

**Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans (ACWV)
VA Central Office
810 Vermont Avenue, NW
Room 930
Washington, DC 20420
September 19-21, 2015**

VA ACWV Members Present:

COL Shirley Quarles, Chair, USAR, Retired
CDR Sherri Brown, USCGR, Retired
Tia Christopher, USN Veteran
MCPO Octavia Harris, USN, Retired
LTC Louisa Long Jaffe, USA, Retired

RADM Joyce Johnson, USPHS, Retired
MAJ Shannon McLaughlin, MNG
Sara McVicker, USA Veteran
COL Felipe Torres, USMC, Retired
COL Mary Westmoreland, USA, Retired

VA ACWV Members Excused:

SPC Latoya Lucas, USA, Retired
1SG Delphine Metcalf-Foster, USA, Retired

VA ACWV Ex-Officio Members Present:

Dr. Nancy Glowacki, Women Veterans
Program Manager, Veterans Employment
and Training Service, Department of Labor
(DOL)

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

Lillie Jackson, Assistant Director, Buffalo VA
Regional Office (VARO) Veterans Benefits
Administration (VBA)

COL Betty Yarbrough, Military Director,
Defense Advisory Committee on Women
in the Services, Department of Defense
(DoD)

Other VA Staff:

Jenee Bailey, VBA
Jelessa Burney, Advisory Committee
Management Office (ACMO)
Anna Crenshaw, VBA
Brenda Faas, VHA
Dr. Sally Haskell, VHA

VA ACWV Advisor Present:

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

VA ACWV Advisor Excused:

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

Center for Women Veterans (CWV):

Elisa Basnight, Director
Dr. Betty Moseley Brown, Associate
Director
Desiree Long, Sr. Program Analyst
Shannon Middleton, Program Analyst
Michelle Terry, Program Support
Janet Elder, VBA (Detailed to CWV)

Nancy Lansing, VBA
James Lucas, Media Services
Mary Stevens, VHA
Douglas Webb, MyVA
Leslie Williams, VBA

Guests:

Dr. Chris Duke, Altarum Institute
Chantell Frazier, Iraqi and Afghanistan
Veterans of America
Abby Friedman, Atlas Research

Wolf Gremel, Altarum Institute
Dr. Karen Metscher, Altarum Institute
Melissa Nairne, DOL
Annette Weber, DOL

The entire meeting package with attachments is located in the Center for Women Veterans, Washington, DC

Tuesday, May 19, 2015, VA Central Office, Room 930

Meeting was called to order by the Chair

- Introduction of ACWV members and visitors.
- Review of agenda.
- Approval of minutes from September 2014 meeting, in Washington, DC.

Update on Center for Women Veterans Activities, Elisa Basnight, Director, Center for Women Veterans, Designated Federal Official (DFO)

- Provided ACWV DFO updates:
 - Discussed the duties and responsibilities of ACWV members.
 - Reiterated the changes made in the 2013 ACWV charter.
- Women are one of the fastest growing subpopulations of Veterans.
 - Based on active duty and recruiting numbers, the percentage of women Veterans is projected to increase.
 - There are 2,020,077 million women Veterans, of the 21,999,108 million living Veterans, (VetPop 2014, Table 6L); 9.2 percent of the total Veterans population.
 - By 2020, they are estimated to be 10.5 percent the total Veterans population.
 - Median women Veteran's age is 49 (male – 64, as of 2013 ACS).
 - Over 80 percent of women Veterans are 35 or older.
 - Women Veterans are more likely to work in government than non-Veteran women.
- Needs and challenges of women Veterans:
 - Women Veterans tell us they need and want recognition and respect, employment, suitable housing, access to and receipt of high quality health care, childcare options, opportunities for social interaction, and want to make a difference.
 - Many women Veterans do not self-identify as Veterans.
 - Many women Veterans are not aware of, and do not apply for, VA's benefits and services.
 - In some areas, access to VA's gender-specific care may be limited; VA may need to use non-VA medical care and contracts.
 - There is a lack of child care options for women Veterans attempting to access benefits and services, employment and education.
 - Women Veterans who live in rural areas and on American Indian Reservations, and who are low income, or elderly have a lower utilization of VA.
 - A lack of transportation to and from appointments makes access difficult.
- Strategic goals:
 - Engage women Veterans to improve their well-being.

- Promote trusted partnerships.
- Organize and operate CWV, to deliver seamless and integrated support.
- Strategic objectives:
 - Improve women Veterans' wellness and economic security.
 - Increase customer satisfaction, through improvements in benefits and services.
 - Deliver policies, procedures, and interfaces that meet the needs and requirements of women Veterans.
 - Enhance CWV's partnerships with Federal, state, private sector, academic affiliates, and non-profit organizations.
 - Amplify awareness of services and benefits available to women Veterans through improved and innovative communication and outreach.
 - Improve CWV's internal process and partnerships within VA.
 - Update the Women Veterans Program (WVP) operating plan, to align with Title 38, WVP Directive and CWV's long term objectives and enabling objectives.
- The Center is implementing a transformation plan in a multi-year approach:
 - FY 2013 was the year of preparation, and training to begin change.
 - FY 2014 is the year of change and full development.
 - FY 2015 will be the year of stabilization.
 - FY 2016 will be the year of assessment and best practices.
- Cumulative fiscal year to date performance update from October 1, 2014 to March 31, 2015:
 - CWV's staff engaged in 149 collaborative meetings, forums, and in-reach events.
 - Activities included keynote speeches, presentations, participation in collaborative meetings, and advisory councils and meetings.
 - CWV's staff answered 281 inquiries, ranging in complexity and issues, from general information requests to personal requests regarding health care concerns, and status of claims.
 - On average, CWV's staff responded in 2.6 days; less than VA's standard of 5 days.
- Web statistics for the period September 2014 to March 2015:
 - Number of visits to the CWV's Web site (www.va.gov/womenvet): 81,907.
 - Number of media interviews: four.
- Women Veterans Program (WVP):
 - CWV leads the collaboration and coordination of VA's three Administrations (VHA, VBA, NCA), and Staff Offices on the delivery of benefits and services to women, through the WVP.
 - CWV, with the WVP, is leading a VA-wide homelessness initiative, to promote women Veterans competitiveness in an effort to prevent homelessness.
 - Collaborative partnerships: CWV aggressively liaisons with other Federal/state/local agencies, as well as other external partners, to build understanding of how collaboration can assist women Veterans.
- CWV FY 2015 accomplishments:
 - November 2014: 20th Anniversary
 - November 2014: memorandum of understanding with the Center for American Women and Politics Public Service and Community Engagement

- December 2014: UniteUs Women Veterans Self-Identification Feedback; more than 15,000 women Veterans members
- February 2015: new strategic partnership with VA's Office of Small And Disadvantaged Business Utilization (OSDBU)
- March 2015: Women's History Month: Twitter Town Hall and Women Veterans Campaign Kick-off
- March 2015: Interagency Women Veterans Employment Initiative Working Group Publication
- Center for Women Veterans FY 2015 in-progress initiatives:
 - October 2014: White House Council on Women and Girls Women Veterans Working Group, FY 2015 focus on employment/entrepreneurship.
 - April 2015: integration with the Health Executive Committee (related to the ACWV's 2012 Report 2012 recommendation #3).
 - May 2015: creation of new strategic partnerships with the U.S. Mint, Department of Treasury, and VA's Center for Innovation.
 - June 2015: designated as a new advisor to Integrated Complex Coordinated Care (IC3).
 - June 2015: execution of the Women Veterans Campaign.

Briefing, VA Innovative Creative Series, Prosthetics and Assistive Technologies Challenge for Women Veterans, Andrea Ippolito, VA Presidential Innovation Fellow

- The vision for VA's Innovative Creative Series is to accelerate development of personalized services and technologies to improve care and quality of life for Veterans, by initiating the VA Innovation Creation Series.
- Innovation Creation Series was launched on May 15-16, 2015, at the Palo Alto VA Medical Center.
- The following initiatives were activated for May through July:
 - Online open innovation challenge experience with Innocentive platform from NASA.
 - Online video and training tools on designing and prototyping.
 - Veteran engagement via non-profit: Ipsos Girls Lounge.
 - Link to a shared repository of designs for future use and iteration on National Institute of Health's 3D Print Exchange.
- On June 12-13, 2015, the Series will host a Maker Fair at the White House, in Washington, DC.
- On July 28-29, 2015, the Series will hold a Make-a-Thon finale at the Richmond VA Medical Center.

Update on VA's Women Veterans Campaign, Dr. Betty Moseley Brown, Associate Director, Center for Women Veterans

- The purpose of the Women Veterans Campaign is to raise awareness and demonstrate VA's commitment to serving women Veterans and to celebrate their stories of service.
 - The Campaign consists of forums/sessions/workshop events in the five VA Regions, from June through September, led by the Center for Women Veterans and the Women Veterans Program.
 - MyVA regional alignment:
 - North Atlantic – Washington, DC, September 22, 2015

- Southeast Region - Bay Pines/St. Petersburg, FL, June 12, 2015
- Continental Region – Houston, TX, August 7, 2015
- Midwest – St. Paul/Minneapolis, MN, September 14, 2015
- Pacific Region – San Diego, CA, July 10, 2015
- Events will showcase benefits and services for women Veterans.
- Each participating facility will invite local internal and external public-private stakeholders, including, but not limited to, VA staff offices, states' Department of Veterans Affairs, local affiliates of Federal interagency working group partners, community partners and Veterans Service Organizations, to highlight their services for women Veterans.
- VHA's Veterans Canteen Service is a major sponsor for this campaign.
- Other Campaign activities facilities may consider:
 - Plan a "Campaign" celebration focused on women Veterans.
 - Dedicate a visible board in your facility displaying women Veterans and their roles in the military.
 - Personalize the Campaign; ask women Veteran employees to submit their military photos (and current photos), and display their military years/military occupational specialty/and where they work at the VA facility; ask them for quote to include on this story board.
 - Reach out to the VSO communities and highlight some of their women Veterans.
 - Encourage staff to view VA's talent management systems of training modules focused on women Veterans. VA partners may view public versions, as available.
 - Amplify women Veterans accomplishments; display a "Did You Know" on outreach materials, flyers, periodicals to highlight accomplishments of these women Veterans.
 - Invite VSO partners and congressional representatives to events focused on women Veterans and their campaigns.
 - They may invite their constituents who are also our Veterans.

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

- In accordance with the Federal Advisory Committee Act (FACA), the members of the ACWV received their annual ethics training.

Update on Recommendation 6 of the 2014 Report of the Advisory Committee on Women Veterans, Diana Williard, Quality Assurance Officer, Compensation Service, Veterans Benefits Administration (VBA)

- Recommendation 6: That the Department of Veterans Affairs conduct and disseminate an assessment of outcomes of the second review of previously denied MST-related post-traumatic stress disorder claims, to ascertain if new policies regarding stressor/marker verification were accurately and consistently applied; to see how many decisions were amended, as a result of the second review; and to conduct gender-specific comparisons of the initial claims decisions and the final claims decisions rendered under the second review.
 - Military sexual trauma (MST):
 - Regulations for PTSD claims, based on in-service assault such as MST, are designed to incorporate all available evidence.

- Service records may lack corroborating evidence, so evidence from other sources may corroborate the Veteran's account.
- VBA looks for "markers."
- Corroborating evidence may include, but is not limited to evidence of behavioral changes (e.g., deterioration in work performance), anxiety without an identifiable cause, statements from associates or family members, requesting transfer, receiving counseling, and/or getting pregnancy tests, diaries, letters, e-mails.
- MST claims:
 - All field personnel handling MST claims completed training on MST processing and sensitivity in 2011.
 - VBA established the Women's Program Task Force (Task Force) in 2011, to further review MST adjudication, resulting in new training on circumstantial evidentiary markers and leading to development of training for clinicians conducting PTSD compensation exams on MST-related claims.
 - Prior to launch of MST-related initiatives, grant rate was 34 percent; after initiatives, grant rate rose and averages about 50 percent for men and women.
- MST Initiatives:
 - October 2012 – additional review of claims.
 - June 2013 – VBA sent outreach letters to 2,545 Veterans.
 - Notified Veterans that they can request a re-evaluation, if MST claim was denied.
 - VBA received 558 letter responses and 261 non-letter responses for re-evaluation.
 - July 2014 – an additional 2,686 letters were sent.
 - VBA identified Veterans with claims that were denied, between 2008-2010.
 - VBA received 345 letter responses and 26 non-letter responses for re-evaluation, grant rate 33 percent.
 - Data updated as new requests are received, as outreach initiative continues.
 - August 2014 – new training material issued.
 - All claim processors received updated materials.
 - Focused on development and markers.
 - September 2014 – focused review conducted.
 - All MST-related claims processed in the special operations lane.
 - Designated MST coordinators are located in every VA Regional Office and available to assist both female and male Veterans.
 - Gender specific comparisons: GAO Report 14-477, *MILITARY SEXUAL TRAUMA, Improvements Made, but VA Can Do More to Track and Improve the Consistency of Disability Claim Decisions* dated June 2014.
- VBA's Challenge Training Program:
 - VBA works closely with VHA's Office of Disability Examination and Medical Assessment, to ensure specific training was developed for clinicians conducting PTSD compensation examinations for MST-related claims.
 - VBA certification checklist allows VA to collect additional data to better track consistency, verifies all necessary development was completed, and must be signed by the Veterans Service Center Manager or Assistant Veterans Service Center Manager.
 - Bi-annual reviews continue.

Update on Recommendation 5 of the 2014 Report of the Advisory Committee on Women Veterans, Richard Harman, Content Strategy Manager, Veterans and Consumers Health Informatics Office, Veterans Health Administration (VHA)

- Recommendation 5: That VHA and the Veterans Benefits Administration (VBA), in order to improve women Veterans access to VA programs and services, ensure that women Veterans receive user-friendly instructions, tutorials, and/or hands-on assistance as needed, in order to enhance their understanding of new technologies such as MyHealthVet and eBenefits.
- Progress made in improving My HealthVet (MHV) help and instructions, and facilitating online access for the online authentication process.
- This progress works toward goal of the recommendation:
 - Providing user friendly instructions to use My HealthVet features – User guides, FAQs, fact sheets, help files are a standard artifact for each release of MHV functionality.
 - Providing ability to accomplish online authentication for MHV.
 - Dependencies exist with other program office resources, contracts, and timelines.
- Women Veteran program managers (WVPMs) at VA medical centers are a growing set of secure messaging (SM) users, enabling them to participate in email discussions on SM with all the various members of a Veterans health care team.
 - MHV has an ongoing program to expand the training and use of SM, so that all VA staff that needs access can become part of the SM distribution, as appropriate.
- Research/Redesign:
 - MHV receiving input directly from Veterans, regarding usability of MHV.
 - A new design and a new publishing system are in the works for 2016.
- New MHV features and instruction:
 - Prescription (Rx) refill tracking – promotion across VA Web sites; update FAQs, Quick Guide.
 - Regulatory changes to popular medications affecting MHV Rx refills reflected in campaigns, educational materials.
- MHV online authentication:
 - Current process requires in-person authentication (IPA), or mailing standard form to the VA facility.
 - Identity Access Management (IAM) working on AccessVA, to have a single sign-on for all US government Web sites, including VA.
 - The Federated Credentials project, found in www.Connect.gov, allows citizens to choose how they are identified.
 - Pilot testing for Federated Credentials on MHV begins early this summer, and will be incorporated into a new design of MHV.
 - Once implemented, plan is to connect to MHV authentication.
- MHV outreach initiative:
 - Planning a coordinated campaign in the month of July, to highlight the benefits of a premium account for women Veterans.
 - Will include internal and external audiences, including suggested events for local VA medical centers.
 - MHV posters, brochures will be distributed to WVPMs.
 - Social media content provided to each VAMC public affairs office.

- Reciprocal linkages between WVHS and MHV.
- Will include online MHV survey question for/about women Veterans.
- Strengthening WVPM participation in SM.

Women Veterans Survey Results, Dr. Patricia Hayes, Chief Consultant, Women’s Health Services, VHA and the Altarum Institute Research Team (Dr. Karen Metscher, Program Manager; Ms. Laura Nelson, Lead Analyst; Mr. Joe Dorris, Statistician; and Dr. Chris Duke, Statistician and Analyst)

- The Barriers to Care survey was conducted in response to Public Law 111-163, Section 201 of the Caregivers and Veterans Omnibus Health Services Act of 2010.
- VHA contracted with Altarum Institute to execute the survey.
- Goal was to collect 8,400 completed interviews from women Veterans: 400 from each of the 21 VISNs, 200 from women who used VA in the past 24 months (users), and 200 from women who did not use VA in the past 24 months (non-users).
- A completed case is a respondent who was read every question in the survey.
 - The respondent had the right to refuse or skip any question.
- Outcome of fielding:

National Respondent Target	Number of Surveys Fielded	National Respondent Result	Simple (Raw) Response Rate	Adjusted Response Rate	Cooperation Rate
8,400	64,345	8,532	13 percent	21 percent	52 percent

- Gold-standard four stage weighting process was applied to each survey response, to make the respondent population representative of all women Veterans nationally.
- Limitations:
 - Sampling data was extracted from VA’s USVETS database.
 - Veterans not in this database will not be represented in results. Results assume this sample is representative of the Veteran population.
 - Veterans Integrated Service Networks (VISN) assignment was based on Veterans current residence, but Veterans may have received prior care outside their current VISN.
 - If any VISN effect occurs, it would not affect National results.
 - Outcomes are measured through survey questions; responses treated at face-value.
- Twenty-four percent of women Veterans are users of VA health care and 76 percent of women Veterans are non-users.
- Users in past 24 months:
 - Sixty-six percent of users of VA health care report receiving all or most of their care from VA.
 - Only 10 percent of VA users report working with a WVPM; of those few, most (85 percent) somewhat or strongly agree that WVPMs are helpful.
- Non-users in past 24 months:
 - Twenty-nine percent of non-users have used VA in the past, but not currently (w/in 24 months).
 - Sixty-seven percent of non-users report that they have never used VA care.

- Thirty-nine percent have applied for some VA benefits (not necessarily health care).
- Six percent reported being currently enrolled for care.
- Barrier 1: Comprehension of eligibility requirements and scope of services:
 - A significantly higher percentage of VA health care system users reported having received information related to VA services than non-users.
 - More women report having sufficient information about eligibility than the number of women who report receiving information. Women may not review information until they perceive they need it.
 - Users and non-users prefer hard copy materials.
 - Comments from the open-ended section of the survey indicated that the materials about eligibility and services currently on the VA Web site are not easily comprehensible.
 - Preference for telephone communication increases with disability level.
 - Recommendations from Atlas:
 - Continually seek opportunities to initiate contact with women Veterans, especially current non-users.
 - Consider policies to put hard copy materials in the hands of non-users on a periodic basis.
 - Evaluate the content or display features of VA websites to create more understandable resources about VA eligibility and services.
 - Consider different communication modes for disabled populations.
- Barrier 2: Effectiveness of outreach about Women's Health Services:
 - Most VA users report having received information on Women's Health Services, compared to non-users.
 - Across VISNs there is significant disparity in the percentage of women reporting having seen information specific to women's care.
 - Disparity may be due to variances in each VISN population, or VISNs' differing programs for communicating with their respective women Veterans populations.
 - Recommendation from Atlas:
 - Explore the communication methods of VISNs with high levels of women's health services awareness and determine if similar methods would be applicable to other VISNs.
- Barrier 3: Effect of driving distance on access to care:
 - Most women Veterans report that it is somewhat easy or very easy to find transportation to VA care.
 - Most women Veterans prefer to drive themselves or have friends or family drive them to medical appointments.
 - There does not appear to be significant demand for VA-sponsored transportation (except possibly for the disabled).
 - The population which has the most difficulty finding transportation to VA is also the population that may be most dependent on VA for care (those with high disability ratings).
 - Recommendation from Atlas:
 - Evaluate enhancing services for transportation support of disabled Veterans.
- Barrier 4: Location and hours:
 - For users who bypass their nearest VA for primary care, issues of perceived quality of

- care/providers and availability of services appear to be more important in selecting a site of care.
- The majority of patients indicated that they had a positive experience getting an appointment as soon as they needed it.
 - Access to primary care appointments lagged behind mental health and routine women's health appointments.
- The more time constrained the individual was (full-time work or caregiving, etc.), the lower the satisfaction with appointment availability.
- Recommendations from Atlas:
 - Improve communication and coordination for appointments by updating procedures and staff training.
 - Manage appointments to improve wait time and see patients at or close to their appointed time.
- Barrier 5: Child care:
 - Overall, 40 percent of women indicated having a dependent child at home.
 - More non-users than users have dependent children.
 - More users than non-users report that finding childcare to attend medical appointments is somewhat hard or very difficult.
 - Women who are not married have more difficulty finding childcare.
 - Finding care is easier as women get older, and is slightly easier for women in rural settings.
 - Generally, many women would like on-site childcare, but did not regard it as a significant factor in deciding to use VA care.
 - Recommendation from Atlas:
 - Adding on-site child care to VA facilities should be a lower priority for action than other barriers.
- Barrier 6: Acceptability of integrated care:
 - Users of VA health care placed a greater importance on having clinics for women only.
 - Women who previously experienced unwanted sexual attention preferred women-only clinics slightly more than those who did not experience unwanted sexual attention.
 - Only 35 percent of women Veterans report receiving their comprehensive primary care in a women's only clinic.
 - More VA users rated having a single provider for all care as very important or somewhat important, compared to non-users.
 - Thirty-six percent of all women who are VA users indicated that having a clinic for women only was very important (60 percent rating it somewhat or very important).
 - In a regression model, importance of women's only clinics and agreement that women can see female providers if they wish were both associated with a greater likelihood of using the VA.
 - Recommendation from Atlas: look for opportunities to provide more women-only care settings, where appropriate.
 - A total of 28 percent of current VA users were not in agreement with the statement that women may see a female provider, if they wish.
 - Open-ended comments provided evidence that some women's clinics only have one female provider and appointments with that provider are frequently backed up.

There may be instances where clinic operations are not in compliance with policies that women may choose a female provider.

- Recommendations from Atlas:
 - Promote availability of female providers in outreach efforts.
 - Ensure staffing models can provide adequate availability of female providers to comply with policy, especially as the choice of a female provider is promoted.
- Barrier 7: Gender sensitivity:
 - Overall users of VA health care are somewhat or completely satisfied with their primary care provider.
 - Older women are more satisfied than younger women.
 - Women with no disability rating are more satisfied than women with 70 percent - 100 percent disability.
 - Women receiving comprehensive primary care in a women's clinic are the most satisfied with their primary care provider.
 - Women not receiving comprehensive primary care are the least satisfied.
 - Differences in satisfaction with provider are seen within and across VISN by clinic type.
 - Women who were more satisfied with their provider used VA more frequently.
 - Overall users of VA health care report receiving a lot of respect from their primary care provider, specialists, and office staff.
 - Older women report receiving more respect than younger women.
 - Women without a disability rating report receiving more respect than women with 70 percent - 100 percent disability.
 - Women receiving comprehensive primary care in a women's clinic report receiving the most respect from providers and staff.
 - Women not receiving comprehensive primary care report that they receive less respect from providers and staff.
 - Differences exist in level of reported respect from providers/staff within and across VISN by clinic type.
 - Women who reported staff being more respectful used VA care more frequently.
 - Gender sensitivity among providers and staff varies by location, but most significantly vary by the setting of care.
 - Providers in women's clinics are viewed as being more sensitive to gender issues and showed more respect to their patients.
 - Given the preconception that VA may not be women-friendly, positive and respectful interactions can improve patient satisfaction, especially in places where a women's only clinic cannot be supported.
 - Recommendations from Atlas:
 - Continue to train providers and staff in gender sensitivity.
 - Review and update all patient-staff interaction training to ensure VA is treating all Veterans with courtesy and respect.
- Barrier 8: Mental health stigma:
 - A quarter of women, and 35% of users, who felt the need for mental health care were hesitant to seek it.
 - More younger Veterans, and Veterans with the experience of sexual trauma report being hesitant to seek care.

- Reasons women were reluctant to seek care include concerns about medications used in treatment and personal and professional concerns.
- Recommendations from Atlas:
 - Reach out to women, especially women with a history of sexual trauma, to overcome the perceived stigma of mental health care and hesitancy to seek care.
 - Provide a safe and welcoming environment to encourage women to seek the care they need.
- Barrier 9: Safety and comfort survey questions:
 - Overall women Veterans strongly to somewhat agree to feelings of safety and comfort with VA sites of care (in general).
 - Older women feel more comfortable than younger women.
 - Women with no disability rating feel more comfortable than women with 70 percent to 100 percent disability.
 - Women with no experience of sexual trauma feel more comfortable than women who did have those experiences.
 - Women who found VA facilities the safest and most comfortable used VA more frequently.
 - Feelings of safety and comfort with a **non-mental** health inpatient visit:
 - Women from OEF/OIF-present feel less comfortable with the ease of the admissions process.
 - Women with higher disability ratings feel less comfortable than women with no disability rating.
 - Feelings of safety and comfort with a mental heal inpatient visit:
 - Women from OEF/OIF-present feel less comfortable with having access to a private bathroom and able to secure the door at night.
 - Women with higher disability ratings feel less comfortable with showering and length of time for the admission process.
 - Overall, women Veterans report that VA facilities are safe and comfortable.
 - The feel of the waiting areas and privacy at check-in were of highest concern and may be easy to impact.
 - Accessible parking areas were also problematic, but due to established facility infrastructures, there may be fewer options to impact this metric.
 - For inpatients, one of the greatest concerns is with the admissions process.
 - Recommendation from Atlas: assess the admissions portion of the inpatient process for improvement in feelings of safety and comfort.
 - Other concerns for inpatient care revolved around elements of physical safety and privacy.
 - Recommendation from Atlas:
 - Identify where improvements can be made for physical safety and privacy in an inpatient setting without compromising the ability to provide care.
- Next steps:
 - The study highlights some actionable areas where VA can invest effort and resources to improve comprehension, access to care, and delivery of services in ways that will influence women Veterans' decisions to seek care through VA.
 - Many of the barriers studied could benefit from additional focused research, to identify more specific actions to improve system usage and patient satisfaction.

- The variation among VISNs on most barriers indicates significant inconsistency in practices and/or resources. Studies to help identify and evaluate best practices would be worthwhile.
 - VA should then establish mechanisms to implement those best practices system-wide, providing additional guidance and support to facilities that lag in the metrics.

Update from National Cemetery Administration (NCA)/ Women and Minority Outreach Coordinators, Faith Walden, Program Analyst, Office of Finance and Planning, Business Process Improvement Service, National Cemetery Administration

- For the fifth consecutive time, NCA achieved the highest ranking of any American Customer Satisfaction Index (ACSI) participating organization public or private, in 2013.
- The Survey of Satisfaction has been conducted annually, since 2001.
 - It is mailed to next of kin (NOK) and funeral directors, and ties to strategic plan and goals for customer service and cemetery appearance.
 - The survey is administered by an independent research contractor.
 - In 2014, 24,000 surveys were mailed to NOK and 8,000 to funeral directors.
 - The same survey will be undertaken in 2015.

Survey Questions	FY 14 Goal	FY 14 Actual	FY15 Goal
Cemetery Appearance	99%	98%	100%
Customer Service	97%	96%	100%
Recommend to Other Vets	99%	98%	100%

- NCA’s mission is to honor Veterans and their families with final resting places in national shrines and lasting tributes that commemorate their service and sacrifice to our Nation.
- NCA’s vision is to be the model of excellence for burial and memorial benefits for our Nation’s Veterans and their families.
- NCA’s responsibilities are: to provide burial space for Veterans and eligible family members; maintain national cemeteries as national shrines; administer the Federal grants program for construction of state and tribal Veterans cemeteries; furnish headstones; markers and medallions for the graves of Veterans around the world; administer the Presidential Memorial Certificate (PMC) program; and administer the First Notice of Death (FNOD) program.
- VA has oversight of 131 cemeteries, as well as 33 other soldiers’ lots, plots and monument sites.
- Women play a critical role in providing burial services to Veterans and their families.
 - Of NCA’s current 1,761 employees, 431 are female, about 25 percent of the workforce.
 - NCA also has 15 women cemetery directors and seven women cemetery administrators, which are senior field leadership positions.
- Over 74 percent are Veterans (the highest of any Federal agency).

- About 28 percent are disabled Veterans and 11.84 percent are women Veterans.
- Ninety of NCA's 131 national cemeteries provide at least one burial option for first interments.
 - The remaining are closed cemeteries only offer second interments; most are satellites of larger, open cemeteries and many are contracted out for maintenance.
- NCA has five regional offices within the new MyVA regions: Philadelphia; Atlanta; Denver; Indianapolis, and Oakland.
 - The largest numbers of cemeteries and personnel are concentrated along the east coast, in what is now the North Atlantic Region and the Southeast Region.
 - Each is led by an SES-level Executive Director and the director's staff, providing direction, operational oversight, engineering, HR, and contracting assistance to the cemeteries located in their geographic areas.
- Several women hold key leadership positions at NCA's VA Central Office location, to include an Acting Deputy Under Secretary and a Senior Historian.
- In FY 2014, NCA interred 125,188 Veterans and eligible family members; the most in NCA history.
 - NCA also provided 365,582 headstones, markers and medallions, issued 618,570 Presidential Memorial Certificates, and cared for 3.4 million gravesites and over 8,800 acres of developed land in national cemeteries across the nation.
- Interments are projected to increase to just over 128,000 in 2015 and 130,000 in 2016, before beginning a gradual decline in 2017.
 - The number of headstones and markers and gravesites maintained will continue to increase as additional interments are performed each year.
- In 2014, volunteers donated 422,890 hours of service to national cemeteries and Veterans and their families, an increase of almost 100,000 hours over a year ago.
- NCA has a strong commitment to small business and Veteran-owned small business.
 - In FY 2014, 85.01 percent of contracting dollars went to small businesses and 66 percent went to Veteran-owned small business.
 - In FY 2014, NCA committed over \$157 million contracting dollars to small business, for a variety of contracting services such lawn mowing, headstone setting, construction and more.
- The National Scheduling Office now supports all VA cemeteries, including providing bilingual representatives to support requests for interment at Puerto Rico National Cemetery.
- Eligibility criteria and scheduling include:
 - Any member of the U.S. Armed Forces who dies on active duty.
 - Any Veteran who was discharged under qualifying conditions (other than dishonorable).
 - National Guard members and Reservists with 20 years of qualifying service, who are entitled to retired pay.
 - Spouses, minor children and certain parents.
- Burial benefits provided to Veterans and their eligible family members include: gravesite (national cemetery), opening and closing of the grave (national cemetery), grave liner (national cemetery), perpetual care of the gravesite (national cemetery), headstone, markers or niche covers (private cemetery), bronze medallion (private cemetery),

Presidential Memorial Certificate for all eligible Veterans, U.S. Flag (VBA benefit), military funeral honors (DoD), and casket and urn (new benefit).

- Upon the family's request, Public Law 106-65 requires that every eligible Veteran receive a military funeral honors ceremony, to include folding and presenting the United States burial flag and the playing of "Taps."
 - The law defines a military funeral honors detail as consisting of two or more uniformed military persons, with at least one being a member of the Veteran's parent service of the armed forces.
 - Other agencies are involved in providing military funeral honors benefits, requiring coordination.
- There are women who have been interred in VA national cemeteries for roughly 200 years (from 1850-present) who are identified in our computer system as Veterans.
 - Total women Veterans interred in VA national cemeteries, as of September 30, 2014 the total number is 45,188.
 - Trend is increasing.
 - It has steadily increased, from 2007 – 2014 (the period of time for which I have been measuring this).
 - In 2007, there were 1,890 women interments in VA national cemeteries; in 2014, the count was 2,318.
- By 2017, it is projected that 96 percent of Veterans and their eligible family members will have access to a national, state or tribal cemetery within 75 miles of their home.
- As a result of Public Law 103-446, VA developed a Minority Veterans Program to respond to a growing need to reach out to minority and women Veterans.
 - The goal of the program is to increase minority and women Veterans' awareness of VA benefits.
 - Most national cemeteries have a minority Veteran program coordinator (MVPC).
 - Forty-two percent of MVPCs are women.
 - Every open national cemetery has an MVPC.
 - In 2014, MVPCs conducted over 1,000 outreach events nationwide.
 - Providing awareness to Veterans, in general, and women in specific, about burial benefits continues to be a challenge for NCA.
 - It is a difficult topic to discuss at outreach events.
 - Pre-need burial eligibility gives Veterans and their families an opportunity to pre-plan.
- NCA's Satisfaction Surveys provide interesting insight about outreach.
 - Almost 60 percent of next of kin surveyed cited family members and friends as their primary source of information about burial benefits.
 - Funeral directors also remain a trusted source, but more next of kin learned of benefits through other Veterans, active duty members or Veterans Service Organizations than in preceding years.
 - Only 88 percent of next of kin say they were aware of benefits prior to need; NCA continues to expand the number and type of events in which it participates.

Wrap up/ Adjourn, Dr. Shirley Quarles, Chair, ACWV

Wednesday, May 20, 2015, VA Central Office, Room 930 and Room 430 (afternoon session)

The meeting was called to order by the Chair.

ACWV Working Session

- The ACWV discussed the Barrier's study and began crafting responses to the barriers.

Comments from Jeffrey (Boomer) Moragne, Director, Advisory Committee Management Office

- Explained the history and function of advisory committees, the members' role on the ACWV, membership terms, and the importance of the members' service on the ACWV.
- Provided an overview of the Federal Advisory Committee Act (FACA) of 1972 and its impact on Federal advisory committees in the government.
 - The FACA significantly reduced the number of committees in the Federal government.
 - It provides extensive guidance for how to run a federal advisory committee.
- FACA committees are only abolished by law.
- Expressed the importance of committee members understanding the ACWV's charter.
- Expressed that the Advisory Committee Management Office is available to advise the ACWV.
- Explained that appointments are generally for one term of service; members can be reappointed for an additional term, but it is not automatic.
- Encouraged members to refer properly qualified replacement members for VA's consideration who can provide good contributions to the ACWV, at the end of their terms.

Greetings and Comments, Robert L. Nabors II, VA Chief of Staff

- VA's goal is to regain the trust of America's Veterans, through transparency.
 - MyVA is the tip of the spear in the "way forward."
 - VA is trying to address what it can do to help Veterans better, and looking at procedures to consider if it is the best way to help.
- Discussed MyVA and explained that it is a plan to enable VA to serve Veterans in the best possible way.
- The service bubble around the corner:
 - Sometimes follows a conflict; looking at the changes VA needs to make for the long term.
 - VA needs to get a handle on the unique challenges today's Veterans face and build infrastructure to meet their needs.
 - A different population (i.e. what will female combat Veterans seek from VA?).
- Emphasized that there is a tremendous amount of good work going on with VA.
 - VA wants to ensure that the good work in facilities continues.
- VA's approach is to be as transparent as possible, and to make sure that Veterans understand what the real issues are and provide the best solutions.
- Veterans need to be the center of everything VA does, and this will make VA transform

into a much better organization.

- Discussed how the call center can be more effective. We are working on creating better business processes.
- There is an increased number of female combat Veterans returning and VA must plan for what the Veterans population looks like and how to address the services they need.
- Discussed leveraging outside/strategic partnerships to assist with reform.
- Went to non-governmental organizations to learn what customer service looks like in the private industry.
 - VA teams met with organizations (i.e. Starbucks, Google, Facebook, etc.) to see what customer service looks like and was informed that VA was not doing it correctly.
- Thanked the committee for their service and being partners in VA's efforts.

ACWV Resumed Working Session on Barriers to Care study.

Update from Veterans Benefits Administration/Reduction of Claims Backlog/Standardization of Claims, Thomas Murphy, Director of Compensation Service, VBA

- The final rule was published in September 2013; effective March 24, 2015, VA created an optional intent to file (ITF) process in which claimants or their authorized representative may notify VA of their ITF by:
 - Initiating and saving electronic application via eBenefits or the Stakeholders Enterprise Portal,
 - Completing and mailing a paper VA Form 21-0966, Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC, or,
 - Over the phone with a VA call center or in person with a public contact representative.
 - At this time VA only requires the 21-0958 for compensation claims.
 - Use of standard appeals form is only required for VA decisions dated on or after March 24, 2015.
- Impact on claims:
 - Forms expedite the claim and appeal processes by gathering all the needed information up front.
 - Requiring standard forms for non-electronic claim submissions is consistent with VA's move toward web-based, paperless, electronic claims processing system.
 - As of April 10, 2015, VBA has received 29,244 ITFs; eBenefits 19,161; National Call Center (NCC), 5,409; and VBMS (Centralized Mail), 4,764.
 - Reduced backlog from peak of 611,000 claims in March 2013, to 151,000 claims for the week of May 19, 2015.
 - A 75 percent reduction in 25 months.
 - Met goal of completing a record-breaking 1.32 million claims in FY 2014 – over 150,000 more than in FY 2013, which was also a record-breaking 1.17 million-claim year.
 - Today, Veterans with a pending claim are waiting, on average, 157 days less for a claim decision compared to the March 2013 peak.
 - Went from touching 5,000 tons of paper annually to processing 95 percent of

- disability claims electronically, with 405,000 claims in electronic inventory; only 22,000 in paper; completed over 3 million rating decisions and nearly 1.6 million claims in the Veterans Benefits Management System (VBMS).
- Enabling Veterans to file claims online through eBenefits:
 - Over 4.7 million registered users; 68 million contacts with Veterans in FY 2014 (86 percent online) versus 9 million contacts (majority by phone) in 2009.
 - Expediting Veterans claims:
 - Forty-two percent of receipts from Veterans Service Organizations (VSO) FY 2015 to date are fully developed, up from 3 percent in 2012.
 - Received nearly 2.5 million disability benefits questionnaires in FY 2014 from VHA.
 - Dedicated non-rating workforce completed 2.7 million non-rating end products in FY 2014:
 - The highest production of non-rating work in 20 years.
 - Fifty percent more than in FY 2011.
 - More automation:
 - One in five Veterans submits online dependency requests; more than half receive payments in under one day.
 - Automatic burial allowance payments to surviving spouses within six days (down from 190 days).
 - Held appeal rates steady amidst increased production:
 - There were 1.32 million completed claims in FY 2014; 11-12 percent (historical rate) appealed, 4-5 percent reached Board of Veterans' Appeals.
 - Often based on additional evidence, 1.2 percent of claims were decided in Veteran's favor.
 - Reduced Veterans pension inventory by 69 percent from, of 36.1 thousand to 11.4 thousand; reduced backlog by 95 percent from, 14.5 thousand to 819.
 - Reduced Survivors' Dependency and Indemnity Compensation (DIC) inventory by 57 percent, from 19.1 thousand to 8.3 thousand; reduced backlog by 88 percent, from 8.8 thousand to 1 thousand.
 - Improved DIC timeliness by 112 days, from 182 to 70 days, while maintaining 99 percent accuracy.

Update on Recommendation 8 of the 2012 Report of the Advisory Committee on Women Veterans, Dr. Susan McCutcheon, National Mental Health Director, Family Service/Women's Mental Health/Military Sexual Trauma, VHA

- Recommendation 8: That VA pursues legislation to allow Servicemembers in the National Guard and Reserves who experience military sexual trauma (MST) during drilling/battle assemblies and annual training to receive free MST-related care from VA medical facilities.
- VA's legal authority to provide health care for MST-related conditions derives from U.S. Code title 38, section 1720D.
 - Historically limited to experiences of sexual trauma occurring during active duty or active duty for training.
 - In 2012, VA submitted a request for this authority to be expanded to include sexual trauma experienced during inactive duty training, which primarily pertains to the

- Reservists and National Guard members on weekend drill training.
- Language enacting the proposed expansion was eventually incorporated into Section 401 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA).
- VA's new authority went into effect immediately after the Act's passage, in August 2014.
- VA subsequently took steps to disseminate information about the expansion to clinical- and business-line staff in its health care system facilities, and to DoD's Sexual Assault Prevention and Response Office (SAPRO).
 - SAPRO advised the leadership of the SAPR programs for each military branch of this expansion of the authority.

ACWV Resumed Working Session on Barriers to Care study.

Wrap up/ Adjourn

Dr. Shirley Quarles, Chair, ACWV

Thursday, May 21, 2015, VA Central Office, Room 930

The meeting was called to order by the Chair

Cervical Cancer Screening/Child Care Pilot/ Update on Recommendation 4 of the 2014 Report of the Advisory Committee on Women Veterans, Dr. Patricia Hayes, Chief Consultant, Women's Health Services, VHA

- Recommendation 4: That VHA evaluate the effect of having VISN lead WVPMs serve only part-time on: women Veterans' market penetration, performance on quality indicators, oversight of training for designated women's health providers, and turnover rates of WVPMs at VA medical centers.
- Public Law 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010, Section 205 required that a child care pilot program be established.
 - Three sites initially selected were Buffalo, New York; Northport, New York; and American Lake-Puget Sound (American Lake), Seattle, Washington.
 - Dallas, Texas became an additional pilot site.
 - Legislative authorities have extended authorization for the Child Care pilots until December 31, 2015.
 - VHA was not able to demonstrate a relationship between use of child care at pilot sites and impact on no-show rates; however, Veterans did voice this service improved access to their appointment.
 - Veteran satisfaction was high with child care provided and allowed Veterans greater access to appointments.
 - An interim report was sent to Congress on March 25, 2015, recommending Congress enact legislation granting permanent discretionary authority to the Secretary to provide assistance to Veterans to obtain child care for their

children while accessing health care at VA facilities.

- Gender-specific care to women Veterans in VHA facilities substantially exceeds that in other systems.

<i>Health Care Organization</i>	<i>Fiscal Year 2012: Percent of Women aged 21-64 with Pap smear within 3 years</i>
Veterans Health Administration	93%
Commercial Preferred Provider Organization	75.5%
Commercial Health Maintenance Organization	73.6%
Medicaid	64.5%

- Update on recommendation 4: That VHA evaluate the effect of having VISN lead WVPs serve only part-time on: women Veterans' market penetration, performance on quality indicators, oversight of training for designated women's health providers, and turnover rates of WVPs at VA medical centers.
 - Implementation of Women's Health Dashboard monitors market penetration at VISN level.
 - National average 28.5 percent market penetration for enrolled women Veterans (4th Quarter Fiscal Year (FY) 2014 results).
- National average 40 percent market penetration for enrolled male Veterans 2014 ACWV Report: Quality Indicators.
 - Performance in Healthcare Effectiveness Data and Information Set (HEDIS) measures for both men and women in VA exceeds private sector, for most measures.
 - Differences in care received by men and women have been documented in VA and non-VA settings.
 - Gap is improving in VA for many measures but some disparities still exist.
- 2014 ACWV Report: Training Designated Women's Health Providers (DWHP).
 - Since 2008, VA has provided intensive training to over 2,000 women's health providers.
 - VHA has launched more than 50 online courses and awarded more than 20,000 units of professional continuing education credits to clinicians in clinical women's health topics in the past four years.
 - Estimated an additional 1,000 providers are in need of intensive training in the near future.

**Update on Recommendation 4 of 2014 ACWV Report, Mike Makki,
Acting Deputy Chief Officer, Workforce Management and Consulting,
VHA**

- Recommendation 4: That VHA evaluate the effect of having VISN lead WVPMs serve only part-time on: women Veterans' market penetration, performance on quality indicators, oversight of training for designated women's health providers, and turnover rates of WVPMs at VA medical centers.
- Report on turnover rates (27 percent rate) for women Veterans program managers (WVPM) and women's health providers:
 - WVPMs exist in several different occupational categories and are not consolidated in any particular organizational location within the medical centers, making it difficult to gather turnover/retention data on them from VHA's human resources systems.
 - During the 2014 planning process, the Chief Consultant for Women's Health Services (WHS) met with the Succession and Workforce Analysis Planning Subcommittee to discuss issues surrounding women Veterans.
 - It is required that the WVPM position be full-time, without collateral assignments.
 - Each facility must have a WVPM, as well as a lead WVPM who is not a facility WVPM.
 - The VISN WVPM must be at least 0.5 FTE.
 - WVPMs must have a clinical background and should be in a leadership track.
 - Workforce planners were asked to address in their 2014 workforce plans whether they have a designated WVPM at each facility.
 - In response to our questions in the national workforce planning guidance, three VISN's did not provide a response.
 - Of the remaining 19 VISNs, all but three indicated that they were fully staffed, with one WVPM at each medical center.
 - Of the three that were not fully staffed, one (VISN 4) indicated that it has one VISN coordinator who oversees women Veteran's activities for all 10 facilities.
 - VISN 23 and VISN 18 said that all but one of their facilities had a WVPM.
 - Data on the WVPM Workforce (from WHS):
 - From 2013-2014, there was 48 percent turnover (10/21) of Lead WVPMs: 3 due to retirement, 6 due to change in VA position, and 1 left VA.
 - There was 27 percent turnover (39/142) for facility WVPMs: 14 due to retirement, 22 due to change in VA position, and 3 left VA.
 - Historical data:
 - FY 2012 - WVPM Turnover was 17.6 percent (WATCH FY 2012).
 - FY 2011 - WVPM Turnover was 17.6 percent (WATCH FY 2011).
 - FY 2010 - WVPM Turnover was 17.5 percent (Skills Assessment

for FY 2010).

Update on Recommendation 1 of the 2014 Report of the Advisory Committee on Women Veterans: Developing the Strategic Plan, Gregg L. Buckley, Director, Strategic Planning Service, Office of the ADUSH for Policy and Planning

- Recommendation 1: That Veterans Health Administration's (VHA) strategic planning process at all levels, and the operationalization thereof, ensure women Veterans' needs are specifically addressed.
- VHA Directive 1075 Strategic Planning Process:
 - Establishes a strategic planning process that assesses the health care needs of Veterans; plans how to accommodate those needs; and ensures compliance with applicable Federal and Department of Veterans Affairs (VA) planning requirements.
 - Outlines a comprehensive planning continuum that effectively integrates various tasks, activities, and reporting requirements associated with budget, capital assets, information technology, human resources workforce development, performance management, and strategic planning within VHA.
 - Defines and integrates VHA planning and capabilities development for VHA Program Offices, Veterans Integrated Service Networks (VISN), and sub-organizations with the needs and expectations of Veterans.
- VHA Strategic Goals and Objectives (2013 – 2018):
 - Based on the foundation of VA core values, principles, and the VHA mission, the plan's goals are:
 - To provide Veterans with personalized, proactive, patient-driven health care.
 - To achieve measurable improvements in health outcomes.
 - To align resources to deliver sustained value to Veterans.
- Sustaining Excellence VHA Blueprint for Excellence:
 - Key VHA Component of My VA is a plan that positions VHA for a major transformation, focusing on the Veteran, and providing consistently high quality health care that is timely, efficient, and effective.
 - An organizing approach for implementation of the VA Strategic Plan, the VHA Strategic Plan, the VA Health Care Modernization Strategy, and many provisions of the Veterans Access, Choice and Accountability Act.
 - There are ten actionable strategies organized under four themes: to improve performance; to promote a positive culture of service; to advance health care innovation for Veterans and the country; and to increase operational effectiveness and accountability.
- Secretary of Veterans Affairs (SECVA) holds implementation of the ten essential strategies detailed in VHA's Blueprint for Excellence as a vehicle for "transforming the Veterans Health Administration."
- VA Environmental Scan:

- The number of women Veterans will increase, which may translate into higher demand by women for health care at VA hospitals and clinics
- Developing adequate facilities, equipment, protocols and staff to treat women's health issues in VA facilities will become important drivers of policy and planning.
- An unexpected and unprecedented lengthy period of peacetime could decrease the number of women Veterans.
- VA programs could be affected by an increase in women Veterans:
 - VHA staffing, facilities and equipment may require development, to meet the needs of potentially greater numbers of women presenting for gender-specific treatment.
 - Women Veterans may enroll in education programs at higher rates than male Veterans according to BLS Current Population Survey data; that sub-trend may elevate use of VBA Education and Vocational Rehabilitation programs.
- Survey of Veteran Enrollees' Health and Reliance Upon VA:
 - Enrollee data on priority level, socioeconomic characteristics, public and private health care coverage—including Medicare—uninsured enrollees, perceived health status, functional limitations, planned future use, and key drivers for usage of VA health care services.
 - Supplement describes the findings of additional analyses undertaken to gain insight into the variation of opinions and perceptions across racial, ethnic, and gender subgroups of respondents.
- Enrollee health care projection model:
 - Supports VA's health care budget, strategic and capital planning, and assess the impact of potential policies and changes in a dynamic health care environment.
 - Projects enrollment, utilization, and expenditures for the enrolled Veteran population for more than 90 categories of health care services 20 years into the future.
 - Number of Veterans expected to be enrolled, their priority, age, gender, special conflict status, and geographic location.
 - Total health care needs of the enrolled Veterans population; the portion of care that they are expected to receive from VA versus their other health care options; and the cost of that care.
 - Captures the impact of aging and gender on enrollment and enrollees' utilization of health care services.
- Health care planning model:
 - Provides a uniform 10-step approach for both identifying the Veteran population and identifying the comprehensive health care needs of Veterans in Veterans Integrated Service Network (VISN) markets over 5, 10, and 20-year planning horizons, and developing strategies to meet those needs.
 - Displays gender population projections by age groups.
 - Specific inputs required on the extent to which comprehensive primary care for women Veterans is provided.

- Strategy criteria include the improvement of timely and appropriate access to health care and elimination of service disparities, including women and rural populations.

Veterans Crisis Line Call Center, Julianne Mullane, Acting Program Management Officer, Veterans Crisis Line, VHA

- Veterans Crisis Line (VCL) call center's mission is to provide 24/7, world-class suicide prevention and crisis intervention services to Veterans, Servicemembers, and their family members.
- Vision is to provide supportive, timely, high quality crisis intervention, and connect Servicemembers or Veterans to the services of their choice to ensure that they never struggle alone.
- Services include:
 - 24/7/365 hours coverage:
 - VCL attempts to answer all calls by Canandaigua VAMC responders.
 - If all VCL responders are busy, calls roll over to National Suicide Prevention Lifeline-contracted backup centers.
 - Crisis intervention via phone, chat, and text.
 - Rescue services for callers who are imminently a threat to themselves or someone else.
 - Follow-up with caregivers at the local VA (suicide prevention coordinators), to verify patient has been contacted and is involved in a plan of care.
 - Education and information for callers about local VAMC and community resources.
 - Warm transfers to local support agencies
- Since its inception in 2007 through 1st quarter FY 2015, the VCL has answered over 1,625,000¹ total calls and sent more than 45,000 rescues to assist callers with emergency services.
 - From inception of chat in FY 2009 to 1st quarter FY 2015: nearly 207,700 chats.
 - From inception of text in FY 2012 to 1st quarter FY 2015: over 32,300 texts.
 - From inception of referrals to 1st quarter FY 2015: over 261,000.
 - Demand for services has increased dramatically over time.
- First full year of operation (FY 2008): 67,350 answered calls (10/1/2007-9/30/2008)
- FY 2014 EOY answered (all locations): 450,940 answered calls (10/1/2013- 9/30/2014).
- Demand for services at the VCL has increased substantially over time, and demand modeling suggests the number of inbound calls to the VCL will continue to increase over time; and demand for services through social media contact channels (chat and text) remains high.

¹ At all locations (VCL Canandaigua and Back-Up Centers)

- Back-up center information:
 - The VCL primarily consists of responders located at the Canandaigua VAMC.
 - In the event that demand for services exceeds capacity at Canandaigua, excess calls are “rolled-over” to a network of contracted back-up centers, coordinated by an external contractor, Link2Health Solutions.

Overview of MyVA Initiative and Implications for Women Veterans/MyVA Advisory Committee, Robert Snyder, Executive Director, MyVA Task Force

- MyVA’s vision is to put the Veterans in control of how, when, and where they wish to be served.
 - Measure success by the ultimate outcome for the Veterans and integrate across programs and organizations to optimize productivity and efficiency.
- MyVA guiding principles:
 - Consider change through the lens of the Veteran to enhance effectiveness and efficiency from his or her perspective.
 - Optimize VA’s unique competencies in health care, benefits delivery, and memorial affairs, while enhancing external partnerships to support service delivery where VA is less well postured to directly deliver service.
 - Integrate operations to improve service delivery and realize efficiencies.
 - Recognize the central role of VA employees in identifying challenges, crafting solutions, and ultimately delivering world-class services to Veterans.
 - Focus on the future in terms of Veteran needs and demographics “skate to where the puck is going to be”.
- MyVA concept was developed as a result of listening to VA employees, Veterans and shareholders.
 - Included more than 150 SECVA and DEPSEC visits to various facilities, over 20 site visits conducted with more than 2,000 employees, across all levels and grades, and over 4,000 ideas submitted to the Idea House by employees.
 - Listening to Veteran interviews and Town halls.
 - Listening to our shareholders, VSOs, Congress, state directors of VA (NASDVA), and union leadership.
- MyVA was told that currently Veterans must integrate services on their own, resulting in poor customer service and frustrated Veterans and beneficiaries; similar themes relayed by VA employees.
 - VA has employees that care deeply about customer service, but they feel they do not have the resources, particularly adequate knowledge of VA and proper training, to deliver quality customer service. Inadequate staffing and poor recruitment, hiring, and retention

- practices.
- Inadequate support functions at the facility level, such as IT and contracting.
- Performance evaluation system does not incentivize customer service.
 - There are pockets of excellence, but operations are not standardized, and best practices are not shared.
- Integration and cooperation between business lines varies significantly.
 - Structures and operations are too complex; decision making is too centralized and takes too long.
- Employees see a need for additional investment in infrastructure, e.g. parking, IT, space.
- There are opportunities to establish better local relationships with private sector, local/state governments, VSOs, and other organizations.
- Communications needs to be simplified and consistent.
- To achieve the MyVA vision, VA is focusing on five primary areas:
 - Improving the Veterans experience by examining Veteran-facing processes and organizations from the Veteran's perspective, to enable every Veteran to have a seamless, integrated, and responsive VA customer service experience every time.
 - Improving the employee experience, by focusing on people and culture, so employees are empowered to better serve Veterans.
 - Achieving support services excellence, by identifying common services that are performed in support of VA mission components, and seeking to optimize these services to increase efficiency and eliminate duplication.
 - Establishing a culture of continuous performance improvement, so conditions are set at the local level for issues to be raised, addressed, and solutions replicated across as many facilities as needed to achieve enterprise level results.
 - Enhancing strategic partnerships by making better "matches" and formal partnerships between community, nonprofit, and other organizations and the work being done for Veterans at VA facilities across the country.
- Current "Top 10" initiatives to improving the Veteran Experience:
 - Foundational:
 - Build the Veterans Experience team: establish in VA Central Office and in the five districts.
 - Customer data integration: create a common view of our customers
 - Menu of services: describe the benefits/services VA currently offers.
 - Eligibility: determine the benefits/services each Veteran earned.
 - Transformational:
 - Unified digital experience: address all digital needs from

- www.veterans.gov.
 - Single 1-800 number: answer all inquiries in a single phone call.
 - One measurement for Veterans Experience: share understanding across VA.
 - Front line employee training: prepare/empower staff to honor Veterans
 - Compensation and pension exam process: refine from Veterans' perspectives.
 - Community Veterans Engagement Board: provide local oversight on VA.
- MyVA is a cultural shift that places the Veteran at the center of everything VA does.
 - The approach is to understand our customers, their needs, and their expectations, understand existing efforts to meet customers' needs, and align programs to achieve coherence and consistency.
 - Support VA to improve customer experiences by advising, sponsoring, or owning initiatives as appropriate.
 - Foster solutions at the local level by training, supporting, and empowering employees to contribute to excellent customer experiences.
 - Foster productive collaboration at the community level among the diverse range of local shareholders.
 - To execute its strategy, the Veterans Experience team is organized around the following functions:
 - Insight and design – orchestrating customer touch points based on a consistent, shared understanding of our customers and their needs.
 - Measurement and performance management – understanding VA performance from the perspective of our customers.
 - Enterprise access and integration – building, deploying, and maintaining the processes and technology needed for a seamless customer experience.
 - Navigation and advocacy – overseeing and enhancing touch points with our customers and stakeholders, ensuring they can understand and easily access VA benefits and service.
 - Operations and governance – enforcing standards of performance informed by the customer's point of view.
- Customers want experiences with meaning, services that support and enable, and a VA they can trust.
 - A community of people that understand and address their unique circumstances and experiences, and a place to bond and support each other.
 - Health care that focuses on Veterans unique needs, education, training, and other support that helps their transition to the next phase and throughout their lives.
 - Standards that are reasonable and understandable to them.

- A place where they feel emotionally and physically safe, clear, reliable information and care in the context of trusted relationships.
- Community Veterans Engagement Boards (CVEBs) are a network of local boards that the Department of Veterans Affairs' (VA) new Veterans Experience (VE) team will help stand up across the country. CVEBs will provide a forum to proactively and directly address Veteran issues and improve the Veteran experience at the local and national levels.
 - CVEBs scope is to resolve issues at the lowest level possible, while working in concert with regional and national leadership to develop solutions and identify opportunities to improve the Veteran experience.
- Compensation and pension exams:
 - The challenge: the current compensation exam process is a government-focused process, not a Veterans-focused process.
 - The solution: create an understanding of the holistic set of issues regarding Veterans' experiences and expectations around the exam.
 - The approach: lead a cross-functional group of people from across VA to conduct a compassionate and thorough discovery and design project; refine the process through an understanding of Veterans' experiences and the drivers/causes of those experiences.

Update from Veterans Health Administration/ Veterans Choice Program, Dr. Carolyn Clancy, Interim Under Secretary for Health, VHA

- Turning challenges into opportunities:
 - Although there is still more work to do, VHA has shrunk the electronic wait list by 55 percent, and is now completing 97 percent of appointments within 30 days of the Veteran's preferred date—20 percent on the same day.
 - VHA hired 8,000 additional medical professionals, increased authorizations for outside care by 45 percent, and rolled out the MyVA initiative to improve the experience of both Veterans and employees.
- Blueprint for Excellence:
 - VA's history of innovation and collaboration makes it well-suited to bridge the public-private "health care divide" in this country, by serving as the model for 21st century health care.
 - The Blueprint lays out the vision for change—not just to repair the recent breakdowns in VHA's system, but to establish a new health care operating model for VA.
 - It is a guide for improving VA health care through specific strategies and actions organized under four themes: improve performance; promote a positive culture of service; advance health care innovation for Veterans and the country; increase operational effectiveness and accountability.
- VA already has a strong foundation on which to build a 21st century health care system for Veterans because of its long-standing focus on patient safety, and is far ahead of the curve with electronic health records and big data.

- VA also has the largest footprint in virtual care in the nation, and is the nation's leader in implementing a modern approach to primary care.
- Perhaps VA's greatest strength is that it has employees who are passionate about and dedicated to the mission.
- There is an opportunity to change perceptions about VA, by:
 - Lengthening VA's lead in areas where it excels and taking the lead in service delivery areas that are lagging.
 - Charting new ground in emerging areas of health care and optimizing care to spend taxpayer dollars responsibly.
 - Improving care by modeling a system that leverages evidence-based, team-based, and patient-centered approaches, emphasizes "wellness" to short-circuit "illness" and uses technology and innovation to continuously improve outcomes, and metrics to monitor and improve performance.
- Priorities and challenges:
 - This year, the Blueprint for Excellence frames VHA's efforts in two priority areas: access and Veteran experience.
 - Resources are a big part of the solution to our access challenges—adding more clinical space and hiring more providers make the biggest impact on expanding access.
 - Offering more virtual care is another key way to expand access for enrolled Veterans.
 - Expand access by authorizing more care provided through academic, federal, and private sector partners.
 - New authorities, like the Veterans Choice Program created by Congress, give VA the opportunity to use purchased care as a tool to address access problems.
 - The Choice Program is a new, temporary benefit that allows eligible Veterans to receive health care in their communities, if VA is unable to schedule an appointment within 30 days, or if the Veteran lives more than 40 miles from a VA facility.
 - VA contracted with two health care companies to implement this program, providing non-VA care for eligible Veterans.
 - As part of the new program, VA issued a Veterans Choice Card to every Veteran who is potentially eligible for the benefit.
 - Eligible Veterans may choose to pursue authorization to receive care outside VA when they qualify for the new program based on the distance of their residence from a VA care facility, or when wait times for VA care exceed the standards set in law.
 - In April, eligibility for the Choice Program was expanded, by changing the calculation used to determine the distance between a Veteran's residence and the nearest VA medical facility from a straight line to driving distance.
 - Since it went into effect on November 5, 2014, more than 45,000 medical appointments have been scheduled through the Veterans Choice Program, and 45,990 Veterans have requested to receive

- care using Choice as of March 17.
- VA continues to provide information about and training on the Veterans Choice Program to employees at medical facilities across the country.
- Community care not only addresses some of our current access problems, it opens the door to other transformative opportunities in care coordination and interoperability.
- Unlike a private health plan, VA retains responsibility for the quality and continuity of care we deliver.
 - VA tracks and monitors the effectiveness of the community care it authorizes—to ensure Veterans are receiving the care they need and a record of that care is imported into the electronic health records system.
 - While participants in private sector health plans may change their plans many times over the course of their lives—Veterans are with VA for the long term, most often a lifetime.
- VA currently has five different pathways to non-VA care, which is confusing for our Veterans and employees.
 - VA needs to make health care between VA and non-VA clinicians as seamless as possible for Veterans, the majority of whom also receive care outside VA.
 - Collaboration between VA and private providers has the potential to leverage improvements in electronic health records, by developing a public-private platform and infrastructure to generate new ways of using patient data to provide better care.
- Increasing the level of care delivered in the community also has the potential to increase high-value care, particularly in reducing duplicative and unnecessary medical testing.
 - Although purchased care is an asset, it is not a replacement for a dedicated health care system for Veterans.
 - America benefits from a strong VA system because of its historic and unmatched contributions to health care on three fronts: clinical care, training, and research.
- When it comes to access, Veterans need to be in control of how, when, and where they are served.
 - VA's job is to help Veterans find a balance between their preferred date for an appointment and providing them the best possible clinical care.
- Veterans' perceptions and opinions are a valuable measure of success in accessing care.
 - VA must ensure that Veterans have an exceptional experience wherever they access care, inside or outside our system.
 - VA is determined to rebuild the trust of Veterans and stakeholders and improve service delivery by focusing on Veteran outcomes.
 - VA is committed to providing high-quality personalized, proactive, and patient-driven care to every Veteran.

- VA must measure success by focusing on Veteran outcomes, optimizing productivity and efficiency, and ensuring that corresponding practices are adopted throughout the system.
- Moving forward, VA must do a better job of identifying and responding to problems now, before they erupt into a full-blown crisis.
 - That starts with identifying the earliest signals of a problem in VA.
 - The feedback received from Veterans and other stakeholders on how VA is doing will be a critical piece of that “early warning system” VA needs to develop.
 - VA’s changing model of care is not about creating a “new” system, but shaping the “right” system for Veterans—health care built on cornerstones of disease prevention, personalized health management, innovation, and customer service.
 - With the strong support of VA’s many partners, VA will improve access to effective and high-quality health care, and provide every Veteran a seamless, integrative, responsive, and personalized experience.

Women Veterans Employment Initiatives, Christi Collins, Acting Assistant Director for Economic Impact, Office of the Deputy Secretary for Economic Opportunity, VBA

- Provided an overview of women Veterans employment initiatives.

Update on Recommendation 3 of the 2012 Report of the Advisory Committee on Women Veterans, Dr. Patricia Hayes, Chief Consultant, Women’s Health Services, VHA

- Recommendation 3: That VA proposes to the VA/DoD Joint Executive Council (JEC) that its annual report adopts a component on women Veterans and female Service members which outlines and develops health care service deliverables for enhancing health care for women Veterans.
 - The VA/DoD Health Executive Committee (HEC) recently realigned its 21 work groups into five business lines.
 - The Clinical Operations business line held its first organizational meeting on April 24, 2015.
 - The business line co-leads requested information, prior to establishing a female Servicemembers and Women Veterans Work Group.
 - Women’s Health Services is gathering the requested information, to be presented at the next Clinical Operations business line meeting, scheduled during first week of June 2015.

Meeting adjourned.



Shirley A. Quarles, EdD, RN, FAAN
Chair, Advisory Committee on Women Veterans



Elisa M. Basnight, JD, MPA
Designated Federal Officer