omayra Cruz-Rodriguez, Deputy ACOS for Primary Care, VACHS

Ms. Santiago-Cotto shared that the mission of the program is to ensure every woman Veteran gets equitable, high-quality, comprehensive health care services in a safe and healing environment in a timely manner.

According to 2020 Veterans population statistics, there are 4,817 women Veterans in Puerto Rico and the US Virgin Islands. VACHS served 8,849 unique women Veterans in FY 2022; 3,236 of them are enrolled in a PACT team. There are two women health

providers in San Juan and 14 women's health primary care providers in all outpatient clinics, and 10 nurses designated as women liaisons. In 2015, they joined the Women's Health Practice-Based Research Network and have done several projects. The program coordinated outreach events and since COVID had a chance for more virtual education activities. In the last couple years, there has been an increase in the younger population. Women's Health used 2020 WHISE funds to expand the program.

Strategic goals for the upcoming year include: continuing to create and promote a sensitive environment to continue cultural transformation to improve health care delivery to women Veterans; developing a specific psychological well-being program including expanding the Whole Health Program specifically for women Veterans; ensuring a workforce proficient on women's health, through training, education and assessment; expanding the maternity care program and educate on VA productive health services, including IVF; and developing sensitivity and skill training to address the specific needs of the LGBTQ and transgender Veterans.

This year, there were 3,236 women Veterans enrolled in Women's Health. The Veterans are generally between 40 to 65 years old, but there is an increase in Veterans younger than 39 who are presenting with very complex issues.

After Hurricane Maria, they dropped to 64 percent of women assigned to a women's health primary care provider, so they had a mini-residency training in San Juan. After completion their metric went up to 81.89 percent. By clinic, there are 1,481 females in San Juan, 337 in Mayaguez, 314 in Ponce. St. Thomas had 130 and St. Croix had 140 showing a small increase. There has also been an increase at the Arecibo and Ceiba Clinics. Women Veterans by race, there are 2,260 White Veterans, 557 are African American and 2,350 Hispanic Veterans. There has been an increase in women from the U.S. moving to Puerto Rico and receiving services; many are in the urban area. We have 68 percent of Veterans with a service-connection, which is very high. There are 483 that are rated at 100 percent for a service-connected disability.

Omayra Cruz-Rodriguez, Deputy ACOS for Primary Care, states that the common diagnoses include hypertension across the board, low back pain, pain conditions in general, musculoskeletal pain conditions, with fibromyalgia being one of the most common, and lipid management. In mental health, major depression, Military Sexual Trauma, and anxiety are very common in the female population.

Santiago states that in 2022 to date, they are at 93.63 percent with breast cancer screenings completed. Quarter 1 was 91 percent, quarter 2 was 91.54 percent, and quarter 3 was 96.92 percent. With women aged 45 and older who screened, are at 92.78 percent. During COVID the breast cancer screening metric stayed at over 90 percent, higher than the national average, because they did not stop providing services. With cervical cancer screening, they are over 90 percent in each metric except ages 21 to 29. overall, an increasing population, but it is still lower than the rest of the Veteran age groups and there are 60.05 percent in that metric and 87.99 in the cervical screen overall for ages 21 to 64, which includes HPV testing. For people 30 and older, they are

at 90.36 percent. There are two providers by clinic. They have two in Arecibo, Mayaguez, and Ponce. They have to continue increasing in Ceiba and Guayama, as well as St. Croix and St. Thomas where they only have one provider.

Cruz-Rodriguez states that the services are provided in a one-stop-shop model, including primary care, preventive medicine, and gynecologic services. In San Juan, the women's clinic has gynecology services in the same space, as well as birth control, prevention, maternity care coordination, breast and cervical cancer screening, nutrition, social work, psychology, whole health services, mental health, emergency care, inpatient medicine and psychiatric care, case management, fertility and IVF, virtual education, and women's health providers at the CBOC clinics, including the US Virgin Islands; there is a provider in each clinic.

There are three models of care. Model 1, women's health services are in the primary care area but it is not a dedicated space for women Veterans and is co-located within the primary care clinics. All community-based outpatient clinics and the San Juan primary care have this model. Model 2, women's health services within primary care but with a separate space for female Veterans, which is in the Mayaguez clinic, and next year in the new Ponce facility it is being contemplated. Model 3, is in the new facility, provides all women's health services in a separate area from primary care, and all other services are within that area, including gynecologic services. They must outsource some services like breast biopsy, breast MRI and breast surgery, mammograms for the US Virgin Islands and some CBOCs, maternity OB care, gynecologic oncology, urology, and infertility and IVF.

There are support groups run by a social worker that meet monthly. There are nutrition classes provided by our dietician, they teach six classes and then there is a new group, lactation classes with our maternity care coordinator, and whole health classes are in the works that will include yoga and such. There is a mind and body group that provides the psychology fellowship program. They just incorporated US Virgin Island and Puerto Rico virtual education workshops. They just started one specific for US Virgin Islands after a focus group with women from St. Thomas and St. Croix who wanted their own education, we have agreed to do that once a month. There is also an alcohol women support group run through our clinic. Santiago does program collaboration with all the different programs.

Every time there is a new female Veteran, they assess whether she had MST during service, and if so, they refer her for mental health services. They keep assessing because we know that sometimes they might not open up right away, we do that with intimate partner violence as well. They also have a suicide prevention program and a caregiver program; always collaborating with those programs and the homeless program. There are three vet centers in the islands located in San Juan, Ponzi and Arecibo North and they all have a women's group. There is an LGBTQ program and whole health whom we continually work and collaborate with. They collaborate with the VSOs, the American Red Cross, Mission Continues, Wounded Warriors, Military One Sources, the American Legion Association, Disabled American Veterans, the Paralyzed Veteran Association, and the Veterans Advocate Office. They collaborate with vet centers, VBA, and La Casa del Veterano where Veterans can be referred

for domiciliary areas or nursing homes. There are decreasing males and increasing females in the area.

Successes are they maintained a 90 percent of the breast cancer screening through COVID 19, had their first women's health mini residency training in San Juan; trained ten providers and nurses over 4 days. One of Santiago's biggest achievements is finding an IVF provider in the community. She has tried for eight years but until they found a more aggressive or educational approach none of the local providers were interested. Through Optum they were able to negotiate an agreement with a provider who she has sent now sent two people to be evaluated for IVF in May, one male and one female. This is important because with their service connection they should not have to travel to the mainland to obtain this service – so thank you to Community Care Chief who have always been there for us.

The first Women's Health Educational Class was provided last year, which Santiago created hospital-wide to provide education to all providers, nurses, and psychologists. This year was the first San Juan Blind Rehabilitation Clinic Women's Empowerment Clinic, dedicated a whole week to females. They have a Lactation Pod in the entrance to the hospital for anyone who needs it. They've had eight editions of the Caribbean Women Voice Magazine. They have the "I Am Not Invisible" campaign with 60 Veterans participating and each was emotional about Mr. Russel traveling to photograph them. There was a weekly virtual series we started in 2020, it is on a different clinical topic each week. There is a new lactation room at the women's clinic to assist our breastfeeding women Veteran. The IRB approved their first women's research project, "Women Veteran Profile at VACHS: Demographic and Clinical Aspects." It started in July of 2017, but we have had delays after hurricanes, earthquakes and COVID. We are hoping to complete it this or next fiscal year. The new WHISE initiative has allowed us to hire some new staff, they hired a medical support assistant, and program support assistant, we requested services from Sonography to be able to do endovaginally sonograms at the clinic. This is a service we offered in the past and the women Veterans preferred that over now having to go to the radiology department. They are also developing gynecology services for the west and souareasrea monthly. They are expanding behavioral health services that specialize in women's health and evidence-based therapy, enhanced administrative support and the maternity care program. The clinic is expanding and will have another provider on the team, as well as recreational therapy. They are developing a Pelvic Floor Rehabilitation Therapy Program. We are also, as I mentioned, expanding whole health.

One of the biggest challenges is to continue identifying providers who want to become WH-PCPs to increase WH1 metrics and have more access for Veterans. We need to explore more community care providers for obstetric services, IVF, and Cryopreservation's services. They also need to expand mental health services with more specialized evidence-based services and increase the number of uniques, especially in younger Veterans returning from deployment.

The Chair opened the floor to questions from the ACWV. Dr. Macri noted that community care providers are reluctant to see VA patients because some of these services are cash-based. When VA only compensates at the Medicare level, it is a significantly lower reimbursement than they would get from private insurance or cash pay. It is possible for WHISE funding to be

used to fill that pay gap and then you may be able to get more community care subspecialists to step up to the plate. Everybody wants to provide care for Veterans, but the problem is they cannot see too many Veterans because the pay gap or the reimbursement gap is so big.

Dr. Carrie Kairys, Deputy Field Director, the Office of Women's Health, responded that WHISE funds could not be used because the funds are medical center dollars. That is different than community care funds. The Office of Women's Health (OWH) tried to supplement different positions, like at the VISN level, but because that fell under a different funding category. But, OWH has requested to get the money in different pots, so they would have more flexibility and was awaiting a response on the request. One thing they have been successful with is using the funding to supplement that gap by providing things like bonuses, sign-on bonuses and annual bonuses. I will take the question forward and see if I can get more information on that.

Dr. Mathewson-Chapman asked where the mammography equipment is located throughout Puerto Rico, since the facility has so many outlying areas; are they totally relying on community care? She also inquired about whether those who are receiving this service through community care have information about results relayed to the Veteran and VA?

Ms. Santiago-Cotto replied that most of VACHS mammograms are done in-house, because they have the tomosynthesis machine. Veterans who live in outlying areas, such as Mayaguez and the U.S. Virgin Islands, prefer to drive to have it done at the facility. Community Care services are available for those that cannot travel, cannot drive and they prefer to do it in the community.

Breast and Cervical Cancer Screening Program
Dr. Ivette Rivera-Rodriguez, Women's Health Medical Director, VACHS
Agnes Santiago-Cotto, Women Veteran Program Manager, VACHS
Lissette Alicea-Vitali, Quality Management, VACHS

The VA Caribbean has two local medical center policies, the first one being the Protocol for Management of Breast Cancer Screening Reports. This allows us to establish a uniform process of following up on breast cancer screening reports and studies. As well, the other policy is Cervical Cancer Screening Guidelines, which help to implement new strategies in early diagnosis and prevention of cervical cancer among female Veterans. They use National Clinical reminders to help the provider identify which Veterans needs to follow on their mammograms, it flags the provider to set up the mammogram. The facilities do tomosynthesis and breast ultrasounds, then Radiology sends the notification letter and notifies the provider and case manager. We were able to hire a case manager or RN care coordinator following all the mammograms, pap smears, and maternity care coordination program thanks to the WHISE program. The provider has seven days to inform patients of abnormal results and the case manager assists in the process with a tracking system. The provider has 14 days to inform patients of any normal results. The case manager can follow through and make sure any community care consult is worked and patients are scheduled; it is helpful for the provider to track abnormal results. The same thing happens with cervical cancer. The PCPs can do the pap smear and consult gynecology for abnormal pap smears. If it

needs attention, pathology sends a note to the case manager, who will follow through. Case managers keep track of all abnormal results and documents the records.

One initiative they have done is bimonthly reports for patients. She reports all the Veterans that need mammograms and pap smears, reminds the nurses of the importance of scheduling that appointment in the monthly meeting, and providers are reminded of the process at the monthly primary care staff meeting. They have a quality management mammography audit, and they are looking closely at community care mammogram referrals. They are looking at the timelines of when they send out the mammogram and the time they receive the results, and the time to then notify the patient. The in-house process is stable, but the process in community care is where they need to follow up. They follow the American Cancer Society guidelines and the Task Force for Cervical Cancer Screening. In the last couple of quarters, they have been stable and increasing to 100 percent last fiscal year for breast cancer screening. For cervical cancer screening, they have been increasing and are now, 100 percent up to date. They have outstanding support from radiology, a person who is in charge of communicating with the case manager.

They have had the challenge of not having a case manager and in several cases, Santiago was tracking results. WHISE funds allowed them to hire a case manager. Another challenge is that the breast MRIs and biopsies are not able to be done in-house they have to use community care. Those areas have to explored to bring in-house if they have the chance to gain the data. Gynecology and sonography are only available in San Juan, and they are expanding that to the west area.

The Chair opened the floor to questions from the ACWV. Seeing no questions from the members, she commended the facility for reaching and maintaining the high rates for the breast and cervical cancer screenings for women Veterans.

Community Care
Dr Angie Zayas-Ortiz, Chief of Community Care
Most Community Care has an administrative and clinical staff. They recently got their nurse manager, and Zayas is the service chief. They have 47.5 full time employees (FTEs) in their service, and that has been the same for over five years. They have created an administrative hierarchy, including people more skilled in program analysis and safety follow-ups, which helps them with safety. The clinical staff is dedicated to patient safety issues, and they have someone following the Community Care mammography consults and other needed consults when BI-RADS come back high. They offer services close to home for people who do not have the ability to come to San Juan, and they follow those closely. VA Community Care offers primary care, specialty, and subspecialty care in the community under MISSION Act eligibility standards if there is a service not offered in the community. They are VA Caribbean and include St. Thomas, St. Croix, and St. John. When they do not have anything available, they have sister hospitals in Florida and have good communication.

There have been challenges with providers because of reimbursement rates, hurricanes, earthquakes, and COVID-19. They have tried to keep providers in their network. There are 250-plus OB/GYN providers on the island and 5 in the US Virgin Islands. There are a lot of specialties in the Virgin Islands that have no provider. There are three specialists in female pelvic medicine and reconstructive surgery in Puerto Rico, but none in the Virgin Islands. There are six gynecology and oncology specialists in Puerto Rico and four in the Virgin Islands. There are six maternal and fetal medicine specialists in Puerto Rico and one in the Virgin Islands. There are 22 obstetricians in Puerto Rico and 2 reproductive endocrinologists in Puerto Rico. There are 50-plus providers in complementary modalities such as tai chi, meditation, and yoga, three are on the Virgin Islands, they need more. With the 43 FTEs, the consults hovered from 2500 to 4000 between 2019 and 2022. The dip in 2020 was from the shutdown for COVID but, they are still managing some of the backlog the pandemic caused on the islands.

Challenges, there are only three IVF providers in Puerto Rico and none in the Virgin Islands. They are not seeing any insurance, and they were finally able to get someone with a single care agreement negotiated through OPTUM and now that person is now seeing couples. They had some issues with claims but Optum is helping them resolve that problem so we do not lose her, she is a great provider. They cannot send the patients to Florida to live for nine months, and the pregnant Veteran could not travel back and forth, so this was the way they could secure services here. They are hoping that they can get one or two more providers in this.

The Chair opened the floor to questions from the ACWV.

Ms. Wright noted that community care puts women Veterans in a difficult situation, when it comes to bill paying, regarding the bills not coming directly to VA or VA not paying them in a timely manner. She inquired about what her office does to support the women in these situations. Dr. Zayas-Ortiz replied that they try to ensure that the facility does not encounter that problem. She asked if there were any specific observations from other visits.

Zayas replied that this facility does not have a problem with bills not being paid promptly. She then asked if there a specific area that you find in other visits you can identify.

Ms. Wright noted that, in certain cases, women are outsourced to the community more often than men. Being able to offer in-house services like mammograms and pap smears is helpful. Generally, more women are sent out because that kind of care is unavailable in the medical facility. Then, they deal with issues like their actual laboratory results getting back to you in a timely manner and communicated to the doctors, the billing cycle and making sure the vendor gets paid in a timely manner so they can continue to see that vendor or provider always. When vendors are not paid, they stop the service and then women can no longer go to that provider.

If vendors are not paid and stop services, and if a provider brings a claim or complaint to them or a Veteran brings a bill or is being charged for something she should not be charged with, they intervene. Since providers are scarce, she makes sure they get back to the provider and see what the problem is. They are sending out very few mammograms. They have to send out pregnancies and births, although there is a part-time gynecologist. Zayas does not identify a higher amount of billing issues with female Veterans than the rest, but they have problems with dental claims because of the erroneous submission of claims. They gave the dentists an orientation and that helped some.

Dr. Zayas-Ortiz indicated that they usually sent women Veterans to community care for pregnancies and delivering babies, since these are not performed at the facility; they do have a part-time gynecologist. Dr. Zayas-Ortiz's office tries to make sure that everything goes smoothly and will immediately address any problems with billing. In San Juan and the U.S. Virgin Islands, she has not identified a higher amount of billing issues with women Veterans than with the rest. They do experience a lot of problems with dental claims, usually because of the erroneous submission of claims. To mitigate the problem, her office provided the dentists with an orientation.

Ms. Joseph inquired about the amount of service available in the community in the U.S. Virgin Islands. There is always some kind of issue going on with the medical facilities there, as well as a lack of providers in certain specialties. She specifically asked if it is easier for Dr. Zayas-Ortiz's office to find community care providers for St. Thomas or St. Croix or if they are just about the same.

Dr. Zayas-Ortiz replied that has been more difficult with St. Croix; it is a bigger island than St. Thomas. In St. Thomas, the Roy Schneider Hospital has had so many administrative changes in the leadership that they have to meet constantly with the new administration members on the board. However, they have always had a wonderful relationship with the facility. They now have a new administrative person, a Chief Financial Officer (CFO) and the Chief Executive Officer (CEO). The CBOC in St. Thomas happens to be across the street from the Roy Schneider Hospital, which offers a lot more opportunities for patients to get services, including gender-specific services. During a recent meeting with the Roy Schneider CFO and CEO, they were able to establish and agreement for coordinated care that would allow VACHS to authorize Veterans to have their blood drawn in Roy Schneider's labs and then have the results send back to the facility. Dr. Zayas-Ortiz also spoke with the CEO specifically about developing a collaboration to get more services, since the CBOC only offers primary care services. The hurricane had caused both facilities to lose their functionality. However, Roy Schneider has recovered more quickly.

With Juan Luis Hospital in St. Croix, the situation is little bit more limited. Once the pandemic emergency is completely over, Dr. Zayas-Ortiz's first priority is to set up a meeting between Juan Luis Hospital and VAHCS—to include Patient and Community Relations and the VAHCS leadership---to see how much more services they can access. There are providers in the community, but it is usually more helpful when many

services can be accessed from one location. She noted however, that the people in St. Croix do not prefer using Juan Luis Hospital; they say it is not up to their expectations.

Dr. Zayas-Ortiz's office makes it possible for Veterans to come to St. Thomas to get the services rather than have them come to Puerto Rico. Community Care is working to make services available in St. Croix so they will not have to travel. They established a contract to provide transportation by charter flights, so Veterans do not have to fit their appointments to accommodate commercial airlines' limited schedules. Since the chartered flights are paid by VA, the plane waits until all the Veterans have received care to do the return flight. That has dramatically improved the customer service, both in St. Thomas and St. Croix. Ms. Santiago-Cotto added that she has seen feedback from patients indicating that things are getting better.

Ms. Parker inquired about the number of women Veterans per month who are sent to the mainland for their care because care was not available through local community care. Dr. Zayas-Ortiz could not provide an exact figure but noted that she found a provider in in St. Thomas who does pap smears there and sees the Veteran for any acute gynecology problems. There is no OB/GYN over there.

Zayas does not have a figure for how many patients they send to the mainland for treatment because they cannot service them. She found a provider in St. Thomas who does pap smears there and sees Veterans for any acute gynecology problems. Most of the women Veterans are coming over because of more specialized types of care, like surgery that is not done on the islands. They do offer some types of radiation therapy on the islands and some types of chemotherapy, but those are the kinds of more specialized treatments for which they usually have to bring Veterans to the mainland. When the mammography machines are down at Roy Schneider and Juan Luis hospitals, they would have to bring women Veterans mainland for screenings that cannot wait. She noted that there are always things that they can improve; they will fix whatever they need to fix and improve things that are going well.

Maternity Care Coordination
Agnes Santiago-Cotto, Women Veteran Program Manager, VACHS
Santiago states that the maternity case manager and coordinator, Adyanette Ortiz-Rodriguez, is on leave, she has been with us since last August. The maternity care program has been running since 2012 or 2013 and a workgroup was created. They provide a VA medical benefit package to all Veterans enrolled in the system, which begins with the confirmation of pregnancy, and a complete maternity standard episode of care continues through the postpartum period. Maternity care is also provided by authorized health care professionals in the community, and some Veterans continue to receive all health care services throughout the VA system during the pregnancy. They also incorporated a social work piece for maternity care, so social work intervenes once a trimester to assess whether there are any social concerns and also to assess mental health status and mood. The services include comprehensive assessment, standard and special labs, screening for genetic disorders, gestational ultrasounds, new specialty consultations, comorbidity conditions, postpartum contraception, and newborn care

seven days after the baby is born, prescriptions, and pregnancy-related education. They manage spontaneous abortion or miscarriage. The responsibility of maternity care coordination is to ensure effectiveness between the VA and the provider. If they receive a Veteran who is pregnant and who has had mental health issues in the past that needs to be assessed or admitted, they send them to the community to a hospital that has both inpatient and obstetric unit. The coordinator monitors the provision of services and tracks the maternal and fetal outcomes. She does statistics, including demographics, pregnancy outcomes, and complications. The coordinator contacts Veterans regularly by phone based on needs until a year after the baby is born. They provide the Veteran with information on community resources and make sure the record is updated to reflect that the Veteran is pregnant. Each pregnant Veteran receives a copy of the Patient Resource Manual or "Purple Book" titled Pregnant and Childbirth: A Goal Oriented Guide to Prenatal. The maternity care coordinator also documents contact information for the obstetrician and makes sure the mother has postpartum care visits six to eight weeks after delivery. They are responsible for any local process to obtain alternative care, such as the breast pump, the nursing bra, the belts and more. The coordinator screens for depression and intimate partner violence, MST, or PTSD.

There are currently 36 females in the program, 18 of whom are pregnant and 18 are lactating. The coordinator has a lactation certification and a doula certification even though the VA does not provide that – she has that extra knowledge. Last year there were 29 and this year there are 35, and they expect a continued increase. The coordinator continues a monthly support group for pregnant and lactating women and caregivers or partners.

They were not able to do the baby shower last Christmas, so she prepare some boxes for mom and baby and sent them out. They are in the process of trying to have a baby shower this year. When Community Care does the authorization, it includes the pregnancy and seven days after the baby is born. If the baby needs medical care in those seven days, the VA will cover all expenses.

The Chair opened the floor to questions from the ACWV.

Dr. Macri asked Ms. Santiago-Cotto if VA has pediatricians to care for newborns, since she mentioned that VA takes care of the baby for a period of time. She wanted to know how the baby received care. Ms. Santiago-Cotto said that the Community Care authorization includes the whole pregnancy and then seven days after that baby is born. If the baby needs any medical care during those seven days, VA will pay for it, but no, VA does not have any pediatricians. During social work sessions, the social worker assesses if the mom is working, how is the family, if she has a plan to take care of that baby and if she has a plan to get medical insurance for that baby. If not, the social worker can refer her to get all that.

Dr. Macri then inquired if the mom receives postpartum care for only the first six weeks; Medicaid is expanding it to a year. Santiago-Cotto replied that the mother gets postpartum care for six to eight weeks. Once the obstetrician gives the discharge from

maternity care, then the mother comes back to receive services with the VA. Santiago-Cotto believes that having the coordinator helps make sure the Veteran will want to come back to VA for care.

Dr. Matthewson-Chapman asked about how they handle maternity care in the U.S. Virgin Islands, specifically if they use local hospitals or community care. Ms. Santiago-Cotto reiterated that the local hospitals are available but there are some challenges with the St. Croix clinics. Frederiksted Health Clinic is the only clinic providing services for all pregnant ladies right now. But, for any other gynecology emergency procedures, they use St. Thomas. For extreme cases, like when they identify a high-risk pregnancy, they would bring women to Puerto Rico.

Ms. Parker asked if maternity care assists with coordination of dental care for pregnant Veterans that they are serving. Ms. Santiago-Cotto indicated that she had not seen this scenario specifically with pregnant Veterans, but she is sure that, if they qualified for dental care, they would be able to receive it. Dr. Kairys clarified that the maternity care authorization does not supersede someone's dental eligibility, but also would not give them any additional benefits. But most sites, of course, most Veterans know if they are eligible for dental care. If they are not eligible, most of the sites have resources for them in the community. Ms. Santiago-Cotto added that, if they do not qualify for VA dental, they refer them to the dental across the street, in Centro Medico.

Adjourn
The Chair adjourned at 2:32 p.m. on the first day of the ACWV-VACHS site visit.

Tuesday, August 30, 2022

Open Meeting/Introduction of ACWV Members
Betty Yarbrough, Chair, ACWV
At 10:03 a.m. PST, The Chair called the second day of the ACWV meeting to order. The Committee members, ex-officio members, advisors, and public guests introduced themselves.

Virtual tour of the VAHSC
Agnes Santiago
Santiago states that the video was prepared for this visit and clarifies that the tomosynthesis machine is at the radiology area on the first floor. They are on the second floor of the outpatient clinic area.

Veteran Experience Committee
Daniel Massa, Patient and Community Chief, VACHS
Massa states that the jurisdiction for San Juan covers the Virgin Islands and they have a 91.6 overall trust score, one of the highest in the VISN. There is a dip in neutral consolidation for the information on the female scale side at 88.5. They used SAIL for information and learning and they used SHEP. He puts the information in PATS-R and he owns the patient advocates so I have the ear and the pulse of people and he listens

to people. Santiago-Cotto and him keep the executives aware of everything going on. There are three areas on the female population that are higher on the V-Signals than the male population for trust. They have a heavy population of Vietnam Veterans, about 70 percent, and because they are elderly, he does not think his female population is as old.

In the A-11 customer system they look at items to make better like how the trust is in the hospital and at home, what is the transparency level and quality are. This month is the first time they are below 90 percent, so they are constantly driving the matrix and finding out what they need to do. Employee helpfulness was at 89.6, and they have to do better. They need to use this panel, ACWV, to give them ideas to improve.

SHEP is a survey for Veterans for access, management, and comprehensiveness of the office staff. Did they treat them with respect, were they clear, did they treat them in their own language, how was communication, and in the end what is the overall satisfaction? For access, it has been almost three years with COVID, access is limited due to us having to get everything shipped. Today is the first time they went down to 27 percent. They have to continue with rules, masking and social distancing, handwashing and vaccination. The rules create friction with the Veterans but they keep working on that. Compliments dipped; they are usually above 50 percent.

The platform Massa uses, PATS-R, analyzes the trends. They have resolved 3,616 PATS-R, the Secretary gave them a good mark and said they needed to answer within seven days. Thankful our staff is supportive because when we give the Veterans the answers, we improve their experience.

Massa shares that there are five categories that they are having problems with. Access, Medication, Referrals, Preferences, and Compliments. They get a lot of compliments because their people treat Veterans with honor and respect. He has 580 referrals and there are no big issues with them, but they could be VBA or NCA related. They appreciate compliments from the Veterans and or family. With provider-staff communication, most of the time it takes a big part because they do not practice LEP, limited English proficiency, which was mandated by President Clinton. They still have not translated all their documents, and as soon as they do it will look better.

The community engagement program coordinator position just closed, and that person, is developing a plan. Massa and George Velez will be there to see the projects they will develop and they are working on recognition. He is looking at the projects they planned.

The Chair opened the floor to questions from the ACWV.

Ms. Yarbrough asked Mr. Massa if the patient advocates work for him and he replied that they do.

Ms. Wright asked if the VISN has community engagement program coordinators and what work they are doing with women Veterans. Mr. Massa replied that they had

recently hired one, Pablo Valentine. He is developing a plan for a project, which will be chaired by the deputy director; Mr. Massa will serve as the co-chair. They are currently working on a recognition initiative. They will begin by giving Veterans their service pins. They are planning projects that look at how to increase women Veterans' utilization, by focusing on what the statistical analysis is specifically telling VA about their experience when seeking care.

Ms. Yardbrough thanked Mr. Massa for the explanation of how they use PATS-R to track trends and to inform them so they can improve services.

Overview of VACHS LGBTQ+ Program
Dr. Yari Colon-Torres, LGBT Veteran Care Coordinator, VACHS
Yari Colon-Torres is a clinical psychologist and LGBTQ Veteran care coordinator. As a collateral position, she has six hours a week to do this work. The mission is to provide policy recommendations and clinical education to support personalized, proactive, patient-driven health care for LGBTQ Veterans. She spends her time consulting and taking care of five central roles: monitoring the environment of care, providing staff education, outreach, being a point person for LGBTQ+ Veterans, and communicating with leadership and other stakeholders.

The services of the program include transgender care, including gender affirming hormone therapy, readiness evaluation, gender-affirming speech therapy, and not yet gender-affirming surgery. That is in the process of being included in the medical package. They offer services related to preventive services, mental health, support groups, treatment and prevention of sexually transmitted infections, family planning, and infertility. They received Top Performer in 2022 from the Health Care Equality Index.

There is no official data on LGBTQ+ Veterans in VACHS, but with a new records system, they may have information about the profile of those Veterans. Colon spends most of her time providing education to providers and staff, including pronoun use and different affirming care, as well as consultation on transgender care.

One success is the environment of care and the use of safety symbols. The hospital has pushed for more representation of LGBTQ+ people to create a welcoming environment. Communication with Santiago and the women's clinic is a success, and they collaborate on training and education.

Challenges include provider competencies and confidence with LGBTQ+ affirming care. They continue to address that, including the availability of prosthetics and different things available for gender-affirming care. Protected time for education is a challenge and lack of data is a challenge at the national level. Six hours a week is not enough for Colon's collateral duty. Some areas need her to reach out and there is a push at the national level to create LGBTQ+ VCCs as a full-time position but she does not know when that is coming.

Ms. Santiago-Cotto added that Dr. Colon-Torres has had a support group of patients for more than 10 years. Dr. Colon-Torres confirmed that a very active support group that meets monthly and has been ongoing for 12 years. It moved to virtual, which increased the number of participants.

The Chair opened the floor to questions from the ACWV.

Dr. Macri noted that there are cancer implications for people who were born with both male and female sex organs asked if VA considers that fact about the transition. Dr. Colon-Torres replied yes.

Dr. Macri added that the American College of OB/GYN has a committee on the underserved, of which the LGBTQ community is part. That committee has multiple publications available on this issue. She noted that she would love to see input from Dr. Colon-Torres's group in some of the publications or some of the discussions that they have on the Task Force for Underserved Women, since it would be in a different cultural setting than where a lot of the doctors and senior leadership come from.

Dr. Macri also asked Dr. Colon-Torres if they provided care to both male-to-female and female-to-male transitioning Veterans, as well as the general LGBTQ+ community. She also wanted to know if privacy in health care is provided both ways, whether transitioning from male-to-female or female-to-male.

Dr. Colon-Torres replied that we do have male-identified Veterans that have continue to want to receive services at the women's clinic because of the welcoming environment and their relationship with the primary care and gynecologist. Even if somebody identifies as male, or is transitioning, they still may need gynecologic care and privacy is one of their biggest issues. It is not so much the male-to-female transition--because we are better at understanding that--but the female-to-male on transitioning is not as welcoming an environment in the OB/GYN or Women's Health Clinic, unless there is a certain amount of privacy as well. Is that something that has been promoted?
It is a conversation to have and there is also space for improvement. Ms. Santiago-Cotto added that they have transgender women and transgender men receiving care at the Women's Clinic.

Colonel McLaughlin asked Dr. Colon-Torres if she has been able to focus on increasing LGBTQ+ Veterans' utilization of VA for care, given that this role is a collateral duty with six hours a week designated to serve in this capacity. If so, then has she reached out to civilian/Veterans organizations to make sure that those populations are reached?

Dr. Colon-Torres said that outreach is an area of improvement in their strategic plan; it is a top priority. During outreach activities, she goes out into the community and connects with different organizations and participates in the pride parade. She is definitely interested in reaching out to civilian organizations to continue to get the word out.

Dr. Macri asked if outreach in Florida, which is also in VISN 8, presents a challenge given the new legislation in the state that limits the type of language that can be used and the services you can provide to women. Dr. Colon-Torres said that she is getting the different layers, including cultural layers of discrimination or legislation that might be discriminatory, and how VA can continue to make efforts to create a safe space. Her office continues visibility in the media, on their Facebook page and through messaging that VA is a safe space, as well as what VA is doing. She has two or three spots during the year to participate in a radio program. Even though there are layers of movement, even in Puerto Rico, of legislation or conversations that are discriminatory, VA is working hard to create safe space for LGBTQ Veterans through education and awareness.

The Chair noted that VA operates under the Federal guidelines. A VA medical center would be the same thing. They have their own police force, and they operate differently, but the environment and legislation of the environment in that state can certainly affect the activities that go on in the civilian sector; that could impact your ability to access those individuals. Dr. Macri noted that all nonprofits are regulated by the states.

Dr. Maricel Rios added that, even though they are part of VISN 8 and have many services that they share with Florida state, Puerto Rico's laws have not changed regarding the language that addresses the LGBTQ community. They do not have discriminatory laws but there are some changes happening also. There are not the same challenges for the Veterans that are on the Mainland in Florida.

The Chair noted that the ACWV will take back a couple of issues to be worked at a higher level, to help the office improve the program. The ACWV can take challenges and issues back to see if they can get corrected or improved and put a little more emphasis behind it. If the issues are already in progress, then they can track it to make sure it does happen and give the Dr. Colon-Torres assistance in the field. The ACWV's main mission is to make the services and benefits better for women Veterans and many times when we do that it helps all Veterans.

Overview of VACHS Behavioral Care Services
Dr. Melanie Perez, **Assistant Chief of Staff, Mental Health and Behavioral Health Science Service**
Dr Maricel Rios-Gonzalez, Assistant Psychiatry Service Chief, VACHS
Dr. Mabel Quinones-Vazquez, Women's Mental Health Champion, VACHS

Melanie Perez states that she has been with the VA for 11 years, formerly the chief of psychology at the West Palm Beach VA. Before that she was military sexual trauma coordinator at the Tampa VA and the cultural competency coordinator. Although states are changing legislation that does not impact the VA's ability to provide the best care for Veterans regardless of whether they are LGBTQ as long as they follow their VHA directives. Their top rating from the Health Equality Index illustrates that the work

focuses on the areas they say they are focusing on. It is different than what they can do on Florida's mainland, just want to make that point.

Perez clarifies that community engagement partnership coordinator positions fall under the suicide prevention team so they can create coalitions and do the outreach for vulnerable populations like LGBTQ+ Veterans. There is a new one starting this week and another next week, both are female coordinators.

The mental health continuum of care is an initiative that started in 2018, and they are implementing it in all their mental health services and standardizing those services throughout VHA. There is the Whole Health System of Care, the first tier you will be hearing from Dr. Almos later today. Then there is self-directed care. They try to focus on reintegration, making sure it is patient-centric so the Veterans know how to come in to services and have phone applications. When they come in through their primary care physician, there is Primary Care Mental Health Integration within the PACT team, we call this team Primary Care Mental Health Integration so they are integrated with the primary care teams that we have, PACT stands for Primary Aligned Care Team. They have psychologists, psychiatrists, LCSWs, and a women's health champion who has one of the few fellowship rotations in women's health. It is limited care, 6 to 12 sessions. If more intensive care is needed, the Veteran is sent to the general mental health program, Behavioral Health Interdisciplinary Program (BHIP). Similar to PACT but it consists of nurses, psychologists, psychiatrists and very important peer support specialist. Peer support specialists are Veterans who have gone through the system and have been there done that and really present themselves as role models and let our Veterans know that there is a light at the end of the tunnel. If there is more specialized care needed, there are specialty mental health services like Mental Health Trauma Recovery Center, the Psychosocial Rehabilitation Care Program, and Mental Health Integrative mental health services. If the Veteran has a severely mentally ill diagnosis, they send a team to the Veteran's home to provide care. If the Veteran is feeling better, that is when they come to psychosocial rehabilitation care at the facility. There are also social work services, including caregiver support program, CWT, neuropsychology, intimate partner violence program, and military sexual trauma. There is an inpatient unit, ABHICU, with 30 beds. That is a staffing challenge, and they are capped at 16 beds. What sets them apart is PIC, the ED psychiatric program. Most Veterans with a crisis come into the psychiatric ED program and can get services right away and can be sent home and work closely with suicide prevention to make sure they are not lost. There are also counsel liaison services providing services while the Veteran is inpatient. There is also a somatic treatment center, that will be expanding to transcranial magnetic services. They are opening the first domiciliary in Puerto Rico, a 40-bed residential program next fall.

There is a peer support specialist to guide Veterans through the entire system. The VA also has community partnerships, and that is what the suicide prevention outreach focuses on. They partnered with the Governor's Challenge for suicide prevention in Puerto Rico and the Virgin Islands. Suicide prevention is infused into all levels of care because it is their number one priority.

The unique Veteran population is 62,356, and 33 percent of those are served through mental health services, for a total of 20,748. Seven percent of those are women, and there is an increase at the VISN on the whole with women Veterans. There is a mind and body group in the substance abuse program. There is also a Moving Forward Problem-solving group that also has an application that goes with it. There is a focus women's group for PTSD/substance abuse in San Juan. There is a LGBTQ+ wellness group. They also have special emphasis programs; part of the system is employee education as well as Veteran education on all the resources available.

Rios-Gonzalez states that the unique number for 2022 for mental health was 20,748, and 7.2 percent was women. For mental health inpatients 6.36 percent were female in the first quarter 2022 and 5.33 percent for second quarter. The percentage of females in the mental health outpatient setting was 6.97 percent in the first quarter and 7.02 in the second quarter. The number of encounters per quarter was 14.63 in the first quarter and 13.33 in the second quarter. The percentage of women diagnosed with mental health diseases is 6.83 and 6.85 percent for both quarters. Divided by age, for female Veterans under 25, 4 percent have moderate recurrent depression and 4 percent have severe recurrent depression without psychotic features. Eight percent of the population shows depression as the main diagnosis, and that is the most common diagnosis in the ambulatory setting. The second is anxiety disorder and PTSD in the very young population. For 25 to 34, there is 8 percent of recurrent moderate depression, and anxiety is second, and chronic PTSD is third. In this age group it is one of the highest numbers, the number one diagnosis is depression, number two anxiety, with PTSD at six percent and generalized anxiety disorder as a last diagnosis. For 45 to 54, depression is 10 percent recurrent moderate and 2.5 or 3 percent severe depression. The second diagnosis is chronic PTSD, and anxiety disorder is last. For 55 to 64, the most prominent diagnosis is depression. The only difference is for 85 plus they started to see mood disorders combined with neurocognitive disorders. The most prominent diagnosis is depression and the second is anxiety or PTSD.

Quinones-Vazquez states that female Veterans receive mental health services throughout the mental health continuum of care. They have PCMHI, primary care mental health integration services, through which they provide Veterans with CBT-I, brief CBT for pain, brief ACT pain, Morivivi, which means they die and are alive at the same time, referring to pain, and CALM, a mindfulness group. They have brief CBT for depression. They provide short- and long-term psychotherapy through her, staff psychologist, and psychology fellows. They provide group psychotherapy. They also provide psychiatric evaluations and brief treatment in collaboration with mental health or behavioral health clinic. There is a psychiatric resident five months of the year. They also evaluate and treat patients who need longer-term therapy or medication.

In 2008, the women's clinic had a group of mental health professionals working with the women visiting the clinic. In 2011 they applied for a fellowship in women's psychology and they were awarded two positions. Two years later, they were awarded two other fellowship positions for PCMHI. At this point they have been with the fellowship for 11

years, graduating 44 fellows from the program, 22 of which specialized in women's psychology. Many of them are working in the hospital, some are located in the PTSD Clinic, others in Mental Health Clinic, the graduates bring a lot of knowledge about gender-specific psychology and mind and body issues. The women fellows see PCHMI patients from 6 to 12 sessions and work with long-term patients for a year. They see a lot of trauma and sometimes that is difficult to separate from childhood trauma, or military sexual trauma, or combat trauma. They focus on trauma but treat other symptoms with therapists, psychodynamic, interpersonal and feminist approaches to work with women issues.

Most presenting problems are life-cycle related, like pregnancy, infertility, sexuality, menopause, and aging. There are a lot of new patients who are 25 and under, and that challenges them to expand their knowledge and to keep up to date with younger Veterans. They are collaborating with the maternity coordinator so those women can receive services right away, more preventive than remediation. They also work with intimate partner and relational violence, deal with sexual orientation issues, with gender and cultural issues. They try to have a wide understanding the presenting problems. They do couples therapy less often, but Quinones-Vazquez is trained in family and couples therapy and sees more of them. They also offer group therapies that vary, there is standard therapy but especially now with younger patients with different problems, they are adding group offerings.

One standard group therapy is women's body wisdom. They work on the mind-body connection and specific issues with social and cultural values related to females. There is a women's sexuality group. There are a lot of sexual issues because of trauma and other issues, and it includes all orientations. We view this from a female perspective, we talk about psychoeducation and also about processing healthy sexualities, hand ow to feel more comfortable with it. Quinones-Vazquez is creating a group for disordered eating and healthy bodies because of results from interviewing new patients who are presenting issues with their body image. They have group psychotherapy for pain and another group to be created for women transitioning from the military to civilian life.

They also offer the Assessment of Readiness and Consent for Hormone Therapy for patients who are transitioning. Quinones-Vazquez does the evaluations, and she trains fellows to help her or collaborate. They work in collaboration with Dr. Colon, the LGBTQ coordinator. Patients are referred to them for an evaluation to assess readiness, if they are ready, they refer them to the endocrinologist to proceed with hormone treatment for gender transition. She is the women's mental health champion in San Juan and there is another in Guayama. The role connects providers to services to enhance treatment for women Veterans and provides training on women Veteran issues about every week. She also creates reproductive mental health consultations, we consult patients that are presenting issues like mental health, but related to pregnancy or postpartum, menopause, and different biological processes that they are going through. She consults to other programs in the hospital like the ER, the psychiatry intervention center, the mental health clinic, PTSD, New Beginnings, MHICM, homeless, neuropsychological evaluations, testing, Community Care, and Whole Health.

One common theme at the clinic is military sexual trauma at the top. It is complex and a lot of patients present with it. There are also intimate partner violence issues as well as mental health conditions like depression, anxiety, PTSD, maternity and other reproductive issues, menopause and perimenopause, homelessness, chronic pain, adjustment issues from military to civilian life, sexuality issues, and menstrual disorders.

They have continued care throughout the pandemic despite the positivity rate of 25 percent. The psychology internship and fellow integration into the Women's Clinic has been a success. The wait time is minimal compared to before. I am also located in the clinic that facilitates a lot of the referrals, so they do not have to go to through a waiting period, I am here and providers consult with me.

One challenge is the population is younger and many vets have children, so coordinating childcare with appointments is difficult, so they had virtual appointments. There is a high no-show and cancellation rate, Quinones-Vazquez has a hypothesis that it is partly due to the multiple roles women Veterans have to play. There are also multiple vacancies at the mental health clinic, which sometimes stops the flow of referrals.

The Chair opened the floor to questions from the ACWV.

Dr. Mathewson-Chapman asked if they invested in Zoom and other video conferencing options to address the no-show rate and cancellations and to prevent women Veterans from having to bring their children to appointments.

Dr. Quinones-Vazquez reiterated that her office uses a virtual platform called VBC often but admitted that there are connectivity issues sometimes. At the beginning of the pandemic, people were not as experienced with the media; now they have developed some expertise. When the connection gets interrupted, they talk on the phone and then reschedule soon after so that continuity is not lost. Additionally, her office uses Zoom and WebEx for conferences. But for one-on-one and for groups sessions, they use VBC.

Ms. Parker asked about how much outreach—getting the word out to the community about the services-- is conducted continuously. Dr. Quinones-Vazquez credited Ms. Santiago-Cotto's efforts in letting people know about the office. Dr. Colon promotes the services on a radio program that she participates in regularly. Dr. Quinones-Vazquez and Dr. Colon-Torres participate in other events like the Mental Health Summit, which is held for VA providers and the community to let them know about the services that they provide for women Veterans. They also participated in public virtual forums in support of awareness campaigns, such as military sexual trauma (MST) awareness, breast cancer awareness or heart awareness, and use the opportunity to let every know that these services are available. Finally, Dr. Quinones-Vazquez does in-reach to another provider so they know about the services her office provides.

Dr. Perez added that as part of the suicide prevention team, they are required to do at least five outreach activities each month and must submit an after-action item on whatever outreach activities they completed at the end of the month. Whenever there is any event--for example, a women's month event--those things are attached to the outreach. So, it is a coordinated effort. The weekly radio show, "Everything about VA," has a tremendous target audience and outreach. Anything that is happening within VACHS is presented there. It is an integrative effort that Mr. Massa presents and many others. This is a great platform; whether there is an earthquake, COVID or a hurricane, the radio stations usually do not go down. Dr. Quinones-Vazquez added that they also post information on VA's Facebook page. Their weekly educational series is promoted through Facebook and other media.

Jari Moreno, Chief for Social Work Service, mentioned that as part of the facility-wide outreach plan, they have a facility outreach coordinator. They also report all their outreach activities to the minority program in the station. According to their reports for the year, the Women's Health Clinic did over 27 outreach events, impacting over 542 women Veterans. He wanted to note that the facility has a larger plan to do outreach and the Women's Health Clinic and Ms. Santiago-Cotto have been actively involved.

Ms. Santiago-Cotto mentioned that she promotes services on the U.S. Virgin Islands' radio show. Their weekly educational sessions air on Wednesdays at 3 p.m. and they address different topics available for Veterans, caregivers and staff.

Military Sexual Trauma (MST) Program
Eduardo Vicenty-Santini, MST Coordinator, VACHS

Santini started off with, they provide services to Veterans and service members that identify under the new VHA Directive, the Deborah Sampson Act. The population that the MST program serves has increased because they now provide services to Veterans who received discharges other than honorable. Santini works with servicemembers experiencing any unwanted physical assault or sexual harassment. If the situation happened in training or active duty, they could provide support or limit it to mental health from primary care. He works with VBA with this population and with claims processing and with claims related to MST experience, also with this type of discharge. It is important for this population to validate their experience to the system and have the service that was denied in the past. They ensure that the population receive free treatment for the health conditions related to MST. No documentation is needed related to the event under the Deborah Sampson Act and VHA Directive.

Santini has contact with every medical facility in the Caribbean and the CBOCs and is the contact person for this population. He interviews the Veterans, explores their needs, offers alternatives services, helps scheduling primary care, and referrals to meet with VBA so they can submit a claim. He also contacts the vet centers to provide free services, they sometimes share patients based on their needs. He is collaborating with Sharp program from every military branch in Puerto Rico and the Caribbean and knows all the personnel from the bases. They share information and he brings them to the

institution to provide earlier treatment and access to VACHS. He collaborates with the VBA, VSO in Guayabo and has a woman help him with the female Veteran claims and a male helping with the male Veteran claims. It is important to provide early access to services to prevent deterioration or development of other mental health conditions. He is an advocate and sees that some Veterans under MST services are not treated equally, and some were banned because they had a bad discharge, and he can reach them and bring them back to the institution with the new directive to give them the care they need.

In the last 12 months, the population was 616, and they got 23 percent of females positive and 1.5 males positive. The screenings are equal to the statistics that said for every 3 females one has an MST experience and out of every 50 males, one has the MST experience. This is equal to the national benchmark they follow, but they are also working with the continuation of completing the MST reminders at the first evaluations during the Veteran experience to provide earlier services. There are 50 percent of patients have not been screened for MST and almost 50 percent of the population is screened, and they are working with the clinics to change this.

In provider complaints, they are near 100 percent every year. There were two from primary care in 2022 and 11 from mental health that needed to complete the procedures. They are new personnel that are working with TMS, and they are working together to complete TMS mandate training related to MST. This is the percent related to when the patient comes to the institution, and they increased the percentage in the last year. Providers do not always realize that people with diabetes, obesity, and other conditions could be related to the MST experience and addressed under the MST box. In the last fiscal year there were 45 new positive women Veterans and 12 male Veterans.

Successes in the last year include collaboration with Clinical Rodriguez for additional rape kits at the ER to comply with their policy. They also use their ER Department here to collect the evidence related to the event. Another success is provider education related to VHA Directive 1115. They do new employee education related to behavioral health and primary care services. Santini works with the Women's Clinic in all their activities to serve the women's population that experiences MST. They do community service education about program services and how to contact us. Santini is on the violence prevention Director Committee, and he provides education on safe environment, reporting, and orientation for prevention of sexual harassment in the work environment to our employees, Veterans family members and visitors. He works with the IPV program coordinator, they identify the population, share most of the needs and identification to promote a safer environment to be a trauma informed institution.

Santini's challenge is increasing the MST reminder compliance and also complying with Answer the Call Campaign. They need better access to patients and calls looking for their services. They also need to increase the provision of close groups like MST groups. He has collaborations VBA Sexual Assault Division with VSO collaborations, Vet Center Services, Sharp Program, Rodriguez Clinic Fort Buchanan, CAVV and COPOP State Police Division.

The Chair opened the floor to questions from the ACWV.

Ms. Coleman notes that it can be very difficult for women Veterans to write the statement that accompanies the claim since it usually asks them to describe what happened and it can bring up all the negative situations that transpired after the assault or the harassment. She asked Mr. Vicenty-Santini if he helps women Veterans experiencing this issue connect with a mental health provider who can help them as they go through the claims process, because the claim normally cannot be processed without it.

Mr. Vicenty-Santini replied that this situation would vary from patient to patient. Not every patient feels comfortable the first time he provides information for submitting the claim or completing a statement related to what happened. He makes himself available if they need him. He makes the referral for the Veteran service organization to provide the orientation. Sometimes, they request his support to complete the statement. Sometimes they feel more comfortable completing the information with their mental health provider working with them about their experience.

They have lots of questions about what VBA will screen because they fear they will be re-victimized in the process. Mr. Vicenty-Santini provides them with an orientation on how the process goes so they will be more comfortable with the process. He informs them that VBA is just going to address and evaluate the symptoms, because they cannot be service-connected for MST. They can be service connected for symptoms related to MST, such as PTSD, depression and anxiety.

The Chair noted the importance of realizing that although the percentage for the females reporting MST is really high, the number for the males is higher. She further clarified that the numbers show more males are affected by MST than females overall. However, in the female population, you are more likely to have, by percentage, been affected by MST. Although the committee's focus is women Veterans, she wanted to acknowledge that MST is an issue that impacts the total Veterans population. She thanked him for including both of those numbers to illustrate a more complete story.

Intimate Partner Violence Assistance Program (IPVAP)
Daniel Pelaez Serrrano, Intimate Partner Violence Program Coordinator, IPVAP, VACHS
Jari Moreno Sanchez is the Chief of Social Work Services. Daniel Pelaez Serrano is a social worker who falls under social work services. It is important to note that more Veterans are coming forward to speak about MST. Pelaez Serrano is the coordinator for the Intimate Partner Violence Assistance Program.

The Intimate Partner Violence Assistance Program provides awareness to staff, facilities and stations, including caregivers and people in the community. They are developing partnerships with shelters, courthouse services, the police, and available community services. The VA has resources but in IPV, they need community services,

especially for housing. They serve people who experience IPV, including Veterans' partners who are non-Veterans and including staff. They also serve people who are using IPV (abuser), they are working to create a screening for them too. They have a Relationship Health and Safety Screening. They also run a Strength at Home Program, an evidence-based group therapy for Veterans using IPV.

The coordinator implements the program in all facilities. They have a good connection with the women's clinic therapy group. He gives guidance to individual case managers. He promotes community partnerships and participates in national calls for orientation and training.

The Relationship Health and Safety Screening is the tool that they use to measure risk, and they do it every 12 months. They have done over 14,000 screenings through all the stations, and they have attempted 18,000. For female Veterans, the total number of attempts is 1,107, consents is 873, and 20 positive. That means the first screen resulted positive, and those received an intervention from Pelaez, other mental health or primary care staff. Nine of them resulted positive in the secondary screening that measures the danger of the situation. In that case, the Veteran is referred for deeper intervention, which could include legal action or police intervention. For St. Thomas, St. Croix, and Vieques, they have done 182 screenings, 2 positives, 1 positive in the second screening. It is important to let people know that the VA cares about the health of their relationship. The screening explores the type, frequency, and danger of the abuse. Even if the person is not allowed to complete the screening, they use the opportunity to educate and provide resources.

The Chair opened the floor to questions from the ACWV.

Ms. Wright asked Mr. Pelaez about the Strength at Home Program. He explained that the Strength at Home Program provides cognitive behavioral therapy, group therapy and evidence-based therapy, for those that are using violence in their relationship. It is a two-hour, 12-session therapy, in which they work several topics to eliminate or reduce the use of violence in their relationships. The IPVAP is responsible for implementing these clinical services to all the facilities.

Ms. Wright noted that there is a huge increase in their cohorts and inquired about the reason for the increase. Specifically, is it outreach or word of mouth that is impacting participation in the program. Mr. Pelaez attributed it to the education and the training in the facility. The clinical staff is very aware of this program and is recommending the program to those Veterans that were identified as using violence. Also, the judges that work in domestic violence court are aware of the program and are referring Veterans. The community also knows that these services here in VA.

Dr. Moreno Sanchez added that VACHS's Facebook webpage has information about the program, too. So, they are using several avenues to educate and to promote these sessions for Veterans. Mr. Pelaez also added that he is the point of contact for VA's

White Ribbon initiative, so they are spreading the word about the White Ribbon Pledge, to promote that preventive initiative as well.

Dr. Mathewson-Chapman inquired about the age groups of the women that they are screening. Are they also looking at older women and their partners? Mr. Pelaez replied that they screen regardless of age.

Dr. Macri noted that the program avoided using the term “perpetrator,” opting to instead use the language “using violence.” She also noted that there could be overlap with the person who has an affinity or a tendency to choose violence as one of their main means of resolution and perpetration of MST. She then asked Mr. Pelaez if they considered implementing prevention initiatives with the cohort at Fort Buchanan, reserve forces and the National Guard, noting that providing interventions or education on alternatives to use of violence be more impactful than screening after an event has occurred.

Mr. Pelaez explained that the Strength at Home is a specialized program for those that are using violence in an intimate relationship with their partners. They are required to complete an assessment to explore if they are eligible or are a candidate for this program. He also noted that IPV treatment and MST could overlap. In a recent case they received where this overlap exists, the plan of action is to explore treatment options to see which type would be better for the Veterans and to determine if this individual is eligible for the Strength at Home program. He also acknowledged that his office tries to avoid using the terms victim, perpetrator, or abuser. They can assist Veterans involved in MST, but they should be evaluated closely because the Strength at Home Program is very specific for those that are using that type of violence in an intimate relationship.

Dr. Macri made a point that, when Service members are deployed together, those become intimate relationships. They do not necessarily involve MST, but they are very intimate relationships. Narrowly defining relationships may result in lost opportunity.

Mr. Moreno-Sanchez added that he is one of the social workers who provides the assessments; he uses this cohort to satisfy his clinical requirements. When necessary, they refer Veterans to other levels of care or programs. Sometimes they qualify for the program but may not be ready for group therapy. They can also do individual sessions if needed. They do the assessment at intake, as well as throughout the 12 sessions. At the end, they measure the outcomes to know if there is opportunity for improvement regarding implementation of Strength at Home and continue to assess Veterans for follow up treatment.

Other efforts in the works include working with the national office to develop a Strength at Home for couples and to translate all the educational and treatment materials for Veterans.

Ms. Joseph noticed that, since the double hurricanes in 2017 and COVID, there has been more visibility in the U.S. Virgin Islands regarding all of the domestic violence that

is occurring. She asked if the Strength at Home Program is unique to the Caribbean or the VISN and what special activities they are doing, particularly in the Virgin Islands? Because she grew up in the U.S. Virgin Islands, she is aware that those in her culture tend to not speak about what is occurring at home. What is VA doing to bring out more of that information from the Veteran population, especially the older folks who are home alone and maybe have younger children taking advantage of them or partners taking advantage of them in a sexually violent manner?

Mr. Moreno Sanchez replied that the screening process is throughout the VACHS, including St. Thomas and St. Croix. The office does face challenges. Pre- Hurricane Irma and Hurricane Maria, they met annually with the government and the community partners in the U.S. Virgin Islands to assess the needs of the Veterans. They planned to resume conversations and assessments with these partners in FY23. Clinically, they have limited mental health providers in U.S. Virgin Islands. They do screening and can refer to Strength at Home.

They continue to seek opportunities to grow the services provided in the U.S. Virgin Islands, so they can provide the same level of care to U.S. Virgin Islands Veterans.

Mr. Pelaez added that they have very consistent and very strong communication with the staff in St. Croix and St. Thomas, sending them educational materials and all the information needed to contact the office and community services.

Suicide Prevention Program
Rosa Gonzalez-Santos, Suicide Prevention Coordinator, VACHS
Rosa Gonzalez-Santos is the suicide prevention coordinator since 2008. The VA program is based on a public health approach using universal strategies and recognizing that suicide prevention requires ready access to high-quality mental health services supplemented by programs directly addressing the risk of suicide. There are four suicide prevention coordinators and six case managers working to provide service for Veterans at risk for suicide. The mission is to reduce suicide risk through prevention, individual care, and collaborative decision-making processes.

There are four coordinators, six case managers, four in San Juan, one in the large CBOC including Mayaguez and Arecibo, and another supporting Ponce and Guayama. They provide service to inpatient cases and outpatients, including Veterans who are inpatient in non-VA facilities. Care managers are nurses working in the mental health clinic. There are 11 in San Juan, 3 in Ponce, one in Guayama, three in Mayaguez, and 2 in Arecibo. They have a Suicide Prevention Community Engagement Partnership Coordinator, a new position there to collaborate with the community. There is an extended team member for a transition program, MST coordinator, women's health program, whole health manager, legal case manager, homeless coordinator, and IPV coordinator. They work with the chief of VA police, the local recovery coordinator, and the care manager in the mental health program and the interdisciplinary treatment teams in mental health programs.

Of 120 cases, 11 are women, which is 9 percent. The most frequent diagnosis is major depression. The ages range from 27 to 63 and the era of service is most frequently the Persian Gulf, Vietnam and post-Vietnam era.

Suicide prevention metrics from CHARM1, emphasizing their focus on high-risk and post-discharge cases in the emergency department. They are reported to be number one in suicide prevention metrics and are continuously compliant. The metrics include post-discharge follow-up for high-risk patients, cases visiting the ER, and screening for suicide in ambulatory care using the Columbia Severity Rating Scale. CHARM1 meets weekly to discuss findings and opportunities for improvement, and has maintained over 90 percent compliance from February to July. They also have a decreasing trend in the number of cases that fail the screening from 2021 to 2022.

They have a robust suicide prevention at the facility, aligned with the integrated stepped care model. They emphasize providing timely support to providers and close follow-up for high-risk patients. The suicide prevention coordinator, Gonzalez-Santos, has achieved sustained compliance throughout 2022, and there is integration of case managers in the mental health interdisciplinary team meetings to discuss at-risk cases and patient needs. The facility also maintains collaborative relationships with both VA and non-VA psychiatric facilities and agencies, ensuring consistent care for Veterans. They are involved in the Whole Health Program, Discovery Program, and provide support to the PACT team as part of the VICTOR integrated model. Additionally, they collaborate closely with the emergency department and participate in the Governor’s Challenge, with support from the chief of staff office.

Their challenges include increased demand for support for the Suicide Prevention Program from other providers. They also have limited community resources. They have a slow staffing recruitment process. The contact information is provided.

The high-risk patients are those flagged for recent suicide behavior, some of whom are receiving inpatient care without community support. Female Veterans identified as high-risk are sometimes sent to the day hospital program for continued outpatient care within the facility. High-risk patients are followed up for three months, with weekly appointments in the first month. If a patient misses an appointment, the psychiatrist, site nurse, and case manager follow up to ensure contact is maintained. There is also a post-discharge evaluation measure for high-risk patients, with four appointments in 30 days, and three follow-up appointments for any medical condition that may aggravate a mental health condition upon discharge. VACHS is the only facility in the nation meeting this measure. Aftercare is emphasized to reduce high risk, and for patients with multiple no-shows, the team may conduct home visits if necessary.

The team has been actively engaged in the Governor's Challenge, beginning the mapping process in June and continuing to hold meetings to discuss their plans. They are focused on identifying Veterans and families at risk and screening for suicide, aiming to improve communication between the community and the VA. Safety planning is a priority, and they seek to establish community facility safety planning similar to their

own. Their VA and Community Integrated Team for Suicide Prevention, which existed before the Governor's Challenge, meets monthly to address various aspects of suicide prevention. Standardization of processes and language is emphasized by Perez to ensure consistency. The team is distributing gun locks and addressing the cultural prevalence of suicides by hanging, aiming to develop safety plans specific to such methods. They also plan to conduct focus groups with survivors to gather insights on potential support measures. Additionally, they are exploring opportunities to share data resources and are in the process of establishing mutual understanding with the Department of Health to facilitate information sharing. The team is scheduled to attend a follow-up meeting for the Governor's Challenge for the Virgin Islands and Perez is actively learning about the process.

The Suicide Prevention Program provides support to its staff through initiatives such as the Whole Health Program and relaxation skills training, emphasizing the importance of allowing time and resources for staff to debrief and cope with challenging cases. The program has enjoyed consistent support from higher-level authorities and has maintained a stable staff for the past five years, recognizing the difficulties associated with turnover. While there may not be a specific wellness program tailored for the suicide prevention team, efforts are made to ensure that postvention coordination is in place to support the staff. The team has been operating in emergency mode prior to the pandemic due to earthquakes, and although some staff have left the island, ongoing support is available to those who remain.

The Chair opened the floor to questions from the ACWV.

Ms. Parker had a question regarding the women Veterans they identified as high risk and what they defined as high risk. Ms. Gonzalez-Santos replied that the high risks patients can be those that are flagged because they have recent suicide behavior, or they are receiving inpatient care and do not have the support of the community. Some factors will increase the risk; those cases are identified with a flag in the record because they need close follow-up. They have a protocol for these cases. Some women Veterans receiving care that are identified as a high risk can be sent to the day hospital program, if necessary. Currently, the women Veterans are served in ambulatory care in mental health, not the day hospital.

Ms. Parker asked about the duration of the women Veterans’ stay in the program after identified as high risk. Ms. Gonzalez-Santos replied that they continue the follow-up for three months after discharge for patients that are identified as a high risk. But in the first month, they receive weekly appointments and weekly intervention. If the patient has an appointment with the psychiatrist but it does not show, the psychiatrist has to call the patient. If the patient does not answer, the program’s site nurse and the case manager provide follow-up.

Dr. Perez added that one of the measures that she shared is the post-discharge evaluation measure. If the Veteran is high risk for suicide, they are to get those four appointments within 30 days. The team continues to provide additional services to these

Veterans. Not only are they receiving the regular mental health services through VA or the community, but the suicide prevention team is an additional resource to that, which gets evaluated at 90 days to determine if the Veteran should still be flagged as high risk. Also, when Veterans who have a mental health diagnosis are seen in the facility for whatever reason, they are provided three follow-up appointments upon discharge because any medical condition may aggravate their mental health condition. VACHS is only facility in the nation that is meeting that measure. It has memorandums of understanding that ensure that the information they receive about the Veterans include points of contacts, to make sure none of these Veterans fall through the cracks. Ms. Gonzalez-Santos added that if they notice that a patient has multiple no-shows, they discuss the case with the interdisciplinary team. If necessary, a team visits the patient in their home. They want to be sure that Veterans receive the care and know they are not alone.

Ms. Wanda Wright asked about the program's engagement with the Governor's Challenge. Ms. Gonzalez-Santos said the Governor's Challenge started recently in Puerto Rico and they started to map in June. They met with the Puerto Rico Health Department in August about having the community use the same screening as VA; this would be beneficial in identifying at-risk Veterans. They will continue with the planning meetings, focusing on identifying Veterans and family, screening for suicide and information sharing.

Ms. Gonzalez-Santos noted that, before the Governor's Challenge started, they had already established a VA and Community Integrated Team for Suicide Prevention. This team meets monthly to discuss everything that is new in the community. Community partners can also provide information to Veterans and families.

Dr. Perez noted that the state wants to replicate and standardize what VA is doing across Puerto Rico and the Virgin Islands, using the exact same tools and ensuring that all involved are speaking the same language. In the VA health care system, there is a huge focus on "lethal means." There is a quota on the amount of gun locks that VA should disseminate. Looking at the local data, many Veterans are lost to suicide by hanging. When talking about cultural competency and cultural differences, that is an area that VA has not examined. They decided to collaborate with the Health Department on its ongoing local initiatives, such as conducting a focus group—possibly with survivors--to get a sense of what they were thinking and the things that could have helped them at that particular moment. So that is an initiative that is local, something that is impacting this specific population. Focusing on gun locks is not going to make a difference on the way in which they are seeing the local population behave. They are also discussing establishing a community data resource that they can all access and developing some type of mutual understanding with the Department of Health to be able to share information.

Mr. Moreno Sanchez identified the VACHS-led committee with community partners as a best practice. It enabled them to have a lot of discussion already started before the Governor's Challenge started. This is another great example of VA leading.

Standardization of the assessment tools and screening tools is important. They are glad to share and help the community; no matter where the access point is for the Veteran, whether it is in the community or in VA, they will have the same kind of treatment and screening.

Dr. Mathewson-Chapman asked if they are experiencing a heavy turnover in the staff, given that suicide is an emotional area. She also asked if they have regular programs to monitor staff working in these high emotional areas, or if staff comes on their own to talk to someone when they need to. Ms. Gonzalez-Santos replied that other programs, such as Whole Health Program, provide support to staff and relaxation skills. The Suicide Prevention program gives staff the opportunity to discuss difficult cases during debriefings. Regarding turnover, Ms. Gonzalez-Santos said that have had the same staff for the last year, all nurses. In other facilities they use psychiatrists and psychologists. She is interested in seeing the program grow to provide the best service for Veterans. They plan to include any other provider that needed to continue to provide that for them.

Dr. Perez added that there is a wellness program open for everyone to attend, including staff. It addresses different topics and offers different services, such as providing spiritual support through the chaplain service. Postvention is also important, because when staff loses somebody in their caseload to suicide, it impacts them just like losing a family member. The Employee Assistance Program is also available to staff.

Mr. Moreno Sanchez added that Behavioral Health leads the plan for events, as part of the medical branch of the hospital incident command system. The facility has been in emergency mode since before the pandemic, due to earthquakes in Puerto Rico in early 2020. Behavioral Health went to the impacted area to provide care for Veterans and to alleviate impacted staff, sending providers to take care of the workload and the appointments, so employees could get relief. When an employee dies, Behavioral Health will provide sessions with the team or clinic. Because of all the emergency and tragedies that that they have been through, they have lost professionals leaving the island to work mainland and in other cities.

Ms. Silva from the Chaplain service noted that the chaplains are available on Mondays. They offer meditation moments, collaborate with the Whole Health Program and have memorial services for deceased employees. They also visit the units when there is a crisis or need.

Healthcare for Homeless Veterans
Roberto Vega, Homeless Program Coordinator, VACHS
Jari Moreno, Chief of Social Work, VACHS
Roberto Vega is a social worker and the homeless program manager for the homeless program in Puerto Rico and the Virgin Islands. The program covers Puerto Rico, Vieques, Culebra, and the Virgin Islands, with facilities in Ponce, Mayaguez, San Juan, Ceiba, St. Thomas, and St. Croix.

The program is a part-time position involving specific duties within the Homeless Program Coordinated Entry, which serves as a liaison with the community and is part of the continuum of care for the homeless. The homeless case management and outreach social worker conducts outreach across the island and visits churches to identify Veterans, despite some reluctance from potential participants. There are two transitional housing facilities in Puerto Rico: Casa del Peregrino in Aguadilla and De Vuelta a la Vida. Power outages and communication challenges are common on the island. The program collaborates with transitional housing community members and organizations, including support services for Veteran families and the state Mental Health and Substance Abuse Administration in Bayamon. The program also utilizes HUD-VASH vouchers for permanent housing, provides case management and treatment for healthcare access, follows the Housing First model, offers supported employment services, and employs an interdisciplinary program including occupational therapy. Additionally, they have a Veteran justice outreach program aimed at incarcerated Veterans or those in the legal system, with the goal of linking them to permanent housing, hospital services, and preventing further legal issues.

The Homeless Program received reaccreditation from the Commission on Accreditation of Rehabilitation Facilities. Nationwide, homeless programs are facing challenges in maximizing the utilization of vouchers. The program has successfully achieved the Permanent Housing Placements (PHP1) goal, which involves increasing the number of Veterans finding permanent housing by at least 5% from the previous year. The program evaluates whether it has increased Veteran housing placements by at least five percent from the previous fiscal year and has met that target, despite facing barriers that can impact this metric. Additionally, the program has achieved the OP1 metric, ensuring that 90% of VHA Homeless Program Office-funded positions are currently filled. The program focuses on retaining talent due to the need for a sensitive and empathetic approach, and it has been successful in retaining 90% of its staff.

In 2019, the Homeless Program provided services to 21 Veterans, with ages ranging from 29 to 70 and an average age of 45. A similar proportion of women Veterans presented affective disorders related to bipolar or depression, reflecting national suicide prevention statistics showing 30 percent of women Veterans affected. In 2020, the program served 28 Veterans, with ages ranging from 24 to 70 and an average age of 45, slightly below the national average of 50. The percentage of women Veterans presenting with affective disorders increased to 32 percent. In 2021, 25 women Veterans, aged 24 to 73 with an average age of 46, were served, with 32 percent presenting affective disorders.

Puerto Rico and the Virgin Islands have a limited housing market, with a high presence of Airbnbs and a competitive rental market. There is sometimes a $300 gap between what the voucher can cover and what landlords can earn from Airbnb. The program aims to validate its reputation so that the entire VA system supports the Veterans they serve. The housing market has fewer landlords with more apartments, and if a landlord decides to close off an apartment due to a situation, other apartments may also be affected. The program coordinates between the VA, HUD, and the local public housing

authority to navigate the complex service environment. Additionally, there are two social workers in the Virgin Islands who have knowledge of the landlords and the community, helping to address the complexities of the service.

Nationwide, the utilization of vouchers for homeless Veterans is challenging due to increases in the rental market and cost of living. Landlords raising rents without policies to fill the gap creates difficulties, exacerbated by the Airbnb situation. Despite this, efforts are made to show at least a five percent increase in Veterans moving using the voucher.

To identify homeless Veterans, the program canvasses the homeless core center, which is owned by a social worker in Mayaguez. Walk-in clinics are available for Veterans seeking services, and counselors in hospitals can identify at-risk or homeless Veterans and complete a consult using electronic records, with the Homeless Program providing answers. The program is integrated into the continuum of care with other agencies and can deploy specific social workers for outreach to link Veterans to services. Additionally, they can generate reports to identify women Veterans in different branches of service. By leveraging relationships with landlords, the program can expedite the process for women Veterans with children to occupy apartments before inspections, lease signings, and rent payments, thus addressing the challenge of identifying women homeless Veterans who may be living with a friend or in a car. They may not say they are homeless and most shelters are for domestic violence or substance abuse, and they are in the process of opening up services more for women.

The Homeless Program has 203 vouchers, including Puerto Rico and the Virgin Islands. Vega thinks 25 are specific for the Virgin Islands, and the rest are for Puerto Rico.

The Chair opened the floor to questions from the ACWV.

The Chair began by asking for clarification about the PHP1 metric and the goal to increase by at least 5 percent from the previous year. Mr. Vega explained that the PHP1 metric references the increase of Veterans signing a lease and moving to apartments from the previous year. Voucher utilization nationwide is presenting a struggle. There has been a rent market increase but there is also an increase in the cost of living. Landlords decide, to increase the rent, based on demand. If they decide to increase the rent and they do not have policy really to fill that gap, they get behind. The Airbnb situation makes things worse. Owners are aware of how may vouchers they have and want them to demonstrate that they will present an increase of 5 percent per year of Veterans that move using the voucher.

Ms. Parker asked how they identify homeless Veterans. Mr. Vega replied that they have different sources to identify Veterans. They canvass the Homeless Core Center in Mayaguez; they operate walk-in clinics; and they have counselors through all the hospitals. If social workers or providers identify that a Veteran is at risk or is homeless, they can complete a consult using the electronic record. Also, the office is part of the continuum of care, where they are integrated with other agencies throughout the island

that serve the homeless population. Sometimes Veterans arrive at these other agencies to receive a lunch and a safe haven, instead of the hospital. When this happens, they dispatch the social worker specifically for outreach and to link Veterans to VA services.

Ms. Parker asked if they had a large population of the reserve units for women Veterans who have children and if women Veterans came to them for services. In terms of "couch surfing," women Veterans will not identify as homeless Veterans. Ms. Parker asked if they had a matrix of the breakdown of women Veterans according to the different branches of service. Mr. Vega indicated that they could provide this information. He said that landlords allow women Veterans with children to occupy the apartment until VA completes all of the process--- to include doing the inspection, signing the lease and paying the rent--to shortcut this process and provide housing as soon as possible.

Mr. Moreno Sanchez added that they have an annual CHALLENG meeting where they provide education to community partners and to the continuum of care—which is also comprised of all the state agencies and nonprofit organizations in the community. They also participate in bed counts, where they will go out a night and try to identify Veterans receiving treatment and being served.

Ms. Santiago-Cotto added that if women Veterans have children, they might be living with a friend or they might be living in a car. VACHS has been training nursing staff, providers and social workers on being able to identify that and how to approach them. and ask the questions, providers can notice and refer to the social worker. HUD-VASH and the support of Casa Del Peregrino facility have been great for women Veterans. Before the Homeless Program was as established, they faced many situations housing women Veterans with minor children. Most of the shelters in the community either are for domestic violence victims or for substance abuse. She has been around for a while and has seen an increase in services for Veterans.

Ms. Miller inquired about the number of HUD-VASH vouchers do you have available. Mr. Vega replied that a total of 203 vouchers are available for Puerto Rico and the Virgin Islands. Twenty-five are specifically for the U.S. Virgin Islands and the rest for Puerto Rico.

Whole Health Program
Dr. Alicia Olmo-Terrasa, Whole Health Program Manager, VACHS

Dr. Olmo-Terrasa emphasizes that the whole health program is not a separate entity from primary care, but rather a model aimed at transforming the services provided and educating providers. In the VA Caribbean, they have integrated trauma-informed care as a core component of their plan, emphasizing the need to incorporate trauma-sensitive care in all aspects of their services. They have established care coordination that takes into account the individual needs and preferences of the Veterans served. They have integrated Whole Health into their system, avoiding the need for referrals to initiate conversations, and they routinely evaluate referrals through spot checks. The Whole Health clinical care provided is evidence-based and includes complementary and

integrative health (CIH) modalities to support shared goals with Veterans in primary care. They have providers who have received education in complementary health practices such as tai chi and mind-body interventions, and they have a dedicated Whole Health coach. Additionally, 1.5 CIH providers offer complementary interventions for women, with 356 women actively participating in CIH, including high-using female Veterans who continue to engage with the program.

The Whole Health program has recruited complementary integrated health providers and aims to have 10 staff certified in trauma-sensitive yoga by 2023. This certification will enable them to offer alternative complementary interventions that integrate the body for Veterans who have experienced trauma, emphasizing the importance of providers understanding trauma-sensitive yoga.

The program's pathway, serving as its entrance, has brought on a female Veteran from St. Croix as the whole health partner, supported by WHISE funds. Alongside tai chi, the program also offers guided meditation, yoga, and battlefield acupuncture, and is in the process of credentialing hypnotherapy and biofeedback. They have achieved positive numbers in comparison to the VISN for yoga and have added another provider for CALM. Additionally, they have received an innovation grant to develop a virtual platform and are working on an application to provide a personal health inventory in Spanish.

The Chair opened the floor to questions from the ACWV.

Ms. Parker asked if tai chi is the only alternative that they offer, or if they offer other approaches like acupuncture. Dr. Olmo-Terrasa replied that they offer guided meditation, tai chi and yoga. They are beginning to offer battlefield acupuncture in primary care and establishing a referral process. They are also in the process of completing credentialing for hypnotherapy. In VISN 8, they train for hypnosis at the same time, so all the facilities are in the same process in terms of biofeedback and hypnotherapy. We have good numbers for yoga participation. They have trained set of providers in tai chi this year and are ready to open more clinics offerings tai chi. They also have an additional provider in CALM. They are expanding and providing that education needed to provide more complementary treatment.

The Chair asked if yoga and tai chi are available online. Dr. Olmo-Terrasa replied that they are offered virtually and confirmed that they have virtual groups in VACHS.

Dr. Macri noted that when she attended the Integrated Health and Wellness Clinic at the Washington DC VAMC, they were given a CD as part of their package. This presented a huge barrier because newer laptops do not come with CD player; some would have to buy a separate drive for their computer. She asked if VACHS’s programs can be utilized completely on online or if they provided DVDs as part of the program. Dr. Olmo-Terrasa responded that do not use here the DVD; the program is online. Additionally, they were granted an innovation grant and are working to make the personal health inventory into an interactive tool available in Spanish since the material was in English. This will help the Spanish-speaking population VACHS serves.

Overview of Post 911 Military 2 VA Case Management Program
Mary Cervera, Program Manager, VACHS

Mary Cervera is a social worker and the program manager for the post-9/11 Military to VA case management program, which was established to oversee the transition and continuity of care for Veterans since 9/11. The program collaborates with the Department of Defense (DoD) to facilitate the transition of servicemembers from US military treatment facilities to VA health care facilities. Its mission is to facilitate access to VA health care and provide ongoing biopsychosocial support to new Veterans through transition assistance and care management, particularly focusing on women with additional challenges during the transition. The program is responsible for facilitating the transition of care for active members referred by military treatment facilities and outpatient active duty servicemembers presenting to the VA, and it conducts outreach with the main military branches.

The program has been involved in 17 activities, providing services for women in suicide prevention, military sexual trauma (MST), intimate partner violence, and other programs. Many transitioning service members have multiple conditions, including traumatic brain injury (TBI), amputation, burns, chronic pain, fibromyalgia, combat and non-combat stress, and PTSD, among others. The transition to civilian life can be challenging and may contribute to psychosocial conditions related to adjustment. The program helps improve and coordinate care for servicemembers, providing them with information, assistance, and support to access services and facilitating the enrollment and registration process and they orient people on eligibility by doing a service claim.

The program conducts screenings for Veterans entering the facility to identify risk factors and case management needs, and coordinates services with the Women's Clinic program to expedite the enrollment of post-9/11 women Veterans and provide other care coordination services. They also offer additional programs in the community for post-9/11 Veterans and assist Veterans relocating from Puerto Rico to other U.S. counties.

Since 2018, the program has successfully facilitated the enrollment and registration of 97 percent of women Veterans and provided referrals to primary care, coordinating their first appointments with labs and primary care. They also facilitate access to Whole Health and provide Discover VA, an orientation for new Veterans. Additionally, they coordinate services for behavioral health and provide orientation on financial and education benefits, specialty services, VET centers, and Veteran Service Organizations (VSOs). Since October, they have assisted 2187 unique women who were recently separated from the Persian Gulf War.

The program faces challenges in providing services, particularly in the transition process, and these challenges are more prevalent among women and racial and sexual minority Veterans. Issues such as financial stability, family caregiving responsibilities, and lack of social support contribute to higher stress, injury, and depression rates among women compared to men. The program collaborates with the women's clinic to

support pregnant women. In the last fiscal year, 955 post-9/11 Veterans, including women, established care at the facility and were screened, with 103 referrals received, 18 percent of which were for women. Currently, 105 individuals are actively being case managed. The program is engaged in outreach efforts with the Army National Guard, Army Reserve, Wounded Warrior Expo, and Women Veterans Healthcare Brief Virgin Islands.

The Chair opened the floor to questions from the ACWV.

The Chair began with a question about how the transition plays into the work done on the electronic health record, especially since it would give the office access. Ms. Cevera noted that they have gained expertise through having access. It is a good tool to facilitate the coordination of care. They have access to records in DoD as well as records from other VA facilities throughout the country. This information can be used to help expedited specialty services for Veterans and help to make transition smoother from DoD to VA.

Ms. Parker asked for clarification on the metrics presented regarding the program's facilitation of access for 97% of women Veterans since FY18 and what the number of 2,187 Veterans referenced. Ms. Cervera explained that there were 2,187 women Veterans who came for first time visits to the facility. Those 2,187 women were not necessarily all served in the program but they were served in the facility. The program had received 13 women at the time of reporting--13 post 9/11 women referrals in FY22.

Adjourn
At 2:44 p.m. ET, the Chair adjourned the first day of the VACHS site visit.

Wednesday, August 31, 2022

Open Meeting/Introductions
Betty Yarbrough, Chair, ACWV
The Chair called the third day of the ACWV meeting to order. The Committee members, ex-officio members, advisors, and CWV staff introduced themselves.

Overview of Veterans Advocates Offices Puerto Rico
Agustin Montanez, Puerto Rico Veterans Advocate Officer
Agustin Montanez Allman is the Veterans advocate for the Government of Puerto Rico, overseeing a small agency with 15 employees. He has been with the government for 28 years, serving as an Assistant District Prosecutor for 10 years before taking on the role of State Director for Veteran Affairs. As a Gulf War Veteran and Bronze Star recipient, he brings personal experience to his advocacy work. His agency operates under Public Law 79, which enables them to act as advocates for Veterans and their families in dealings with state agencies, municipalities, private employers, and companies. Their services include assisting with VA claims, such as compensation, pension, location benefits, and medical services, handling approximately 1,500 to 2,000 claims per year.

With an estimated 69,000 to 100,000 Veterans on the island, Montanez and his team work to provide support to Veterans and their dependents/families through a network of claims officers located throughout Puerto Rico. As the agency responsible for enforcing Law 203-2007, the Veteran's Bill of Rights in Puerto Rico, they ensure that state agencies, municipalities, and employers comply with the law's provisions regarding benefits and services for Veterans. They have the authority to investigate non-compliance, establish administrative procedures and hearings, and impose fines when necessary. Additionally, they have specific responsibilities outlined in law 218-2003 concerning benefits and rights for National Guard members. Furthermore, the agency conducts outreach and provides guidance to employers on USERRA, the federal law protecting Veterans in the workplace.

The State Veterans Home in Juana Diaz, operated by the agency, has been serving Veterans for 23 years and currently accommodates 140 residents, the majority of whom are Veterans, along with 12 spouses or widows. The facility offers domiciliary services and a nursing home, providing medical attention and care to the residents. They have effectively managed the COVID-19 situation, ensuring that all residents have been vaccinated. Additionally, since 2014, they have managed a state cemetery in the western part of the island. The agency also conducts outreach programs, engaging with Veterans' organizations, churches, employers, and other interested parties to share information and support.

Law No. 234 of 2018, known as the "Law for the Welfare and Support of Veteran Women in Puerto Rico," was established to address the needs of approximately 5,000 female Veterans on the island during their transition to civilian life. The Puerto Rican government formed a board to develop a strategic plan aimed at fulfilling the requirements of female Veterans. The board includes representatives from various government departments and agencies, focusing on areas such as work and health, identified as primary needs for female Veterans. Despite facing challenges in the form of natural disasters, the pandemic, and economic and political issues in the last five years, they have been working to update and analyze the strategic plan in preparation for their next meeting in September. Additionally, Public Law 189 designates March 9 as Female Veterans Day in Puerto Rico.

Montanez's agency faces significant challenges due to its small size, including the need for budget and employees. A majority of the Veterans they serve are over 60 years old and require extensive care. The agency works closely with the VA Hospital, which is heavily utilized by Veterans, but faces recruitment challenges due to medical professionals leaving for better-paying jobs in the mainland US. Despite these challenges, Montanez has achieved notable successes during his tenure, including saving the Veterans Home from closure in 2010 and securing certification and inspections, ensuring its smooth operation for the past 12 years. Additionally, the agency has successfully obtained and managed around $7.1 million for the construction and operation of a cemetery since 2014. The office, established in 1997, has been actively supporting military personnel in Puerto Rico for the past 12 years, providing assistance with claims and various situations. Despite the challenges posed by natural

disasters and the pandemic, they have maintained their operations and built strong relationships with Veterans Service Organizations (VSOs) and other relevant entities. The agency has been actively engaging with Veterans to address their needs and has fostered positive relationships with the hospital, Benefits Administration, and cemetery administration. They are focused on empowering Veterans with the Bill of Rights and are working to make Puerto Rico a more attractive place for Veterans, as the Veteran population on the island is decreasing due to various factors such as relocation and retirement.

The Chair opened the floor to questions from the ACWV.

Ms. Wright asked Mr. Montanez whether the law regarding women Veterans lead them to establish a full-time position for a woman Veteran to work with women Veterans. Mr. Montanez explained that this is one of the areas they are discussing as they establish the strategic plan. It is something that they need to request. His office can create a position, but the over-board commission makes the decision to approve and where to put the position.

Dr. Macri asked for confirmation that Puerto Rico does have an accredited nursing home; if it is a VA accreditation or a VA certification; how it is staffed; and if it is a federal designation or internal to VA. Mr. Montanez confirmed that the nursing home does have VA certification. It is under the state and territory nursing home program of VA. They receive a per diem, but also receive a state subsidy. It is inspected annually by VA, the Puerto Rico Health Department and the Family Department. His office works closely with VA. They recently received funding, under the American Recovery Act and the COVID Act. They were able to obtain a 90-kilo generator. When there is no electricity in Puerto Rico, they do not have the capacity for air conditioning and then have to send spinal cord residents to the VA hospital. But with this 90-kilo generator and the chiller they recently bought, they do not need to move anybody from the facility, not even for hurricanes and other disasters.

Ms. Parker asked for clarification on a metric presented previously, specifically whether the 5,000 women Veterans noted also included women Veterans residing in the U.S. Virgin Island. Mr. Montanez explained that at the time they were working on the strategic plan, the total was about 5,000 to include the U.S. Virgin Islands. They report having about 4,100 women Veterans in Puerto Rico. The higher number VA reports includes women Veterans in the U.S. Virgin Islands.

Ms. Parker also inquired about the female representation on the over-board, specifically whether both Puerto Rico and the U.S. Virgin Islands are both represented. Mr. Montanez explained that this is local law pertaining only to Puerto Rico only; they do not have jurisdiction to make laws for the U.S. Virgin Islands.

Mr. Montanez revisited a previous question regarding how they run the Veterans Home. Since it was established 23 years ago, they have used a private contractor that runs the day-by-day operations. To satisfy VA regulations, his office has a state employee that

serves as a monitor. This person keeps him informed about everything that the private contractor does at the facility.

Overview of Virgin Islands Department of Veterans Affairs
Patrick Farrell, VI State Director of Veterans Affairs

The slide titled "They've Served. Now let us serve them" showcases the efforts of the Virgin Islands Office of Veterans Affairs to recognize and celebrate women Veterans. It highlights their initiatives during Women's History Month in March, where they hold events to honor women in the community, as well as the proclamation signed by the governor and lieutenant governor to recognize June 12 as Women Veterans Recognition Day. The office brought women Veterans from different islands to Government House for a ceremony and hosted a lunch to celebrate them. The office, which is state-run similar to Puerto Rico, focuses on strong advocacy for both male and female Veterans. The current leader, Farrell, will have served in the position for eight years as of January, and the office maintains a good relationship with their federal counterparts through the VA Caribbean Healthcare System. Agnes Santiago, a colleague from the VA, works closely with them, supporting their events and meeting women Veterans to understand their needs.

The next slide provides information on the utilization of VA services by women Veterans in the Virgin Islands. It indicates that there are more than 306 women Veterans in the territory, which is a significant portion of the estimated 8,000 total Veterans in the Virgin Islands, constituting about 10 percent of the overall population. Historically, the image of the VA, especially for Vietnam Veterans, was not favorable, resulting in a low uptake of VA services by Veterans, including women Veterans. While progress has been made in providing more services for women Veterans, there is still much work to be done in this area. Farrell hopes for increased utilization of the services offered to Veterans in the future.

The presentation also touches on the challenges faced in advocating for VA care in the Virgin Islands. Farrell has encountered difficulties in ensuring that the territory is properly represented in national association maps and data presentations. This lack of representation has posed barriers to accessing the appropriate level of service. Despite these challenges, Farrell remains committed to improving Veterans' access to the services they deserve.

One of the significant barriers to VA medical care is the issue of phone access. This has been a persistent problem, making it difficult for individuals to reach the necessary facilities. In cases where Veterans visit community-based outpatient clinics in St. Thomas or St. Croix, there are no emergency services available, and these clinics lack a local hospital or medical center associated with the VA. When Veterans require medevacking, they are often transported to the VA medical facility in San Juan, but occasionally they may be taken to mainland hospitals, primarily in Florida. In situations where Veterans end up in civilian hospitals, there is a lack of VA case management, despite the fact that the medical issue originated in a VA facility. This is a concern for

individuals like Farrell, as there are Veterans who prefer to exclusively utilize the VA system due to its high-quality facilities and providers.

The lack of case management is a significant concern for individuals seeking VA medical care because it results in a lack of continuity in their treatment. When patients return to the VA for ongoing care, there is often a disconnect in understanding what occurred between leaving the community-based outpatient clinic (CBOC) and receiving care elsewhere.

Farrell has emphasized the need for a local representative from the Community Care Office in the Virgin Islands to address this issue, as well as advocating for improved access to CBOCs for local law enforcement personnel. Given that many law enforcement personnel in their small community are Veterans who carry licensed weapons at all times, they are unable to enter CBOCs with these weapons, potentially hindering their ability to seek care through the VA. Farrell suggests the implementation of lockboxes at CBOC entrances and authorized personnel to assist law enforcement personnel in securing their weapons while receiving care.

The Chair opened the floor to questions from the ACWV.

Ms. Joseph asked, regarding phone access, does VA still challenges with contacting personnel on the island? Most of the VA phone systems run on VOIP. Changes with Sprint and Liberty has caused most of the phones on the islands to be inaccessible. When she uses Google Voice, she cannot call any numbers in the U. S. Virgin Islands. She asked if they are hearing other Veterans express that challenge when trying to access VA facilities are located off-island. Mr. Farrell indicated that had not heard that issue, as VOIP is not as common in the territory as it would be on the mainland, and especially for the elder Veterans who do not use VOIP as much. With Liberty, their cellphone carrier, it is not an issue when VA is calling in to the Veterans. There is an issue with Veterans calling out to the VACHS.

Ms. Joseph then inquired about Veterans, especially women Veterans, receiving medication, given the way the post office system operates. Mr. Farrell noted that there have been some issues with medication. Fortunately, the CBOCs have authorization to issue a seven-day supply of most medications when they realize that there is a problem. If that temporary supply is depleted before the supply coming from off-island arrives, the CBOC may not be able to issue it depending on the type of medication. If the Veteran goes to Puerto Rico themselves, then they can get the medication issued from the VACHS pharmacy. The U.S. Virgin Islands does not have a pharmacy locally; Veterans only have the VA pharmacy.

Ms. Wright asked about if women Veterans in the U.S. Virgin Islands are sent to community for pregnancy, mammography, and gender-specific care, given the CBOC's limitations and not actually having a local health care system. Mr. Farrell confirmed that to be true. Ms. Wright followed up by asking if they are facing challenges with bills not being paid in a timely manner, if women are receiving bills due to non-payment from VA

, or that the provider is no longer providing a service because they have not been paid in a timely manner. Mr. Farrell indicated that they absolutely face this situation in the U.S. Virgin Islands. They first noticed the issue with women Veterans using Tricare; those providers then were unwilling to see the Veterans. So, some of the Veterans had to travel to Puerto Rico, even when pregnant, to get some specific care. At one point, they had no providers within the U.S. Virgin Islands that were willing to see women Veterans because of that.

Ms. Wright also asked if there was a state Veterans home or a cemetery in the U.S. Virgin Islands. Mr. Farrell replied that there is no state Veterans home, but they are in the process of getting a state cemetery hopefully in funding 2023.

Ms. Santiago-Cotto shared that the VACHS used to provide gynecology services in the U.S. Virgin Islands. Years ago, the facility used to come to the local clinics and provide monthly gynecology services. They provided this service for about eight years. There was a full-time provider who traveled the third week to provide gynecologic services on St. Thomas on Thursday and then travel to St. Croix. Once he retired, the surgery department determined that it was beneficial for the primary care providers to provide the gender-specific care services.

VACHS is trying to train primary care providers on the island. The facility's inability to maintain stable primary care providers on the island is a challenge. They are hiring a new provider at the St. Croix clinic who will be on board in the next month. They are planning to train her to become the women's health primary care provider. They are also exploring the idea of sending one of the surgery department providers to the island to provide services.

Overview of Services Offered by Puerto Rico Government
Yara Aulet, PR Government

Yara Aulet, a social worker in women's advocacy, represents Mildred Oyola and works with the Oficina de la Procuradora de las Mujeres (OPM), which was created by the Office of the Women's Advocate Act. The OPM is empowered to enforce public policies that ensure women's rights and promote gender equality. It focuses on taking proactive measures to eliminate discrimination against women and safeguard their human rights, particularly in areas such as violence against women. The OPM is responsible for overseeing compliance with laws benefiting women and aims to promote women's empowerment, equality, and equity while eradicating discrimination and violence. Additionally, the OPM provides education to the community to support affirmative decisions in defense of women's rights. They operate emergency call lines offering 24/7 orientation services, handling thousands of cases, including those involving victims or survivors of violence. The hotline ensures confidentiality and provides women with a platform to share firsthand information about their situations. For the Veterans and other women, including elderly women, they offer emotional and psychological support, legal assistance and guidance, referrals and coordination of service, support and legal

intersection in the court of the country, as well as monitoring of service in the community. The number of the line is 787-722-2977.

The Chair opened the floor to questions from the ACWV.
Ms. Joseph if the office was funded by the Puerto Rican government to assist Puerto

Rico women Veterans. Ms. Aulet replied that the office works with all of Puerto Rico,

including Veterans.

Ms. Santiago-Cotto added that the women's program has always worked very closely with the police office in terms of referring patients in cases of domestic violence, information about shelters, referrals, legal assistance and orientation. For many years, all of VACHS's social workers collaborated with this office in the past, referring victims of domestic violence, as well as any Veterans they identified that should be receiving services from the Oficina de la Procuradora, VBA and women's health. Mr. Montanez added that his office also works closely with the Women's Advocate Office. Mildred Oyola, who is a part of the Procurador del Veterano advisory committee works with his office; she helps prepare the strategic plan.

Lieutenant Colonel McLaughlin asked about the type of legal assistance provided to the women that might come to her program, specifically if there are volunteer lawyers or if it is like a clinic to help fill out forms. Ms. Aulet noted that they have two lawyers. They get an orientation, and her office oversees. If someone has an issue, they send the referral to the lawyer and they can explore the situation delegation. They refer to other groups that give legal representation; they do not give legal representation.

Overview of Puerto Rico National Cemetery
Juan Nieves, Director, Puerto Rico National Cemetery
The National Cemetery Administration oversees two cemeteries in Puerto Rico: the Puerto Rico National Cemetery in Bayamon and the Morovis National Cemetery in the municipality of Morovis. These cemeteries were established by a law passed after the Civil War in 1862, prompted by the need to bury the large number of individuals who died during the conflict. Prior to this law, servicemembers were buried where they died, without designated national cemeteries. The mission of these national cemeteries is to provide Veterans and their families with a final resting place in national shrines, offering lasting tributes that honor their service and sacrifice to the nation. In addition to burial and gravesite maintenance, the administration conducts various ceremonies throughout the year to pay homage to Veterans. The goal is to set a standard of excellence in burials and memorials for the nation's Veterans and their families.

Before becoming a national cemetery, the site was previously used as a shooting range by the Navy and was part of a large Navy base in northern Puerto Rico. Due to the need for new burial land for servicemembers, the Army received a land donation from the Navy and subsequently opened and operated the cemetery until 1975. The Army had five military cemeteries, most of which were located near Army hospitals or bases and

were eventually closed due to capacity issues. All remains from these cemeteries were transferred to the new cemetery in Bayamon by 1962. Currently, the Bayamon cemetery accommodates 73,000 Veterans and eligible dependents, conducting 1,900 to 2,000 burials annually. Recognizing the imminent closure of the Bayamon cemetery for new internments, efforts to acquire land for a new cemetery began in 2007, and construction of the replacement began in 2023. The new cemetery, which is 2 1/2 times larger than the Bayamon site, is designed to provide burial services for the next 100 years according to the master plan. While the new cemetery has seen only 101 burials since last month, this is attributed to the majority of Veterans residing in the metropolitan area. The Bayamon cemetery remains open for services, with 41 full-time employees, 30 in Puerto Rico and 11 in Morovis. Ninety-three percent of those are Veterans and 15 percent are woman Veterans.

The burial eligibility for military members and Veterans in Puerto Rico, Morovis, or any national cemetery includes those who died during active duty or were honorably discharged Veterans. If they served for at least 20 years or qualify for retirement, their dependents are also eligible. The scheduling office for these services is located in St. Louis, Missouri, and is accessible 362 days a year via an 800 number. The benefits provided include opening and closing of the grave, perpetual care, a government headstone or marker, replacement of the marker if needed, a burial flag, and a Presidential Memorial Certificate, all at no cost to the family. Additionally, there may be eligibility for a burial allowance. Since 2016, a Pre-Need Program has been established, allowing Veterans to pre-establish their eligibility for burial services, streamlining the process for their families when the need arises.

Since 2016, a Pre-Need Program has been available for Veterans to establish their burial eligibility while they are alive by submitting a form online, by mail, or by fax. All the Veteran's information is uploaded into the system so that when the need arises, the family can simply call to schedule the service without needing to provide additional information.

In terms of women Veterans already interred, as of August 22, there were no women Veterans buried in the new cemetery in Morovis, but there were 199 interred in Bayamon. The women Veterans interred include 2 from Afghanistan, 4 from Iraq, 13 from the Persian Gulf, 1 from Kosovo, 59 from Vietnam, 35 from Korea, and 85 from World War II. The organization is pleased with the increasing use of their services by women Veterans.

The Veterans Legacy Program, established in 2016, aims to gather local history through partnerships with students, educators, and universities. While Puerto Rico does not currently have this program, there are five or six cemeteries across the nation that participate. The program collects local history and creates videos, which are then shared with schools and colleges, modernizing the approach to memorialization. In 2020, a virtual platform was launched to honor Veterans, providing individual pages for 3.8 million service members with images of marked headstones and information about

the Veteran and cemetery. Users can upload mementos, pictures, or letters to honor their Veterans in perpetuity.

Nieves, a representative, considers the successful opening and operation of a cemetery before the closure of Bayamon to be a significant achievement. Bayamon has approximately 30 more months of capacity for caskets and 3 years and 1 month for cremation, after which all interments will move to the new cemetery. Additionally, the organization is pleased with the successful hiring of female Veterans. The leadership has instilled a commitment to doing things right the first time, emphasizing the importance of providing the best service for every interment.

Nieves faces challenges in identifying female Veterans and promoting the services available to them. He is uncertain about the number of female Veterans and believes that outreach efforts are needed to inform them about the services offered at the VA hospital and the cemetery. Additionally, the new cemetery's location outside the metro area is a challenge, as many Veterans prefer a location within the metro area. However, Nieves anticipates that this challenge will diminish over time as the new cemetery becomes the primary facility for interments.

Ms. Santiago added that the biggest challenge for her regarding outreach is that they do not have data. They estimate 5,000, but she believes there are more than 5,000. She thinks this is something that Montanez was trying to incorporate in the strategic planning of the advisory committee that he had. If they knew how many Veterans they have in Puerto Rico, perhaps they could address the services better, just letting them know the services are available for them. Nieves states that he has been in the cemetery many years, and he is very glad that he gets invited to many outreaches. They know that they need to go out and let them know about the cemetery.

Ms. Tiglao asked if there is a campaign, they (Puerto Rico Government) do leading up to Veterans Day to have them register and identify themselves as one, which perhaps allows them to have an unofficial count for those who participate. Santiago states that prior to the COVID pandemic, they were in the process of planning a big event. They were trying to get ideas on a big event to bring them on board to be able to register, and to see if they can get more ideas of how many and the needs. They honor Veterans during the day of March 9, and the governors do some events. She thinks it is more of getting out the message. They might need to be using more media, like radio. Female Veterans are younger than male, so they might need to be using some areas like social media and TV. Montanez states that as part of the strategic plan, they have a strategy of using the activities to register. One of their objectives is to have the data, because that is a big problem. The one that is the most reliable is the one that VA has.

The Chair opened the floor with a comment, prior to questions from the ACWV.

The Chair noted that she that the work they do is so important because it provides a final, lasting memory to the loved ones of Veterans. Getting this new cemetery was a lot

of work, but it is also a fantastic addition to their capabilities of providing that service to Veterans.

Ms. Parker inquired about the number of women Veterans in the cemetery and wanted to know more about burial eligibility for minor and dependents. Mr. Nieves explained that any children of qualifying Veterans that die while they are minors, or before the age of 23 if they are in college, qualify to be buried in the national cemetery. Some people believe that the Veteran needs to die first but that is not the case. They determine eligibility through the Veteran and then bury the dependents. The Veteran does not need to die first. In the plot, there is room for two people. If more dependents qualify, then they use more than one gravesite.

Ms. Wright added that disabled dependent children do not have to be minors to qualify. Mr. Nieves confirmed her statement. Additionally, Ms Wright noted the low number of women buried (199) versus the total number of Veterans buried (73,000) and inquired about the possibility of the cemetery increasing collaboration with the Women Advocate Office or the WVPM to improve outreach to women Veterans. Mr. Nieves replied that he could definitely do that and added that they do a lot of outreach; this includes collaboration with Ms. Santiago-Cotto and other agencies. They have never conducted outreach specifically for women Veterans to that was not in collaboration. Ms. Santiago-Cotto noted that she would be open to him visiting the women's clinic.

Ms. Santiago added that the biggest challenge for her regarding outreach is that they do not have data. They estimate 5,000, but she believes there are more than 5,000. She thinks this is something that Montanez was trying to incorporate in the strategic planning of the advisory committee that he had. If they knew how many Veterans they have in Puerto Rico, perhaps they could address the services better, just letting them know the services are available for them. Nieves states that he has been in the cemetery many years, and he is very glad that he gets invited to many outreaches. They know that they need to go out and let them know about the cemetery.

MS. Wright added, I think you have a great idea, Agnes, as far as sharing data, if you're allowed to. One of the ways that we are able to get more data -- and I don't know if you guys give like Veteran license plates or Veteran driver's licenses -- if they will share their data with you. You can find a lot of Veterans who don't use the VA system but have it on their driver's license.

Ms. Santiago-Cotto I believe that we talk about that in one of the meetings with the Procurador. That's something that we need to continue exploring, yes, because Veterans actually were asking, and they had asked me about the license plate.

Mr. Nieves: This might go beyond the scope of this committee but we need to place the question once again on the Census 2030 that you are a Veteran. And I think it hurts us, since in 2000, that question was removed. So hopefully that's asked once again in the census in the future.

Ms. Yarbrough: Okay. Thank you very much. One of the things you might consider is I know that there are Retiree Appreciation Days, and that could be a good place for you to do your outreach.

Mr. Nieves: We are invited to participate. We are invited to many, many, many outreaches, and I'm very glad. I've been in the cemetery many years, and I'm very glad that I get invited to many, many outreaches. And we participate, and we know that we need to go out and let them know about the cemetery. So we work this out.
MS. YARDBROUGH: Okay. Terrific. I think we have a question or a comment from Agustin. Oh, no, it went away.

Mr. Nieves: No, I was going to mention -- I'm sorry. Yes, we have a license plate, but we noticed that they were not being requested. And we went to the Veterans' organizations and talked to them, and one of the things that many of the Veterans didn't feel identified with the art of the license plate. Three weeks ago we had a meeting with the Transportation Department, and we are working to see if we can get some new designs and see if the Veterans get motivated to obtain the license. We are trying to work with that.

Ms. Yarbrough: Great. Thank you for that information. And we have Ms. Tiglao.

Ms. Tiglao asked if there is a campaign they (Puerto Rico Government) do leading up to Veterans Day to have them register and identify themselves as one, which perhaps allows them to have an unofficial count for those who participate. Santiago states that prior to the COVID pandemic, they were in the process of planning a big event. They were trying to get ideas on a big event to bring them on board to be able to register, and to see if they can get more ideas of how many and the needs. They honor Veterans during the day of March 9, and the governors do some events. She thinks it is more of getting out the message. They might need to be using more media, like radio. Female Veterans are younger than male, so they might need to be using some areas like social media and TV. Montanez states that as part of the strategic plan, they have a strategy of using the activities to register. One of their objectives is to have the data, because that is a big problem.

Mr. Montanez: Yes, as part of the strategic plan, we have a strategy of using the activities to register. One of our objectives is to have the data, because that's a big problem, as we have talked. We don't have the data. The one that is the most reliable is the one that VA has, and we have been working to see how we can -- that's the first objective, the data collection, to have the correct data for working with the needs of women Veterans. And yes, activities are one of the strategies that we want to use to get that information, yes.

Ms. Yarbrough: Okay. Great. Thank you very much. Obviously, all the briefings have created a lot of questions. We appreciate your time in answering those. And to all the different agencies that briefed us during this block, thank you very much for taking the

time to do that.

Overview of the San Juan VA Regional Office (VARO) Business Lines
Regional Contact Center
Compensation and Pension
Anthony Coltrane, Assistant Director, San Juan VARO
Anthony Coltrane, the Assistant Director at the San Juan Regional Office, is temporarily assuming the role of Executive Director while Leanne Weldin is absent. Their office includes a Veteran Service Center with a vacant manager position, currently filled by Timothy Stephenson. Jose Vega is the division chief for the Veterans Readiness and Employment Division, and the Regional Contact Center has interim coaches in place due to a vacant position. Margarita Castillo is currently the chief of the Support Services Division, and Angela Briscoe oversees the new Military Sexual Trauma Operations Center. The office has a total of 417 full-time equivalent (FTE) employees, with 247 working remotely across Puerto Rico and the U.S.

The San Juan Regional Office is proud to report that the grant rate for VBA benefits related to Military Sexual Trauma (MST) has risen to 76 percent for fiscal year 2022, up from 56 percent in fiscal year 2018. They are currently approving 3 out of 4 claims submitted for MST. Over the period from October 1, 2020, to September 30, 2021, they received over 25,000 claims. However, for some of the denied claims, 44 percent of females and 42 percent of males had no diagnosis, and for others, the disability was not incurred or related to service. During that time frame, 50 percent of females and 53 percent of males were denied. From October 2021 to April 2022, the denial rate for females was 55 percent for no diagnosis and 47 percent for males, and for claims related to not occurring during service or related to service, the denial rate was 40 percent for females and 47 percent for males. Notably, 70 percent of MST disability claims are filed by females and 30 percent by males.

They are resuming in-person outreach within the Virgin Islands. They have set aside one week per month at this time.

Regarding disability benefits paid out in Puerto Rico and U.S. Virgin Islands, Veterans exceed $54 million monthly.

Veterans Service Center (VCS) Overview/Topics
Timothy Stephenson, Acting Veteran Service Center Manager, Puerto Rico VARO
Tim Stephenson is currently serving as the Acting Veteran Service Center Manager in the San Juan Regional Office. The office has observed a growing population of women Veterans and anticipates this trend to continue. This demographic shift underscores the need for increased outreach and support for women Veterans. In 2018, approximately 9 percent of the Veteran population were women, and this is projected to increase to 13.5 percent by 2030. Anthony Coltrane mentioned that around $54 million per month is awarded to women Veterans. A breakdown for fiscal year 2022 reveals that as of July

31, 2022, over $28 million in award compensation has been paid out to female Veterans.

The San Juan Regional Office has implemented several initiatives to support women Veterans. Their women's Veteran coordinator collaborates closely with the MST Division and MST leadership, organizing quarterly outreach events tailored to the needs of women Veterans. Additionally, the office offers four different methods for Veterans to schedule appointments to discuss new claims or any other services they may require. These include a toll-free number, email, the VERA system website, and a local phone number where Veterans can leave a voicemail to schedule appointments.

Veteran Readiness and Employment (VR&E) Overview/Topics
Jose Vega, VR&E Officer, Puerto Rico VARO
Joe Vega serves as the Veteran Readiness and Employment Officer for the San Juan Regional Office. He oversees the Veteran Readiness and Employment Program, previously known as Vocational Rehabilitation and Employment. The program's name was changed to "Veteran Readiness and Employment" to present a more positive image to potential employers. The program's mission remains focused on helping service-connected Veterans receiving VA compensation to prepare for employment and overcome employment obstacles. Currently, they are serving over 400 Veterans and have received 448 applications, with 17 percent from female Veterans. As of August 19, 92 Veterans have successfully rehabilitated through the program, including 13 female Veterans. Post-pandemic, outreach efforts have increased, allowing for face-to-face interactions and participation in events such as the Women's Expo for Veterans at Fort Buchanan, which provided access to 153 female attendees. Additionally, they continue to provide remote support for Veterans. Besides the three counselors they have in San Juan, they have one counselor assigned to Mayaguez on the west side of the island, and another counselor assigned to Ponce on the south side.

They are always looking for ways to strengthen collaboration with stakeholders for the benefit of all Veterans. Most recently, they took part in the LULAC convention in San Juan, Puerto Rico, where they had the opportunity to meet with other Federal agencies for the purpose of presenting their program and inviting them to open up to host their Veterans in the Non-Paid Work Experience Program, which is an established program where the Federal agencies or state agencies agreed to provide training to Veterans.

The slide Vega is showing is the caseload they were carrying as of the 5th of this month, showing 94 female Veterans who were participating in their program.

MST Operations Center
Angela Briscoe, MST Veteran Center Manager, Puerto Rico VARO
The Operations Center, reporting directly to the San Juan Regional Office, manages employees spread across the United States and San Juan. In May 2021, VBA centralized military sexual trauma (MST) claims processing to five regional offices, later adding three more offices, totaling eight offices handling MST claims. During the second quarter of fiscal year 2022, the MST Operations Center was established to work

alongside the eight sites processing MST cases. The aim is for the eight assisting sites to transition away from MST claims processing once Briscoe's division is fully operational and able to manage their current inventory and older cases. The MST division currently employs 172 full-time equivalents (FTE), with approximately 151 onboard and plans to hire an additional 20 employees within the next 60 days.

The team has achieved significant milestones, having completed over 2,235 Military Sexual Trauma (MST) rating claims since the end of June. Their grant rate has shown improvement over the years, and they anticipate further increases as their claims processors become more proficient in handling MST claims and collaborate with VHA partners for exam requirements. A visual representation on the next slide demonstrates the increasing grant rate from October 2021 to July 2022, attributed to enhanced training, communication, collaboration, and increased MST claims filed for both male and female Veterans.

While the Operations Center has been established, each regional office still maintains MST coordinators for both male and female Veterans and continues to conduct outreach activities for MST claims processing. The sole responsibility of Briscoe's division is claims processing, while the other sites will assist with outreach, serving as points of contact at the regional offices and maintaining relationships with medical centers and social workers to ensure comprehensive support for Veterans to bridge the gap and provide points of contacts when they have a Veteran visit their office that may need additional assistance.

The Chair opened the floor to questions from the ACWV.

MS. YARBROUGH: I have a question. So let me make sure I understand. You're going to have the MST Operations Center, and so you will have the employees -- because it will be a remote division -- is that the right word? So you're going to have employees all over the United States? And those employees will work for you. Okay. But we have women Veteran coordinators and MST coordinators at the regional offices also. So what's the relationship between the individuals all under the MST Operations Center and those two other individuals that are at regional offices?

In response to the Chair’s question, they will have employees all over the United States. Those employees will work for Briscoe, report to her, with the sole charge of processing MST claims. Any MST claim that Veteran files will be under the juris of her office and/or one of the eight help sites. However, by the end of the calendar year or early fiscal year 2023, the goal is that the help sites would focus on traditional claims processing, and MST would be solely the focus of her office in their mission and responsibility. They have women Veteran coordinators and MST coordinators at the regional offices also. As far as the relationship between the individuals under the MST Operations Center and those two other individuals that are at regional offices, the difference is that the employees who report to the MST Operations Center are claims processors. They are Veteran service representatives and rating Veteran service representatives that will process the disability claim for the MST condition, as well as any other disabilities that a

Veteran may file. The difference is that in the regional offices where the coordinators come into play, they act as a liaison.

Ms. Yarbrough: That was a great explanation that delineated the duties and responsibilities, so thank you very much. We have some other questions, and we will start with Lieutenant Colonel McLaughlin.

Ms. McLaughlin: My question is for Mr. Coltrane. I really appreciated the breakdown on the MST claims, showing how many male Veterans versus female Veterans were approved for those claims. Do you likewise have data or a chart for disability claims in general? In other words, not just focused on MST but what the rates of approval are for men versus women?

Mr. Coltrane: I am sure that that data is available but if not, we can request it. But I do not have those numbers.

Ms. McLauglin: Okay. Thank you.

Ms. Yarbrough: Mr. Coltrane, we look at if regional offices are looking at the possibility of unconscious bias. We all know that all of us have different biases. Many of us have things that we do, and it's related to our cultures, our genders, and all different types of things in the environment. And one of the things we have been concerned with, not just directed at your area but across VA, is unconscious gender bias. So that's one of the things that we have looked at long and hard, for quite a few years now.

Mr. Coltrane: I'm sure that a lot of the data that you mentioned, it can be obtained. So if there is anything that you would like from that, or a list that you would like to forward to us, I'm sure we can send that forward and request.

Ms. Yarbrough: Thank you, sir. I appreciate that.

Mr. Coltrane: No problem.

Ms. Yarbrough: Next we will go to Ms. Lachrisha Parker.

Ms. Parker: My question is for Mr. Stephenson. You briefed on the disability compensation, and I wanted to know, with your MST outreach coordinators, once they make the initial contact, how long does it take for the individuals to receive an appointment in person? I'm trying to see how long it takes. Normally, on some cases, we have experienced that Veterans schedule an appointment and it's two months, right, or longer, or it could be a walk-in situation that they had a cancellation for that day. So I'm kind of trying to see what's the time frame, on average.

Mr. Stephenson: In response to Ms. Parker’s questions about length of time for appointments, Mr. Stepheson noted that Regarding the MST outreach coordinators, the length of time it takes for the individuals to receive an appointment in person can vary

depending upon what means they want to use. If one were coming into any of the regional offices or contacting any of the regional offices, they could request to either have an appointment scheduled or all of the regional offices have a public contact area, where they can come in and establish a claim or ask questions about existing claims. It is at the discretion of the Veteran in terms of what their needs are. In terms of setting up an appointment, if they choose to go into the office, they could speak with someone at that time, or they could use one of the other means available. One of the systems recently implemented by the Veterans Benefits Administration is called VERA, which is basically a link on a website that any Veteran has access to, and they can schedule an appointment or find a regional office convenient for them. At the regional office, their focus is mainly on the compensation benefits aspects, and historically two months is not a time that it takes to simply get an appointment. Currently at the San Juan Regional Office, they have one of the busiest public contact areas, but Veterans can come in and schedule an appointment that same day. For the hospital, historically appointments cannot normally happen on the same day for any type of treatment. That might take a little longer at a VHA facility.

Mr. Stephenson: And so when you also talk appointments are you talking appointments with the regional office or with the hospital, because there's going to be a little difference there.

Ms. Parker: Okay. Thank you very much.

MS. Santiago-Cotto: Adding a little bit about the process. Once we identify an MST patient here, the social worker is very involved in the process of referring, or even me or the MST coordinator. We refer to the MST coordinator in VBA, the appointment could be the same day or next day. But the appointment for evaluation, as a C&P appointment, that is the one that might take longer, because it will go after they evaluate the case in the process. If they want to evaluate that case with an examiner, then they have to schedule an appointment with the C&P provider. By experience, before it took forever, I mean like years, years and years, but this process has improved significantly. I've seen cases being resolved in six months. VA has improved a lot in their processes. So that's my experience with Veterans.

Ms. Yarbrough: Thank you for adding that in. We will go to Dr. Cynthia Macri now.

Dr. Macri: I have several questions, and I'll try to be as brief as possible, but I'm very, very concerned about one thing that you said, and I've heard many, many times before from other places when I was not on this committee. And that is the need to substantiate a sexual trauma or sexual assault allegation in order, and then have to have a diagnosis in addition. What do you mean by that?

Stephenson states that as part of the claims processing aspect, when a Veteran files a claim, part of the guidelines and regulations required to establish service connection just have to be met. Historically, some of the data they use to establish service connection may not be as clear-cut or readily identifiable. He thinks that that has been one of the

things that the VBA has greatly improved. There is an internal term they use called "markers." If someone were filing a claim because of an injury to their knee or back, that information might be readily identified in their military service treatment records. With their military sexual trauma claims, some of those identifiers might not be as available because of the nature of what has taken place. In consistence with their requirements to establish service connections, one of the reasons they have the MST Division and MST coordinators is because their mission is to help identify and establish those markers or identifiers for the purpose of establishing service connection for their Veterans. Sometimes the information is not as clear in the medical treatment records as in other claims situations.

Marci asks whether there is a "secret code" or "magic diagnosis" that will get somebody compensation. Stephenson states that it is almost impossible to establish one diagnosis definition that would apply to every Veteran in every situation. Even if they narrowed it specifically to their MST claims, each individual is going to have a different scenario. Part of the claims process is that the regional office or Benefits Administration works in conjunction with the hospital. There is the need for anyone who files a claim for compensation to be examined by a VA examiner. That is the component they do not control. They rely on the expertise of the medical provider and their familiarity with the DEM book that has the codes.

Ms. Briscoe states that she agrees in support of Stephenson that there is not a magic code or anything like that. She wants to ensure everyone understands that a Veteran does not have to have an in-service diagnosis to be granted a service connection. When they look at it from an agency standpoint and things, they have done to improve how they develop the questions they ask their servicemembers to attempt to ensure that they do not have to relive the trauma multiple times, that is where their coordinators really come into play. If they decide to file a claim, when they come into public contact and/or when a claim is processed, there are specific things asked to ensure that all the bases are covered. They have a Developmental Marker Checklist, where they look to see if there was a change in the servicemember's performance around the time frame, if they go from being rated exceptional to underperforming, if there were disciplinary actions taken, or if a sexually transmitted disease occurred. So, they look for specific things, understanding that there will not be a diagnosis. When they go through that process to answer those questions and document accordingly, when exams are sent over to the medical center to support the disability claim, they are identifying that and putting that information into the exam request so the examiner knows specifically what they have identified to help provide the nexus and bridge the gap on top of the specific criteria that is in the C&P examination template. It used to be very difficult for a service member to support an MST case. They do a better job helping their Veterans identify the information, ensuring they do not feel the burden is 100 percent on them because this is such a unique and difficult topic for them to discuss, and acknowledging that a lot of the information they typically would have in an ordinary claim for back or neck will not be there. They do a better job at doing their due diligence to assist in supporting and providing that information to the C&P examiner when an exam is ordered.

Macri asks about jobs that only require certifications and not degrees. She states that when she tried to get a certification, she was told there was no way to pay the Texas A&M department unless she was enrolled in a degree program. Vega states that once the vocational evaluation is done and the employment handicap is identified, they try to help the Veteran select a feasible vocation. If the academic institution is vendorized and certain programs are approved, then that school will be able to take care of their Veterans. As far as Microsoft and AWS having certifications, they would need to follow the vendorization as well.

Mr. Coltrane states that MST affects people of all genders, ages, sexual orientation, ethnic backgrounds, and branches of service. And like any other type of trauma, MST can negatively affect a person's mental and physical health. Many of the things that Briscoe's team is designed to do and train is to make sure they look at these markers. That threshold now is much lower to be able to identify and allow that Veteran to be able to obtain that exam. That gives the Veteran the opportunity to be able to express and share those things that they need to be able to get through with the physician. After that, what happens with the clinician is not always because of what they did to obtain the exam. Once that exam is obtained, then the Veteran being able to express and convey those things to the clinician at that time.

Ms. Yarbrough: Thank you very much, sir. I appreciate that as well as the other members. We've exhausted all the questions that we have right now. I'm sure we will have more later. Sir, with you and your team, you have given us a lot of good information. I even got a little choked up over it. You've given us an opportunity to ask a lot of questions, which we truly appreciate. And we appreciate all the work that's being done. And I think this might have been the first time that we heard about the MST Operations Center and how it's going to operate, and the explanation between the relationships, so that was fantastic in answering all of our questions. So we appreciate all of you stepping forward from VBA and spending some time with us today, and we hope you have a great day.

Committee Discussion

The Chair began discussion and preparation for subcommittee breakouts. She discussed the next day's schedule, which will include the ACWV's out-brief to the facilities' leadership followed by the ACWV's observation of the VACHS's virtual women Veterans town hall meeting. The out-brief may allow for a chance to have further discussion with VISN 8 and VACHS staff before the town hall.

Ms. Wright asks about where the facility displays photos of the women Veteran program manager. Ms. Santiago stated that there are photos of her everywhere, including at the VBA office and each CBOC. She showed a video yesterday morning. They prepared a welcoming banner with information that is right where one takes the elevator to the second floor. Next to the banner, if one turns right they will see the "I Am Not Invisible" campaign, and if they turn left, they will see the women's health wall that was shown in the video. If one continues walking in the hallway, they will see the Women's Clinic. The whole second floor of the outpatient clinic is for women. If one goes to her office in

Ponce and all the other CBOCs, her poster is also over there. There used to be something at the main entrance, but due to traffic and the pandemic, Infection Control tried to limit banners and posters around the facility. But they can look at that and request a space somewhere on the first floor.

Regarding the gynecology services they provide in San Juan, Santiago states that they have three part-time providers, two female and one male. The chief is Dr. Lisandra Pagan, who has been with them for the last five years, and is Monday through Wednesday. They also have Dr. Idelvais Pinero, Wednesday through Friday, and Dr. Alvarez (male), Mondays and Thursdays. All three provide everything, including outpatient procedures at the clinic, LEAP, cryosurgery, and biopsies. They have operation room schedules and do surgeries on the third Wednesday of the month. They can also start infertility services. Pagan and Alvarez are board-certified and Pinero will take the board in October of this year. Pagan has been involved in educating nurses at the inpatient surgical area, in terms of hysterectomies. The nurse, Ms. Dias, collaborates with the fellow psychologist and Pagan. And they have been doing in-service training for the nurse community in the inpatient area.

Macri states that she would like to see the curriculum used to do the mini-residency, because she is not sure who the target audience is, what is covered, and how it is covered. Four days seems a little short. Kairys states that she can send her the official curriculum because it comes from their office.

MS. YARBROUGH: Okay. We should have had time for a good little break, and we have an opportunity to talk about a few things. Before we do that I just want to make sure that we go over a couple of things very quickly, so I don't forget to cover them at the end, like I have been known to do. We have a town hall that we are attending tomorrow after the out-brief, so please remember to register for it. On the agenda there is the link for you to register and then there is the link for the town hall, so please remember to do that. And the out-brief tomorrow is scheduled from 10:15 to 11. However, we will be briefing the entire time so we have a chance to have some further discussion with the VISN 8 and VA Caribbean Healthcare System personnel before the town hall. So just keep that in mind when we adjourn and break, we will discuss the out-brief and how it's structured a little further.

So do we have any discussion other than that for the whole group, based on all three days?

[No response.]

Ms. Tiglao: Thank you so much. And I just wanted to say, one, thank you to all of the presenters throughout these last few days. It's been robust. It's generated, as many have already mentioned, a lot of thoughtful and robust discussions that I'm sure will generate more questions and answers and recommendations that will help serve our women Veterans everywhere in the future. Thank you for the honesty, the candor, and just bringing your whole self to this, to both the committee, the presenters, as well as

our ex officios. Thank you for being here. And I'm going to keep it short and sweet. Back to you, Betty.

Ms. Yarbrough: Thank you very much. Without any further questions or comments, I will adjourn the public portion of the meeting, and we will meet in our appropriate subcommittees. So, everyone have a great day, that's not part of the subcommittees, and for those who are we'll talk to you in a few minutes.

(Whereupon, at 1:27 p.m., the meeting was adjourned until Thursday, September 1, 2022, at 10:00 a.m.)

Adjourn
Betty Yarbrough, Chair, ACWV
At 1:27 p.m., EST the Chair adjourned the third day of the ACWV-VACHS site visit, Yarbrough adjourns the public portion of the meeting so members can meet in their designated subcommittees.

Thursday, September 1, 2022

Open Meeting/Introductions
Betty Yarbrough, Chair, ACWV
The Chair called the fourth day of the ACWV meeting to order. The Committee members, ex-officio members, advisors, staff and VISN 8 guests introduced themselves.

ACWV Out-briefing with Executive Leadership Teams (VHA/NCA/VBA/VISN)
Betty Yarbrough, Chair, ACWV
The Chair provided general comments about the committee's work. The ACWV was established and chartered in November 1983 by Public Law 98-160. It assesses the needs of women Veterans with respect to VA programs, such as compensation, rehabilitation, outreach, health care and other relevant programs administered by VA. The committee reviews VA's programs, activities, research projects and other initiatives designed to meet the needs of women Veterans and makes recommendations to the Secretary of VA on ways to improve, modify and effect change in programs and services for women. Although the committee is advisory in nature, many of the recommendations from its Congressionally-mandated biennial reports go on to be implemented by the Secretary and Congress.

She thanked staff from the host facility for the presentations and especially Ms. Santiago for coordinating the site visit and Dr. Kairys for her outstanding support to the Health Subcommittee. From the VA Sunshine Healthcare Network, VISN 8, she thanked Dr. Chona Macalindong and Lisa Martel. She thanked Ms. Leanne Weldin, San Juan VARO Executive Director for lending her staff to support the meeting, Mr. Coltrane for stepping in and giving the briefing to the committee and the rest of the RO staff sharing great information. Finally, she thanked the Puerto Rico National Cemetery Director,

Juan Nieves, the local Veterans' advocates, Agustin Montanez, Patrick Farrell, Yara Aulet, and all the committee members, advisors, ex officio members, CWV staff, the public members present and all the women Veterans advocates who participated.

Dr. Mathewson-Chapman, Acting Health Vice Chair, provided key observations from the ACWV Health Subcommittee. She began by summarizing the briefings presented on each day and noted some findings. She expressed the ACWV's ongoing concern about VA's tracking of civilian providers billing women Veterans for authorized non-VA care and steps VA is taking to resolve the problem. The committee is finding that bills are sometimes going to the woman Veteran instead. She thanked the facilities for diligently providing information requested during the meeting, such the average age and the number of women Veterans utilizing the San Juan VA Medical Center and information about VACHS's outreach efforts, social media, radio broadcasts and virtual classes for all women of all ages to participate in continuing educational outreach programs.

Some of the best practices identified include: becoming a center of excellence for military sexual trauma; increasing VA medical center enrollment; and strengthening emergency management and aligning resources to meet the needs of women Veterans. The performance measures demonstrated that they are diligent about providing cancer screenings for women and even use extra hours on Saturdays for Pap smears to make it more convenient for working women. Mammograms are provided in-house and some in the community, particularly in areas like Virgin Islands and St. Croix. There are three Vet Centers available in the community for non-hospital care. The VA Homeless Program is accredited as a rehabilitation facility by VA. The Whole Health Program provides a variety of holistic health programs with a special emphasis on women achieving their own personal spiritual and health goals. They facility's film does well to showcase VA's services for women Veterans--even those that are over the age of 50—however, it needs to also include more information about personal health for the menopausal age group and encourage them to seek VA health care programs. It could also show what is available for them regarding long-term care, how Whole Health programs can help them mentally, physically.

Another challenge is that VA is an accredited long-term facility in Puerto Rico, but with the increasing elderly population, there needs to be some planning for future long-term care facilities, including the VA Caregiver Home program. Since women live about 10 years longer than men, soon there will be many elderly women Veterans seeking long-term care and aging in place. VACHS will need to ensure that there will be an option for age-appropriate and long-term care for them.

The ACWV expressed concern regarding the Strength at Home Program. There might be a barrier for women to participate in this program because couples are counseled together; the woman who is the victim may be in a situation where she is forced to deal with a violent partner.
In terms of translation services in Community Care, information is provided both in Spanish and English; Dr. Mathewson-Chapman noted a concern about the availability of information translated in other languages for women Veterans that settle in Puerto Rico.

The ACWV also expressed the need for a Community Care coordinator to be assigned to the Virgin Islands to help coordinate any of the women that transported to Puerto Rico VA for any kind of services. The committee is interested in coordination of services for incarcerated women Veterans, such as health care, housing, benefits, and care coordination before they are released.

Ms. Parker provided the Benefits Subcommittee's key observations on behalf of Vice Chair McLaughlin. Parker talks about implementing Women Veteran Law 234, adding women Veterans to the staff and the outstanding work as out-front leaders in MST and with outreach efforts across the board. Women are typically the caregivers in the family, making appointments for transportation and childcare; efforts to reach them where they are commended. Regarding LGBTQ+, the ACWV applauds the efforts made to seek out resources by partnering with other organizations in outreach efforts, utilizing social media, radio shows and other platforms informing more women Veterans about available programs, finding ways to distribute information to women that may have barriers. Safety for all Veterans, especially women, throughout the facility is an ongoing serious concern. They suggested the facility with the VA chief security officer for assistance with concerns, giving special emphasis to the MST Operations Center for the breakdown in their numbers and continuing the trend with approval ratings, which are slightly lower than the national average (perhaps due to rebuilding during the pandemic and other disasters in the Caribbean).

The MST numbers broken down by male and female were good examples for best practices in moving forward. Ms. Parker gives congratulations for the new cemetery and states that the Caribbean Women Magazine being in two different languages is outstanding work. She suggested that the cemetery do what is possible so they can get an accurate number of women Veterans in the cemetery. For the RO, she suggested they enhance their ability to capture gender specific breakdown of all disability claims awarded to men and women so they can possibly identify and assess unconscious biases that might occur.

They urged leadership to make the LGBTQ+ program care coordinator position a full-time position, or at least allot more than six hours per week, so coordinators can have adequate time to address the needs of the population.

The Chair and DFO gave closing remarks and allowed the host facility points of contacts to provide comments.

Meeting Adjourned
Betty Yarbrough, Chair, ACWV
At 11:05 a.m., EST the Chair adjourned on the last day of the ACWV-VACHS site visit.

Wanda Wright

Colonel Wanda Wright, USAF, Ret.
Current Chair, Advisory Committee on Women Veterans

Lourdes Tiglao
Designated Federal Officer, Advisory Committee on Women Veterans