2019 National Minority Veterans Summit
Day 1

September 27, 2019
Dallas, TX
WE ARE ONE
2019 National Minority Veterans Summit
September 27 - 28 / Sheraton Dallas Hotel, Dallas, Texas

https://youtu.be/Z36l18tXjHM
Stephen B. Dillard
Executive Director
VA Center for Minority Veterans
Presentation of the Colors

Navy Color Guard

Naval Air Station Joint Reserve Base Fort Worth
National Anthem

Wanda Frey
Volunteer Vocalist
Native American Song

Anthony Nauni
Comanche Nation Outreach
Invocation

Chaplain Tonia J. Hatchett
Interim Chief of Chaplain Service
VA North Texas Health Care System
Native American Prayer

John Tiddark
Former Captain, U.S. Special Forces
Vietnam Veteran Recipient of the
Purple Heart & Bronze Star of Valor
Introduction of the VA Deputy Secretary

Stephen B. Dillard
Executive Director
VA Center for Minority Veterans
Welcome Message

Honorable James Byrne
Deputy Secretary
U.S. Department of Veterans Affairs
Intermission

VA Deputy Secretary James Byrne & VA Minority Veteran Program Coordinators

Meet in Dallas Ballroom D-1
Provides food, coffee, retail & vending services in over 200 VA Medical Centers across the county

Also provides additional services such as optical shops, barbershops, and concessionaire stands in select locations

Revenue generated from VCS is “given back” to VA Programs
2019 Summit Partner VCS (cont.)

Shopvcs.com

- SPORTSWEAR & ACCESSORIES
- FOOTWEAR
- JEWELRY & WATCHES
- ELECTRONICS
- HOME
- FAMILY
- MADE IN USA
- VETERAN OWNED BRANDS
- MILITARY PRIDE
- SPORTS
- TECH
- TRAVEL AND TICKET SERVICES

NEW BENEFITS ARE WAITING FOR YOU ON ShopVCS.com

Veterans enrolled in VA healthcare, their families and VA employees have access to ShopVCS.com - and it's free to sign up. Start saving on thousands of products from hundreds of top brands.

Create Free Account

Revenue generated from VCS is “given back” to VA Programs
2019 Summit Partner VCS (cont.)

Giving back to veterans

With every purchase, vcs “gives back” to veteran programs

- National rehabilitation games
- Women veterans
- Veterans suicide prevention
- VETERANS Homelessness programs
- DISASTER RELIEF
- WARRIOR TO SOUL MATE
- More…
Additional 2019 Summit Partners
Opening Remarks for Administration Leadership

Dennis O. May
Deputy Director
VA Center for Minority Veterans
Matthew Sullivan
Deputy Under Secretary for Finance & Planning
VA National Cemetery Administration
Margarita Devlin
Principal Deputy Under Secretary for Benefits
VA Veterans Benefits Administration
OUTREACH.VBACO@VA.GOV
VBA’s Commitment to Serving Minority Veterans

Margarita Devlin
Principal Deputy Under Secretary for Benefits
September 27, 2019
In our differences lie our strengths
Minorities in the Veteran Population

In 2014
minorities comprised 22.6 percent of the total Veteran population in the United States.

By 2040
minorities are projected to make up 35.7 percent of all living Veterans in the United States.
Minority Representation at VBA

A decade ago

- 39% of VBA employees were minorities
- 490 Minority senior leaders at VBA

Today

- 45% of VBA employees are minorities
- 812 Minority senior leaders at VBA
VBA is Committed to Minority Veterans

- Broad-spectrum research of VA policies and processes
- Robust communication with minority Veterans
VBA’s Minority Veterans Program

VBA employs 56 minority Veterans program coordinators (MVPCs)
- to increase local awareness of minority Veteran-related issues
- develop strategies for increasing their participation in existing VA benefits programs

MVPCs are located at regional offices, health care facilities and cemeteries
VBA is Committed to Minority Veterans

The VBA MVPC duties include:

- Connecting with local minority organizations
- Raising awareness of VA benefits among minority populations
- Supporting activities addressing the unique needs of minority Veterans
- Distributing educational and outreach materials to targeted outreach groups.
Coordinators *averaged over 20 hours* of outreach per month nationwide in FY 18

Targeted outreach to minority Veterans at outreach events was *27% in FY 17 and 36% FY 18*

Increased number of minority Veteran outreach activities from *7,301* in FY17 to *over 8,000* in FY18, reaching nearly *100,000* minority Veterans

MVPC outreach efforts yield positive results
Outreach to Native Veterans

MVPCs provided critical training to Tribal Veterans Representatives. MVPCs also worked alongside the Office of Tribal Governmental Relations at Tribal Claims Clinics.

In FY18 VA held 33 Tribal Claims events with 24 tribes across 12 states. These events reached approximately 1,100 Veterans and yielded 730 new claims for VA benefits.

Through the first 22 events in FY19, VA has reached over 730 Veterans and received 330 claims.
Outreach Results

**Resources**

56 Minority Veteran Program Coordinators

at VA Regional Offices nationwide

**KPIs** (Thru 2Q/FY19)

**Over 8,500**
Outreach Activities Conducted

**Over 250,000**
Veterans Contacted

**Over 10,000**
Contacted through Targeted Outreach to Minority Veterans
Looking Ahead

Planned Projects (through End of FY19)

- First-ever National Minority Veteran Summit
- MISSION Act information on website and in outreach materials
- Introductory Videos on website
- Ongoing local and national outreach and partnership development (to include American G.I. Forum, LULAC, NAACP, Tuskegee Airmen, Inc.)
For VA customer service, call: **1-800-827-1000**

To learn more about VA Benefits, visit: [benefits.va.gov](http://benefits.va.gov)

For more specific questions, access: [Inquiry Routing & Information System (IRIS)](https://iris.va.gov)

Subscribe to the VBA Benefits Bulletin

Regional Office Directory
Lawrence Connell
Chief of Staff for the Under Secretary
VA Veterans Health Administration
• Customer Service
• Implementing the MISSION Act
• Electronic Health Record
• Transforming our Business Systems
Minority Veterans’ Unique Healthcare Challenges

• Chronic disease disparities
  o Higher rates of hypertension and diabetes among older minority Veterans, especially Blacks and Hispanics

• Access to Health Care
  • Health Care access is an important determinant of health outcomes.
  • A prostate cancer study published in JAMA Oncology showed that where access is equal, survival rates are equal between blacks and whites.
Shrinking the Disparity

VHA is developing innovative solutions for closing the gap of health disparities

• Outreach programs designed to increase minority Veterans’ use of services
  o For example, VA Heart of Texas Health Care Network (VISN 17) implementation of MOVE! Program.

• Diversity training programs aimed at increasing staff members’ understanding of patients’ cultural needs.
  o Cultural Competency
  o Unconscious Bias
Charged with reducing disparities in healthcare and enabling all Veterans to achieve equitable health outcomes

• Partners with program offices and medical centers to increase access to equitable care.

• Working with Mental Health on Suicide Prevention
  o Requires identifying and reducing the life stressors that lead to vastly different rates of suicide among different groups of Veterans.
  o Making materials more culturally oriented.
Outreach to Minority Veterans

- Current VHA priorities such as achieving high reliability, improving access to care, supporting Whole Health for Veterans, and reducing variation depend upon reaching out to Minority Veterans.

- Suicide is the highest clinical priority for VA. Suicide is a national health concern that affects all Americans. That’s why we are working with community partners across the country — including faith communities, employers, schools, and health care organizations — to prevent suicide among all Veterans, including those who may never come to VA for care.
  - The rate of suicide was 2.2 time higher among female Veterans compared with non-Veteran women.

- VA is committed to ending homelessness among Veterans. VA conducts outreach to proactively seek out Veterans in need of assistance.
• Successful launch June 6th
• Streamlined community care program
• Strengthens VA’s care and empowers Veterans to choose their care
VA MISSION Act of 2018

Dr. Jennifer E. MacDonald
Director
VA Office of Clinical Innovations & Education
Leading the Future
Delivering an excellent experience of care for Veterans, families, and caregivers is at the core of VA’s approach to the MISSION Act.

VA is one integrated system with direct and community aspects of care delivery.

The MISSION Act strengthens both aspects of care delivery and empowers Veterans to find the balance in the system that is right for them.

VA is leveraging this opportunity to grow into an optimized, customer-centric network.
MISSION Act Key Elements

- Strengthens VA’s ability to recruit and retain clinicians
- Expands eligibility for caregiver services to all eras of Veterans
- Empowers Veterans with increased access to community care
- Combines multiple community care programs into a unified integrated experience
- Authorizes “Anywhere to Anywhere” telehealth provision across State lines
- Creates ability for VA to match infrastructure to Veteran needs
- Establishes a VA Center for Innovation for Care and Payment
- Establishes access to urgent care in the community

Choose VA
VA
U.S. Department of Veterans Affairs
MISSION Act Timeline
Implementation Readiness

- Communications
- Regulations
- Processes & Policies
- Training
- Technology
- Acquisitions

Stakeholder Engagement and Cross-functional Collaboration
June 6, 2019: Successful Launch

Operational Community Care Program

Supported by Veteran Education

Transformational Drivers

- Strategic Plan
- Underserved Facilities
- Recruitment and Retention
- Staffing Capacity
- Telehealth Strategy

Operational Community Care Program Supported by Veteran Education
**Veteran Engagement**

**VA MISSION Act**

**How will the MISSION Act benefit Veterans?**

The MISSION Act empowers Veterans and enhances care options. VA will:

1. Continue to be a trusted, caring partner.
2. Meet Veterans where they are, with the right care at the right place and the right time.
3. Provide telehealth in their home, in a VA facility, or in the community.
4. Focus on providing an excellent experience for Veterans and their families.

[Image: ChooseVA]

For more information on the VA MISSION Act, visit [www.missionact.va.gov](http://www.missionact.va.gov)

[Image: ChooseVA]

**VA MISSION Act**

**How will the MISSION Act benefit VA staff members?**

The MISSION Act empowers employees and strengthens VA care nationwide. The MISSION Act:

1. Improves ways to hire staff and keep them onboard.
2. Creates “Anywhere to Anywhere” telehealth that links Veterans with their care teams across state lines.
3. Allows VA to lead with cutting-edge technology.

[Image: ChooseVA]
VA MISSION Act

Your Care is Our Mission

Through state-of-the-art facilities, cutting-edge technology, and increased clinician recruiting and retention incentives, VA continues to enhance its coordinated care system through high-quality VA health care and community care provider networks.

Enrolled Veterans will soon receive a brochure in the mail which outline the changes to the Community Care program effective June 6.

To learn more about the MISSION Act go to www.missionact.va.gov

Enhanced VA Options Under the MISSION Act: Important Information for Veterans
Community Urgent Care Signage

*English and Spanish
Community Partner Engagement

More than 7.5M engagement opportunities with Veterans, families, caregivers, and survivors

Partnerships in Action for MISSION Act outreach:
- RallyPoint 1.6M
- Walgreens 4.2M
- VetTix 1.2M
- Team Red, White, and Blue 141k
- Student Veterans of America 1,500 schools; 700k students
- College Campuses (VBA VetSuccess on Campus Program) 104 sites; 86k students
- DoD Military Installations (VBA Integrated Disability Evaluation System Program) 71 installations; 18k active cases
- Community Veterans Engagement Boards (CVEBs) 152 boards

MISSION Act links, booklets, and brochures information provided to:
- State VA/ County VA
- Consumer Financial Protection Bureau
- Administration for Community Living (HHS)
- Military OneSource
- DOL DVOPs/LVERs
- LinkedIn
- Elizabeth Dole Foundation
- Bob Woodruff Foundation
- America’s Warrior Partnership
- Boulder Crest Institute
- American Legion Auxiliary
- Code of Support
- National Ass. of Veteran Serving Organizations
- TAPS
- Red Cross MVCN
- Marcus Institute for Brain Health
- Cohen Veteran Network
Implementation Achievements

- Three critical regulations completed on schedule
- Eleven Congressionally Mandated Reports delivered on time
- Decision Support Tool in the cloud and enabling software pushed to 400,000+ devices on schedule; follow-on software upgrades successful and ongoing
- Veteran education brochure mailed to ~9 million enrolled Veterans
- New community urgent care network established
- VA Health Care Options handbook distributed to all facilities and shared with VSOs
- Training goals met and exceeded; follow-on focused training complete
- Training provided for National and local VSOs
- External and internal communications toolkits published and shared with stakeholders
- Field Implementation Guide published and distributed
- Community Care Guidebook published and distributed
- New Veteran feedback dashboards established: contact centers, social media, VA.gov
- Improvement achieved in the prompt payment of providers
- Completed more internal and external clinical consults on June 6th than expected at baseline
- Additional call center capacity launched, and collaboration with VSO call centers initiated
- MISSION Act landing page created on VA.gov and continually updated
- Joint Operations Center established with VHA, OIT, Communications, and key Department subject matter experts
Toward On-Demand Access

Choose VA access
Care When You Need It

If you have a need for primary or mental health care right away, you can have it addressed the same day during regular business hours.

The tools you want for the care you need!

- See a member of your PACT
- Get answers through secure messaging
- Pharmacy access and refills online or by phone
- Tele-health video conferencing
- Call your PACT or Mental Health Team with questions or for information

At the [Facility Name] you can be seen by your provider or another appropriate clinical staff member, based on availability and your care needs; via telephone, smart phone, through video care, secure messaging, or other options. For medical emergency always call 911 or report to the emergency room closest to where you are located.

Talk to your Patient Aligned Care Team (PACT) or your Mental Health Team to learn about your options and timely access to care when you need it.
2018

- >2.2 million episodes of care
- >780,000 Veterans served
  - 900 VA sites of care
  - 88-90% Satisfaction
- ~13% of Veterans received an element of their care through a telehealth modality
Jacquelyn Hayes-Byrd
Executive Director
VA Center for Women Veterans
Supporting Women Veterans

Center for Women Veterans

Briefing presented to
Minority Veterans Summit

Presented By Jacquelyn Hayes-Byrd, Executive Director
Center for Women Veterans
Center for Women Veterans established November 2, 1994 by Congress

Our Mission:
- To monitor and coordinate VA’s administration of healthcare, benefits, services and programs for Women Veterans.
- To serve as an advocate for cultural transformation (within and in the general public) in recognizing the service and contributions of women Veterans and women in the military.
- To raise awareness of the responsibility to treat women Veterans with dignity and respect.

Our Vision:
Modernize the Center to become the portal for all things women Veterans and extend its outreach to all women Veteran Champions, reaching women Veterans nationally and internationally, ensuring equity in access, eligibility, care, and service delivery.
CWV’s Strategic Approach and Operating Plan identifies five critical areas in accordance with Public Law 103-446:

1. **Outreach**: Spread the good news among women Veterans
2. **Internal and External Advocacy**: For the needs of women Veterans
3. **Research**: Advocate for the inclusion of women in research that informs VA policy and practices
4. **Performance Management and Compliance**: Build a culture of compliance and accountability
5. **SECVA**: Support the Executive Director with sufficient resources

- **Modernization** and **Alignment** will ensure CWV assists with enterprise-wide performance management and compliance in order to ensure women Veterans receive equitable services and benefits.
Current Outreach Initiatives Include:

1. National Baby Shower (Tool Kit)
2. Monthly Partners Breakfast
3. Women Veterans Trailblazers Initiative
4. I am NOT INVISIBLE Campaign Toolkits
5. Women Veterans Summit - 2020
6. Recognize/Assist Congressional Women Veterans Task Force
7. Women Veterans “Champions” – Non-governmental, States, and across VA enterprise

Special thanks to Veteran Canteen Service for their sponsorship of our initiatives
CWV’s 2019 Annual Outreach Theme

Features a traveling photo and digital exhibit with auditory stories highlighting a diverse selection of women Veterans Trailblazers.
I am Not Invisible (IANI) Campaign

Innovating health care and just outcomes, while unmasking our true character.

Women Veterans and Survivors Awareness and Advocacy Month.

ChooseVA

VA | U.S. Department of Veterans Affairs
• Browse the VA Website, become familiar.
• VHA Women Veterans Call Center: Call or Text **1-855-VA-WOMEN** or 1-855-829-6636.
  - Chat through WV Healthcare Website: [www.womenshealth.va.gov](http://womenshealth.va.gov/).
• VA Crisis Line: **1-800-273-8255 and press 1**.
• Chat online at [www.VeteransCrisisLine.net](http://www.VeteransCrisisLine.net) or send a text to **838255** to receive support from specially trained professionals, 24 hours a day, 7 days a week, 365 days a year.
• White House VA Hotline: **1-855-948-2311**.
Resources

- Other Resources from www.va.gov
- Caregiver Support: (http://www.caregiver.va.gov/)
- Make the Connection: (http://maketheconnection.net/)
- Homeless Veterans (http://www.va.gov/homeless/index.asp)
- Burials and Memorials: (http://www.cem.va.gov)
- Center for Women Veterans: (http://www.va.gov/womenvet/)
- MyHealthE Vet: (https://www.myhealth.va.gov/)
- Office of Survivors Assistance: www.va.gov/survivors/
1) Phone: (202) 461-6193
2) Email: 00w@VA.Gov
3) Find us online at www.va.gov/womenvet
4) Facebook and Twitter using @VAWomenVets
5) Women Veterans Call Center

6) Crisis Hotline:

Portal for All Things Women Veterans
Please Engage Our Presenters & Meet Fellow Veterans
Kimberly P McLeod
Deputy Vice-Chairman
VA Board of Veterans’ Appeals
Mission
The Board’s mission is to conduct hearings and decide appeals properly before the Board in a timely manner. 38 U.S.C. § 7101(a).

Background
The Board is the Secretary’s designee to decide appeals for all three administrations (VBA, VHA, NCA). The Board Chairman reports directly to the Secretary. 38 U.S.C. § 511(a).
Board 2.0 Priorities

**Service**
- To each other
- Across the VA enterprise
- Best service to Veterans and their families

**Modernization**
- Technology
- Process
- Streamline operations

**Action**
- Respond to inquiries
- Hold hearings
- Decide and issue decisions
Realigned to provide Veteran-facing service and meet the mission-critical requirements.
AMA Decision Review Process

Providing Veterans with more choice and control as well as clear and understandable communication.

VBA, VHA, and NCA

- **The Claim** (Establishes Effective Date)
- **Decision** (Improved Notice)
- **Supplemental Claim**
  - New Evidence
  - 125-Day Avg. Goal
- **Higher-Level Review**
  - Same Evidence
  - 125-Day Avg. Goal

Duty to assist

**Choice and Control**

Board of Veterans’ Appeals

- **Appeal (NOD)**
  - 3 Options
  - 365-Day Avg. Direct Docket Goal
- **No SOC or VA Form 9**
- **120 Days**
- **Court of Appeals for Veterans Claims**

Except for appeals to the Court, all filing deadlines are **one year**.
<table>
<thead>
<tr>
<th>Priorities 2016</th>
<th>Priorities Today</th>
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</thead>
<tbody>
<tr>
<td>Legacy appeals</td>
<td>Legacy appeals</td>
</tr>
<tr>
<td>Advancing AMA</td>
<td>AMA Direct Lane (Board) (365 days average processing goal)</td>
</tr>
<tr>
<td></td>
<td>AMA Evidence (Board)</td>
</tr>
<tr>
<td></td>
<td>AMA Hearings (Board)</td>
</tr>
</tbody>
</table>
### Which AOJ lane to choose?

<table>
<thead>
<tr>
<th>When to choose</th>
<th><strong>Supplemental Claim</strong></th>
<th><strong>Higher Level Review</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim needs new evidence.</td>
<td>If you don’t need new evidence, but think a mistake was made.</td>
<td></td>
</tr>
<tr>
<td>The Duty to Assist applies and VA will help you gather the evidence.</td>
<td>A higher-trained AOJ reviewer will review your claim and make a new decision.</td>
<td></td>
</tr>
<tr>
<td>A new decision will be made looking at the new evidence.</td>
<td>No new evidence will be added.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How long</th>
<th><strong>Supplemental Claim</strong></th>
<th><strong>Higher Level Review</strong></th>
</tr>
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<tbody>
<tr>
<td>125 days (on average)</td>
<td>125 days (on average)</td>
<td></td>
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</table>

*AOJ= Agency of Original Jurisdiction (VBA, VHA, or NCA)*
## Which Board docket to choose?

<table>
<thead>
<tr>
<th></th>
<th>Direct</th>
<th>Evidence</th>
<th>Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When to choose</strong></td>
<td>If you think a <strong>mistake</strong> was made.</td>
<td>If you have <strong>new evidence</strong> you want a Judge to consider.</td>
<td>If you want a <strong>hearing</strong> before a Judge.</td>
</tr>
<tr>
<td><strong>What will happen</strong></td>
<td>The Judge will review the same record and make a decision.</td>
<td>You will have <strong>90 days</strong> from your NOD to submit any new evidence.</td>
<td>You will be placed on a list for a hearing before a Judge by videoconference (or in DC).</td>
</tr>
<tr>
<td></td>
<td><strong>No new evidence</strong> will be added.</td>
<td>The Judge will make a decision considering the evidence you provided.</td>
<td>After your hearing you will have <strong>90 days</strong> to submit new evidence.</td>
</tr>
<tr>
<td><strong>How long</strong></td>
<td><strong>365 days</strong> (on average)</td>
<td><strong>Over 365 days</strong></td>
<td>Based on availability. Currently the Board has 98 Judges. There are approximately 69,000 Veterans waiting for hearings.</td>
</tr>
</tbody>
</table>
Fill out VA Form 10-182 to appeal to the Board of Veterans' Appeals.

- If you want the Board to review your case as quickly as possible, choose Direct Review.
- If you have additional evidence for the Board to review, choose Evidence Submission.
- If you want a video conference hearing with the Board, choose Hearing Request.
- If you choose the same lane for all appeals, use one form.
- If you choose separate lanes for appeals, use separate forms.
### Legacy System

- Remand for:
  - Duty to assist (DTA) errors that occurred at any time during the pendency of the appeal
  - Medical examinations and opinions
  - *Stegall* compliance

- Following required development, AOJ makes a new decision. Unless the AOJ can grant, the appeal is returned to the Board with the same docket number.

### New System

- Remand for:
  - DTA errors (including related to examinations), **but only if the error occurred prior to the AOJ adjudication on appeal (pre-decisional)**

- Board cannot request VHA or independent medical opinions

- Appeals **not** automatically returned to the Board following development.
Board Legacy Appeals Inventory

LEGACY APPEALS INVENTORY

Peak end of February 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>FY 2018</th>
<th>FY 2019</th>
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<tbody>
<tr>
<td>Oct</td>
<td>156,195</td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td></td>
<td>100,947</td>
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<td>Dec</td>
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<tr>
<td>Sep</td>
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</tbody>
</table>

End of FY 2018

- 137,016
AMA APPEALS INVENTORY

FY 2018
FY 2019

Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep

0 367

14,852
Legacy Hearings Pending

Pending Hearing Requests

17% Decrease
(12,951) while still receiving requests)

End of FY 2018: 75,946

10-Month Period:

August 2019: 62,995
FY19 Accomplishments

• Fully implemented AMA as of its effective date of February 19, 2019, in collaboration with VA colleagues.
• Judges and attorneys work all dockets in legacy and AMA to ensure VA keeps the March 2016 promise to prioritize legacy takedown and work AMA cases.
• Continued support for Advance on the Docket status for Veterans living in locations impacted by natural disasters as well as automatic ADO status for Veterans aged 75 years and older.
• Established Caseflow access for VSOs and other stakeholders.
• Expanded eFolder Express access to allow Veterans and their advocates to download the claims file.
• Initiated surveys in collaboration with VEO. These surveys query Veterans about their experiences during the appeals process at four major stages NOD, Board docketing (legacy), hearing, and decision.
• Transitioned hearing scheduling from VBA in April 2019 and implemented new processes and technologies—learning much and beginning to implement standard procedures for hearings.
• Onboarded 253 personnel.
FY20 and Beyond

- Prioritizing the drawdown of the legacy appeals inventory.
- Testing tele-hearing technology, a version of VHA’s tele-health platform, to help ensure hearings are more accessible to and convenient for Veterans by allowing Veterans to attend hearings using personal devices.
- Adopting VEText to communicate with Veterans via text message to remind Veterans of upcoming hearings.
- Using feedback provided through surveys to improve the appeals experience for Veterans.
- Revising all letters and decisions to ensure Veteran-focused communication.
Useful Links

• Board’s webpage:  
  https://www.bva.va.gov/

• Vets.gov appeals status tracker:  
  www.va.gov
Dr. Kameron Matthews
Deputy Under Secretary
VA Health for Community Care
 Agenda

- History of Community Care
- VA MISSION Act
  - Overview of Key Elements
  - Community Care Changes
  - Expanded Eligibility
  - Urgent Care Benefit
  - Required Provider Training
- Community Care Network (CCN)
- Community Care Resources
History of VA Community Care

1945: Hometown Program
   - VA sets precedent for collaboration with community providers through Hometown Program provider agreements.

1947: Academic Teaching Affiliates
   - VA continues to expand care and training through academic teaching affiliates.

1983: Department of Defense
   - Congress enacts the VA and DoD Health Resources Sharing and Emergency Operations Act to promote health care resource sharing between VA and DoD.

2007: Project ARCH
   - Congress establishes Project Access Received Closer to Home (ARCH) to increase access care for rural Veterans.

2011: PC3 & National Dialysis Contract
   - Patient-Centered Community Care (PC3) established as contracting vehicle to partner with community providers. National Dialysis Contracts to assist in purchasing care.

2012: Veterans Choice Program (VCP)
   - Congress expands Veterans access to community care in response to excessive wait-times and delays.

2013: Indian Health Service
   - Tribal Health Service established reimbursement agreements for care provided to eligible Veterans.

2014: Plan to Consolidate
   - VA submits Community Care consolidation plan to Congress.

2015: Community Health Service
   - VA MISSION Act Passage
     - Consolidated multiple community care programs and appropriated $5.2 billion in VCP funding.

2018: VA MISSION Act Implementation
   - Major changes implemented including expanded eligibility and urgent care benefit for Veterans.

2019: VA MISSION Act Network
   - CCN Contract Awards
**VA MISSION Act: An Overview Of Key Elements**

<table>
<thead>
<tr>
<th>What is the MISSION Act?</th>
<th>Key Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 will fundamentally transform VA’s health care system. It will fulfill the president’s commitment to provide Veterans with more choice in their health care providers. The Act includes four main pillars:</td>
<td><strong>Community Care</strong> - Consolidates VA’s multiple community care programs into one that is easier to navigate for Veterans and their families, community providers and VA employees.</td>
</tr>
<tr>
<td><strong>1. Consolidating VA’s community care programs.</strong></td>
<td><strong>Caregivers Program</strong> - The Act expands eligibility for VA’s Program of Comprehensive Assistance for Family Caregivers (PCAFC) by including eligible Veterans from all eras of service.</td>
</tr>
<tr>
<td><strong>2. Expansion of Caregivers Program</strong></td>
<td><strong>Asset and Infrastructure</strong> - The Asset and Infrastructure Review (AIR) process in the Act will provide VA the necessary flexibility to align its infrastructure footprint with the needs of the nation’s Veterans.</td>
</tr>
<tr>
<td><strong>3. Flexibility to align its asset and infrastructure</strong></td>
<td><strong>Recruit and Retain</strong> - The Act will allow for additional, improved recruitment efforts, including a new scholarship program, greater access to VA’s education debt-reduction program and improved flexibility for providing bonuses for recruitment, relocation and retention.</td>
</tr>
<tr>
<td><strong>4. Strengthening VA’s ability to recruit and retain health care professionals.</strong></td>
<td></td>
</tr>
</tbody>
</table>

**What is it NOT?**

The MISSION Act is not a step toward privatization. It’s about significantly improving Veterans’ experience and enhancing their access to care.
Community Care: Key Changes

New for Veterans

Veterans receive new benefits under the Veterans Community Care Program. These benefits include:

- Access to urgent care
- Expanded eligibility for community care
- Scheduling by the Veteran and VHA
- Technology that streamlines communication

New for Community Care Providers

Establishment of the Community Care Network and Veterans Care Agreements. Community providers must now:

- Undergo an industry standard credentialing process
- Complete mandatory training
- Be subject to an exclusionary process
- Submit claims within 180 days from date of service

New for VA Staff

Introduction of new and modernized IT systems and business processes that will result in:

- Fewer manual process / increased automation
- Increased availability of processes metrics
- Broader options for care coordination
- Faster, easier, auditable information sharing
MISSION Act: Expanded Eligibility Overview

**Best medical interest of the Veteran**
- Required care or services are not offered
- Care or services are non-compliant with VA’s standards for quality
- Lack of full-service medical facility
- 6 Community Care eligibility criteria established by MISSION Act
- Care or services not provided within designated access standards
- Grandfathered eligibility from Veterans Choice Program

**ACCESS STANDARDS**

<table>
<thead>
<tr>
<th></th>
<th>Primary Care, Mental Health, Non-institutional Extended Care</th>
<th>Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drive Time</strong></td>
<td>30 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td><strong>Wait Time</strong></td>
<td>20 days</td>
<td>28 days</td>
</tr>
</tbody>
</table>

ChooseVA
VA
U.S. Department of Veterans Affairs
MISSION Act: New Urgent Care Benefit

**Coverage**
Veterans access providers in the network when it is convenient for them without needing pre-authorization.

**Eligibility**
To be eligible for urgent care, Veterans must:
- Be enrolled in the VA health care system AND
- Have received care through VA from either a VA or community provider within the past 24 months

**Copays**
Access to urgent, non-emergency care (e.g. non-life threatening conditions) through the VA contracted network. Services such as:
- Colds
- Ear infections
- Minor injuries
- Pink eye
- Skin infections
- Strep throat

**Priority Group(s) Copayments based on number of visits in a calendar year**

<table>
<thead>
<tr>
<th>Visits</th>
<th>First three visits</th>
<th>4th and greater visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>$0</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>6</td>
<td>$0</td>
<td>$30 per visit</td>
</tr>
</tbody>
</table>

If related to a condition covered by special authority or exposure:
- First three visits: $0
- 4th and greater visits: $30 per visit

If not related: $30 per visit

7-8 $30 per visit
BILLING

Providers submit medical records to VA for appropriate follow up

BILLING

URGENT CARE

Providers submit medical records to VA for appropriate follow up

BILLING

URGENT CARE PRESCRIPTIONS:

VA will pay for or fill prescriptions

- Provider may write prescriptions for up to a 14-day supply
- Prescriptions can be filled at a contracted pharmacy within the VA network, in VA, or at a non-contracted pharmacy
  - If a noncontracted pharmacy is used, Veterans must pay for the prescription and then file a claim for reimbursement with the local VA medical facility
- To find an in-network pharmacy, providers and Veterans can use the VA Facility Locator

BILLING:

Urgent care provider bills VA's Third Party Administrator (TPA) and VA may bill the Veteran the applicable copayment
**MISSION Act: Required Provider Training**

**VA MISSION Act (Section 131 and 133):** Establishes new requirements for non-department providers treating Veterans.

- Ensures safe opioid prescribing practices
- Establishes new competency standards and requirements
- VA developed training courses that all licensed independent providers must complete.

**Independent Licensed Providers**

*All providers with an NPI who treat Veterans must complete VA required training courses*

- VHA TRAIN (https://www.train.org/vha/), an external learning management system, to host the training courses.
- Providers must create an account in VHA TRAIN and include an NPI number in their VHA TRAIN profile before registering and completing training.
- Applies to providers who work through:
  - PC3 (and TriWest)
  - CCN (and CCN TPAs (Optum and TriWest))
  - Veterans Care Agreements (and VA)
The Community Care Network (CCN) is a new set of region-based contracts to provide health care services in the community through a contractor who builds the associated network and processes claims.

Benefits of the CCN:

- Gives VA control of Veteran care and experience
  - VA is taking back scheduling, care coordination, and customer service functions

- Gives VA convenient access to a network of qualified, credentialed providers

- Gives VA a streamlined community care processes
  - by including more services under CCN
  - by no longer adjudicating claims

Community providers wanting to deliver care to our nation’s Veterans can contact Optum at Join Optum VACCN Network or VACCNProviderContracting@optum.com. (Regions 1, 2, and 3)
Community Care Resources

General Information
- **MISSION ACT 101: How the law will improve VA’s ability to deliver health care to Veterans** – Provides an overview of changes under the VA MISSION Act. (VAntage Point, 02/11/19)
- **VA MISSION Act: What is the latest on community care?** - Highlights VA’s efforts to-date for improving community care, what to expect, and next steps. (VAntage Point, 03/19/19)
- **Fact Sheet: Veteran Community Care – General Information (VA MISSION Act of 2018)** – Provides greater detail about community care improvements, processes, expected timeframes, and FAQs. (VAntage Point, 04/09/19)

Eligibility
- **VA MISSION Act: Will you be eligible for community care?** Highlights general requirements surrounding community care eligibility and describes the six criteria under the VA MISSION Act (VAntage Point, 04/09/19).
- **Fact Sheet: Veteran Community Care – Eligibility (VA MISSION Act of 2018)** – Provides greater detail about community care eligibility, examples of how the six criteria would be applied, and FAQs.

Community Care Website (External):
- [https://www.va.gov/communitycare/](https://www.va.gov/communitycare/)

Community Care YouTube Playlist
- [https://www.youtube.com/playlist?list=PL3AQ_JVoBEyys0cr7PzSVvnW1_YVYFs1p](https://www.youtube.com/playlist?list=PL3AQ_JVoBEyys0cr7PzSVvnW1_YVYFs1p)

Communication Resources

<table>
<thead>
<tr>
<th>General Information</th>
<th>Sunset of Choice Program</th>
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</thead>
<tbody>
<tr>
<td><strong>Webpage (Public)</strong></td>
<td><strong>Webpage (Public – Providers)</strong></td>
</tr>
<tr>
<td><strong>Article/Blog</strong></td>
<td><strong>Webpage (Public – Veterans)</strong></td>
</tr>
<tr>
<td><strong>Fact Sheet/FAQs</strong></td>
<td><strong>Article/Blog</strong></td>
</tr>
<tr>
<td><strong>Video</strong></td>
<td><strong>Fact Sheet/FAQs</strong></td>
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<tr>
<td><strong>Current vs. Future Information Sheet</strong></td>
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<tr>
<td><strong>Top Questions Answered Article/Blog</strong></td>
<td></td>
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</table>

<table>
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<th>Eligibility</th>
<th>Urgent Care</th>
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<td><strong>Video</strong></td>
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<tr>
<th>Appointments/Getting Care</th>
<th>Emergency Care</th>
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<tr>
<th>Billing and Payments</th>
<th>Veteran Care Agreements</th>
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<tr>
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<tr>
<td><strong>Fact Sheet/FAQs</strong></td>
<td><strong>Fact Sheet/FAQs</strong></td>
</tr>
</tbody>
</table>
LUNCH BREAK

Please Return by 12:45PM
Suicide Prevention

Dr. Lisa Kearney
Acting Deputy Director
VA Suicide Prevention Program
Lisa K. Kearney, Ph.D., ABPP
Acting Deputy Director, Suicide Prevention
Department of Veterans Affairs

Acknowledgements

Brooke A. Dorsey Holliman, Ph.D.
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Gloria Workman, Ph.D.

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Andrew Moon, Ph.D.

Taunya Jones
Theresa Welch
Emily Howell
Hannah Huntt
Lillie Thurman
The Public Health Approach

VA Suicide Prevention Strategy
Suicide Prevention is Everyone’s Business

- Continue to increase impact of Office of Mental Health and Suicide Prevention
- Reach Veterans and their families
- Develop innovative prevention strategies
- Change the conversation about suicide
- Build community engagement

Choose VA

U.S. Department of Veterans Affairs
National Academy of Medicine (NAM) Classification

**Universal (all)**
Universal prevention strategies are designed to reach the entire Veteran population.

**Selective (some)**
Selective prevention strategies are designed to reach subgroups of the Veteran population that may be at increased risk.

**Indicated (few)**
Indicated prevention strategies are designed to reach individual Veterans identified as having a high risk for suicidal behaviors.
Public health is about working within communities
https://www.youtube.com/watch?v=5woA7SLj4uo
Suicide Data for Minority Veterans
Veteran Population by Race/Ethnicity (2016)

Distribution of Veteran Suicides by Race/Ethnicity (2001-2016)

- White: 76.9%
- African-American: 13.8%
- Hispanic or Latino: 4.6%
- Asian: 2.7%
- Other: 0.9%
- 2+ Races: 0.7%
- American Indian or Alaskan Native: 0.4%
- Native Hawaiian and Pacific Islander: 0.2%
- Unknown: 0.1%

Veteran Population by Race/Ethnicity (2016)

- White: 76%
- African-American: 11%
- Hispanic or Latino: 7%
- Asian: 2%
- Other: 2%
- 2+ Races: 1%
- American Indian or Alaskan Native: 1%
- Native Hawaiian and Pacific Islander: 0%
Older Veteran population accounts for the bulk of suicide deaths due to population size.

Younger Veteran population includes more recently transitioned Veterans and has a higher rate of suicide.
Veteran Population Projection

Veteran Population Projections by Minority Status, 2014-2043

Source: Department of Veterans Affairs, Office of Policy and Planning, Veterans population Projection Model, 2014
Prepared by the National Center for Veterans Analysis and Statistics
American Indian and Alaskan Native Veterans

• Relative to Veterans of other races and ethnicities, American Indian (AI) and Alaskan Native (AN) Veterans are more likely to have PTSD and other mental health disorders, including depression and substance use disorders.

• AI/AN Veterans face significant barriers in access to care:
  – Less likely to be insured than non-Hispanic white Veterans.
  – More likely to delay care than non-Hispanic white Veterans because of transportation problems, not getting through on the phone, and not obtaining a timely appointment.
  – Report difficulty coordinating care across VA and Indian Health Service systems.
  – More likely to live in rural and highly rural areas. AI/AN populations in general report unmet needs for mental health care.
Protective Factors for African American Women (Dorsey-Holliman et al., 2018)

• **Resilience**
  – Experiencing and overcoming adversity
  – Family and community teaching resilience through upbringing

• **Social Support**
  – Family and friends
  – Impact that suicide would have on others, especially children and grandchildren

• **Religion**
  – Faith in God
  – Personal practices, such as daily prayers
  – Religious beliefs leading to negative perceptions of suicide

• It is possible that what is found to be protective for African American Women Veterans may buffer against suicide risk in other populations as well, irrespective of race or gender.
In 2015, 3.7% of all Veteran suicide decedents were identified as Hispanic.

- The percent of Hispanic Veteran suicides was similar for those with and without recent VHA care.

In 2015, 7.1 percent of the Veteran population was estimated to be Hispanic and over the next 10 years, the Hispanic Veteran population is expected to increase by 23 percent to almost 9 percent, or to 1.5 million Veterans.

The states with the largest populations of Hispanic Veteran populations are Texas, California, Florida, Puerto Rico, and New York.
Utilization of Mental Health Services in Minority Populations
• A review of more than 130 studies found that the following factors may be associated with lower service utilization by racial and ethnic minorities diagnosed with severe mental health conditions:
  – Poverty (individual and community level)
  – Stigma
  – Mistrust of healthcare system
  – Lack of familial involvement
  – Religion/spirituality
  – Cultural beliefs (Maura & de Mamani, 2017)
### Increasing Mental Health Service Utilization by Racial and Ethnic Minorities

<table>
<thead>
<tr>
<th>Factor</th>
<th>Community Level</th>
<th>Provider Level</th>
<th>Patient Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Poverty</strong></td>
<td>Increase access to services in underserved areas, including expanding the number of organizations that offer services locally</td>
<td>Train more primary care and community providers to recognize mental health conditions and offer an integrated approach to care for mental health</td>
<td>Educate patients about various mental health resources available to them through community centers or other organizations</td>
</tr>
<tr>
<td><strong>Stigma</strong></td>
<td>Anti-stigma and outreach campaigns can promote awareness and educate the public about mental health services</td>
<td>Promote contact between patients and providers, which helps destigmatize mental health services and improve clinical interactions</td>
<td>Engage in peer support groups or treatments that discuss issues related specifically to minorities and overcoming stigma</td>
</tr>
</tbody>
</table>

(Maura & de Mamani, 2017; Alegria et al., 2016)
### Increasing Mental Health Service Utilization by Racial and Ethnic Minorities

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Mistrust of the healthcare system</strong></td>
<td>Increase the diversity of providers available to the community</td>
<td>Encourage collaborative care and shared decision-making, and offer education to patients in a culturally sensitive manner</td>
<td>Enhance ability of patients to engage in treatment decisions, including weighing the benefits and side effects of various treatments</td>
</tr>
<tr>
<td><strong>Lack of familial involvement</strong></td>
<td>Implement family-focused programs and treatments</td>
<td>Strive to engage families in the patient’s treatment plan when appropriate</td>
<td>Encourage patients to ask for family involvement in their treatment plans where desired</td>
</tr>
</tbody>
</table>

(Maura & de Mamani, 2017)
## Increasing Mental Health Service Utilization by Racial and Ethnic Minorities

<table>
<thead>
<tr>
<th>Factor</th>
<th>Community Level</th>
<th>Provider Level</th>
<th>Patient Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religion/spirituality</strong></td>
<td>Encourage religious organizations to offer evidence-based mental health services or provide referrals to other organizations for mental treatment</td>
<td>Obtaining information about patients’ religious orientations and beliefs may help inform treatment protocols</td>
<td>Incorporate positive aspects of religious beliefs and coping mechanisms, including exploring mental health services that may be offered through religious institutions</td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td>Involve the community in dialogues and the development of programs that target cultural awareness in mental health treatment</td>
<td>Offer training in cultural competence and creating a culturally sensitive patient–provider rapport</td>
<td>Patients can convey their diverse values and preferences to engage in and adhere to culturally appropriate treatments</td>
</tr>
</tbody>
</table>
Racial and ethnic disparities in Veteran’s healthcare utilization require additional research.

- African American and Hispanic Veterans use inpatient mental health services less than white Veterans. However, Hispanic, African American, Asian, and American Indian Veterans use outpatient, primary care, and emergency services significantly more than white Veterans (Koo et al., 2015).
- African American Veterans with schizophrenia or bipolar disorder are more likely than white Veterans with either condition to disengage from treatment at the 12-month follow-up (Fischer et al., 2008).
- African American and Hispanic Veterans are over three times more likely to utilize mental health services than their civilian counterparts. Prior military service increases the odds of seeking care (De Luca et al., 2016).
VA Work to Address Healthcare Disparities

- VA’s Center for Minority Veterans (CMV) serves as an advocate for minority Veterans by conducting outreach activities to promote the awareness and use of VA benefits and services.
- CMV identifies barriers to service and health care access and increases awareness of minority Veteran related issues by developing strategies for improving minority participation in existing VA benefit programs.
- Three primary initiatives include:
  - Minority Veterans Program Coordinator
  - Advisory Committee on Minority Veterans
  - Veteran Business and Economic Development Outreach
- CMV collaborates with 265 Minority Veterans Program Coordinators across the country.
VA Innovative Practices in Suicide Prevention

VA Suicide Prevention Strategy
• The #BeThere suicide prevention initiative teaches members of the community how simple actions can help save the life of a Veteran in crisis. [www.veteranscrisisline.net/bethere.aspx](http://www.veteranscrisisline.net/bethere.aspx)

• Make the Connection connects Veterans, their family members and friends, and other supporters with information on issues that affect Veterans. [www.maketheconnection.net](http://www.maketheconnection.net)

• Coaching Into Care (1-888-823-7458) is a national telephone service from VA that aims to educate, support, and empower family members and friends who are seeking care or services for a Veteran. [www.mirecc.va.gov/coaching](http://www.mirecc.va.gov/coaching)
The Rocky Mountain MIRECC TBI Toolkit gives mental health clinicians information for addressing the needs of military personnel and Veterans with co-occurring TBI and mental health conditions. www.mirecc.va.gov/visn19/tbi_toolkit

CRISTAL is the national expansion of REACH VET predictive models, summarizing key information from Veterans’ health records and calculating their National REACH VET suicide risk tier.

To improve lethal means safety, VA is training providers in lethal means safety counseling and educating Veterans and their families about how safe storage of lethal means can save lives.
• REACH VET uses data to identify Veterans at high risk for suicide, notifies VA providers of Veterans’ risk assessment, and enables providers to re-evaluate and enhance Veterans’ care.

• The VA Suicide Risk Management Consultation Program provides a free, one-on-one consultation for any community or VA provider who works with Veterans. www.mirecc.va.gov/visn19/consult

• The Toolkit for Therapeutic Risk Management of the Suicidal Patient uses clinical, medical, and legal best practices to inform a model for the assessment and management of suicide risk. www.mirecc.va.gov/visn19/trm
VA Suicide Risk Assessment Three-Stage Process

Primary Screen (PHQ-9 Item 9)

- Item #9 will be added to existing clinical reminders for Depression and PTSD
- Identifies those who may be at risk

Secondary Screen (C-SSRS Screen)

- Questions specifically query about suicidal thoughts and behavior
- Improves specificity of screening

VA Comprehensive Suicide Risk Evaluation

- Conducted via new template designed to inform clinical impressions about acute and chronic risk and associated disposition
VA Suicide Prevention Resources for Veterans, Family Members, and Caregivers

VA Suicide Prevention Strategy
Free, Confidential Support 24/7/365

Veterans Crisis Line | Military Crisis Line

1-800-273-8255 PRESS 1

Confidential chat at VeteransCrisisLine.net or text to 838255

- Veterans
- Service members
- Family members
- Friends
S.A.V.E. Training

• Suicide prevention training video that’s available to everyone, 24/7
• Less than 25 minutes long
• Offered in collaboration with the PsychArmor Institute

Available online for free: psycharmor.org/courses/s-a-v-e/
Online resource featuring hundreds of Veterans telling their stories about overcoming mental health challenges.

Hundreds of videos at makeTheconnection.net
Coaching into Care

National VA telephone service which aims to educate, support, and empower family members and friends who are seeking care or services for a Veteran.

CALL 888-823-7458
September is Suicide Prevention Month

- Use this opportunity to show your support for Veterans in your community by:
  - Challenging your organization and extended networks to watch and share the S.A.V.E. training video
  - Sharing campaign materials and graphics in your newsletters and on social media (all resources are available on our new website, www.BeThereForVeterans.com)
  - Posting a short video message on your social media channels to encourage your followers to Be There for Veterans.
    - Don’t forget to use #BeThere and #SPM2019 in your posts!
  - Reminding your networks about the importance of safe messaging around suicide and sharing VA’s Safe Messaging Fact Sheet.
September is Suicide Prevention Month

#SPM19

#BeThere for service members and Veterans.

We encourage you to use the hashtags #BeThere and #SPM19 for all posts during SPM.

www.BeThereForVeterans.com
As discussed in the National Strategy for Preventing Veteran Suicide, social media is an important intervention channel and a key piece of VA’s comprehensive, community-based suicide prevention strategy.

The Social Media Safety Toolkit for Veterans, Their Families, and Friends equips everyone with the knowledge needed to respond to social media posts that indicate a Veteran may be having thoughts of suicide.

The toolkit includes best practices, resources, and sample responses.

Download at https://www.mentalhealth.va.gov/suicide_prevention/resources.asp
Jason Beardsley
Liaison
VA Veteran Service Organizations
Anthony Love
Senior Advisor & Director of Community Engagement
VHA Homeless Program Office
Please Engage Our Presenters & Meet Fellow Veterans
Health Equity

Ernest Moy, M.D., M.P.H.
Executive Director
VHA Office of Health Equity

– and –

Dr. Donna L. Washington, M.D., M.P.H.
VHA Greater Los Angeles Healthcare System
• Office of Health Equity: Created in 2012 to ensure that VHA provides appropriate individualized health care to each Veteran in a way that
  – Eliminates disparate health outcomes and
  – Assures health equity
• Products
    Update expected Winter 2020.
  – Data visualizations on disparities among Veterans (https://www.va.gov/HEALTHEQUITY/Data.asp)
  – Equity Guided Improvement Strategy tool
OHE works with VAMC partners including:

- VHA Office of Health Equity / Quality Enhancement Research Initiative National Partnered Evaluation Center, Los Angeles, to analyze health equity data on Veteran groups
- VA New England Healthcare System (VISN 1) to analyze data on health-related social risks among Veterans
- Center for Health Equity Research and Promotion, Pittsburgh, to translate performance metrics into operational equity tools
- VA Heart of Texas Health Care Network (VISN 17) to implement MOVE programs to reduce disparities faced by Hispanic Veterans
- VA Mid-Atlantic Health Care Network (VISN 6) and Innovations Ecosystem to implement programs to prevent diabetic foot ulcers, which disproportionately affect rural residents
Donna L. Washington, MD, MPH

- Director, VHA Office of Health Equity Enhancement Research Initiative National Partnered Evaluation Center
- Women’s Health Focused Research Area Lead, VA HSR&D Center for the Study of Healthcare Innovation, Implementation & Policy
- VA Greater Los Angeles Healthcare System
- Professor of Medicine, UCLA Geffen School of Medicine
• No competing conflicts of interest
• The views expressed are my own, and do not necessarily represent the position or policy of the Department of Veterans Affairs or of the U.S. government
Projected Growth in Racial/Ethnic Minority Veteran Population

- Currently 24% of Veteran population

% Distribution of Race/Ethnicity by Sex among Veteran VHA Patients

Disparities in Preventive Care Measures by Race/Ethnicity in VHA

Number and percentage of prevention measures for which members of selected groups experienced better, same, or worse quality compared with reference group, 2014 VHA Users

<table>
<thead>
<tr>
<th>Group</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN vs. White (n=10)</td>
<td>8</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Asian vs. White (n=9)</td>
<td>1</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Black vs. White (n=10)</td>
<td>9</td>
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<tr>
<td>Hispanic vs. White (n=10)</td>
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<tr>
<td>Multi-race vs. White (n=10)</td>
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<td>9</td>
</tr>
<tr>
<td>NHOPI vs. White (n=9)</td>
<td>9</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Key: n = number of measures; AI/AN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander.
American Indian/Alaska Native Disparities in Colo-rectal Cancer Screening

Source: Analysis of External Peer Review Program data from VHA Office of Reporting, Analytics, Performance, Improvement & Deployment (RAPID)

Colorectal Cancer Screening – adjusted odds ratio vs. White non-Hispanic

- **0.77** higher screening rates
- **1.34** higher screening rates
- **1.18** higher screening rates
- **1.1** higher screening rates
- **1.02** higher screening rates
- 1.02 higher screening rates
- **1.02** higher screening rates
- **1.02** higher screening rates
- 0.95 higher screening rates

AI/AN = American Indian/Alaska Native; NHOPI = Native Hawaiian / other Pacific Islander
Disparities in Preventable Outcome Measures by Race/Ethnicity in VHA

Number and percentage of prevention measures for which members of selected groups experienced better, same, or worse intermediate clinical outcomes compared with reference group, 2014

<table>
<thead>
<tr>
<th>Group</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
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</thead>
<tbody>
<tr>
<td>AI/AN vs. White (n=5)</td>
<td>2</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Asian vs. White (n=5)</td>
<td>0</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Black vs. White (n=5)</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Hispanic vs. White (n=5)</td>
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<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Multi-race vs. White (n=5)</td>
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<td>5</td>
<td>0</td>
</tr>
<tr>
<td>NHOPRI vs. White (n=5)</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Key: n = number of measures; AI/AN = American Indian or Alaska Native; NHOPRI = Native Hawaiian or Other Pacific Islander.
Race* & Gender** Disparities in Control of Cardiovascular Disease Risk Factors

**Hypertension Control**
- African-American Women: 70%
- African-American Men: 75%
- Hispanic White Women: 80%
- Hispanic White Men: 85%

**Diabetes Control**
- African-American Women: 75%
- African-American Men: 80%
- Hispanic White Women: 85%
- Hispanic White Men: 90%

**Lipid Control in Heart Disease**
- African-American Women: 65%
- African-American Men: 70%
- Hispanic White Women: 75%
- Hispanic White Men: 80%

VA race and gender disparities present for African-American women Veterans, but commercial plans have worse CVD risk factor control (e.g., hypertension control 62% in HEDIS 2016) and greater disparities.

Source: Analysis of External Peer Review Program data from VHA Office of Reporting, Analytics, Performance, Improvement & Deployment (RAPID)
Racial/Ethnic Mortality Disparities

Within VHA, racial/ethnic disparities for some groups
• AI/ANs have higher all-cause mortality vs. Whites
• Blacks have higher cancer and heart disease mortality

Between VHA and U.S. general population, patterns of mortality disparities differ
• AI/AN disparities in male VHA users, but not in U.S. population
• Black disparities in both male VHA and U.S. populations, but smaller in VHA
• No disparities in VHA for Black women, whereas disparities present in U.S. population

AI/AN = American Indian/Alaska Native;
Black = Black non-Hispanic; White = White non-Hispanic

Wong MS, et.al. Health Equity 2019;3(1).
Implications

• Identify underlying determinants of persistent disparities in preventable outcomes, such as determinants of the mortality disparities for AI/AN and Black Veterans

• Conduct ongoing monitoring of Veterans health and healthcare equity, including care delivered through VA and in the community

• Integrate strategies tailored to social determinants of health into quality improvement programs, involving community stakeholders in program design and evaluation

• Reach beyond health care system to community for help supporting life-long behavior change
Acknowledgements

• Collaborators: -- VA Greater Los Angeles HSR&D CSHIIP: W. Neil Steers, PhD; Elizabeth M. Yano, PhD, MSPH; Michelle Wong, PhD; Boback Ziaeian, MD, PhD
  – VA Palo Alto HSR&D Ci2i: Susan M. Frayne, MD, MPH; Fay Saechao, MPH
  – VA San Francisco HCS: Katherine J. Hoggatt, PhD, MPH

• OHE-QUERI National Partnered Evaluation Initiative Funding: VHA Office of Health Equity and Quality Enhancement Research Initiative

• Data:
  – Women’s Health Evaluation Initiative (WHEI) data: Women’s Health Services, Office of Patient Care Services, VHA
  – VA quality data (External Peer Review Program): VHA Office of Reporting, Analytics, Performance, Improvement & Deployment
  – National Death Index mortality data: VA Center of Excellence for Suicide Prevention, Joint VA and DoD Suicide Data Repository
Contact Info

Donna.Washington@va.gov

https://www.queri.research.va.gov/national_partnered_evaluations/equity.cfm
Question & Answer
Mary Kelleher
Director, Program Integration

Nancy Steward
National Event Outreach Lead

Debra Karambellas
National Outreach & Communications Lead

Million Veteran Program
National Outreach and Communications Team
The Million Veteran Program (MVP) is a national research program to learn how genes, lifestyle, and military exposures affect health and illness. Since launching in 2011, over 780,000 Veteran partners have joined one of the world's largest programs on genetics and health.

Veterans who partner with MVP contribute to improving the lives of fellow Veterans and ultimately, everyone. Scientific discoveries from MVP are already underway, helping us reach our goal of transforming health now and for future generations. MVP Video
Diversity In MVP Recruitment

National Enrollee Characteristics

Service Era
- September 2001 or Later
- August 1990 to August 2001 (Including Gulf War)
- May 1975 to July 1990
- August 1964 to April 1975 (Vietnam Era)
- February 1955 to July 1964
- July 1950 to January 1955 (Korean War)
- January 1947 to June 1950
- December 1941 to December 1946 (WWII)
- November 1941 or Earlier
- Multiple Service Eras

Age
- 18 to 29
- 30 to 39
- 40 to 49
- 50 to 59
- 60 to 69
- 70 to 79
- 80 to 89
- 90 to 99
- 100+
Diversity In MVP Recruitment

**National Enrollee Characteristics**

**Gender**
- Male: 89%
- Female: 2%
- Unknown: 9%

**Race**
- White: 75%
- Black: 19%
- American Indian: 0%
- Asian: 1%
- Pacific Islander: 1%
- Other: 3%
Diversity In MVP Recruitment

National Enrollee Characteristics

Top Ten Reported Diseases for Females

- Depression
- Hypertension
- High cholesterol
- Acid reflux/GERD
- Anxiety reaction/Panic disorder
- Migraine headaches
- Other skeletal/muscular problem
- PTSD
- Osteoarthritis
- Other arthritis
Diversity In MVP Recruitment

National Enrollee Characteristics

Top Ten Reported Diseases for Males

- Hypertension
- High cholesterol
- Tinnitus
- Hearing loss
- Acid reflux/GERD
- Cataracts
- Diabetes
- Depression
- Sleep apnea
- Other arthritis
How Can I Help My Fellow Veterans?

Enrollment into the Program-Your Legacy!
• Enroll right here at the Summit
• Enroll at a local MVP Site near you
• Enroll online through the new MVP Online

Resources For Additional Information:

Online: To learn more or join, visit MVP Online at mvp.va.gov today.

Visit the Frequently Asked Questions (FAQ) section of MVP Online to search or browse common questions about the program, participation, privacy, and more.

Phone: Call the MVP Info Center toll-free 1-866-441-6075 (Mon-Fri, 8:00 AM -6:00 PM. ET)

Email: askmvp@va.gov
MVP Sites
What Does MVP Enrollment Involve?

- Filling out surveys at your home about your service/era information, Lifestyle habits, environmental exposures, health information

- If enrolled through VHA access to your health records

- Small vial of blood for your DNA
Center for Minority Veterans (CMV)
November 1994, Public Law 103-446 required SECVA to create Center for Minority Veterans (CMV) and established the Advisory Committee on Minority Veterans (ACMV).

- CMV serves as principal advisor to SECVA on adoption and implementation of policies and programs affecting minority Veterans.
- CMV serves: African Americans, Asian Americans, Hispanic Americans, Native Americans (American Indians, Alaska Natives, Native Hawaiians), Pacific Islanders, and women Veterans who are minority group members.
What We Do

- Educate Veterans, their families and survivors through targeted outreach and effective advocacy.
- Promote the use of VA programs, benefits, and services for minority Veterans.
- Disseminate information and provide culturally relevant programs that enhance Veteran-centric services to minority Veterans (*men & women).
Veteran Demographics 2016

Note: Categories are mutually exclusive. ‘Black’ and ‘All other races’ are not Hispanic. ‘All other races’ includes American Indian/Alaskan Native, Asian, Pacific Islander, and Other (Some other Race and Two or more Races). Source: U.S. Census Bureau, American Community Survey, 2016
Projected Veteran Population

2043

Increasing Diversity in Veterans Population

Note: Categories are mutually exclusive. ‘Black’ and ‘All other races’ are not Hispanic. ‘All other races’ includes American Indian/Alaskan Native, Asian, Pacific Islander, and Other (Some other Race and Two or more Races).
Minority women Veterans comprise 34% of the total women veterans population compared to 21.9 percent minority men Veterans.
1. National Minority Veterans Summit

2. Initiatives/ Campaigns- Million Veteran Program/Crisis Line

3. Collaborate on Research Projects with Office of Health Equity, Center for Health Equity, and Research Promotions

4. Host Lunch and Learn Sessions – Federal Agencies

5. Collaborate with Veteran Service Organizations and partners to reach more minority Veterans

6. Develop MOUs with national organizations (i.e. NAACP, Women Veterans Interactive, Veterans Employment Service Office etc.)
Outreach to Minority Veterans

- Staff/Minority Veteran Liaisons collaboration with internal/external organizations and other closely aligned non-government minority organizations (CMV)

- Secretary’s Advisory Committee on Minority Veterans (ACMV)

- Minority Veterans Program Coordinators (MVPC)
Secretary of Veterans Affairs’ Advisory Committee on Minority Veterans (ACMV)

- Advise the Secretary on VA’s administration of benefits and provision of health care benefits and services to minority Veterans
- Provide annual report to the Secretary outlining recommendations, concerns, and observations on VA’s delivery of services to minority Veterans
- Meet with VA officials, Veteran Service Organizations and stakeholders to assess the VA’s efforts in providing benefits and services to minority Veterans
- Make periodic site visits and hold Veterans Town Hall meetings

Secretary’s Advisory Committee on Minority Veterans
December 11, 2018
Minority Veterans Program Coordinators (MVPC)

- Interdepartmental program 265 coordinators collaterally assigned within VHA, VBA, and NCA

- Support and initiate activities that educate and sensitize internal staff to the unique needs of minority veterans

- Target and participate in outreach activities and educational forums utilizing community networks

- Assist the CMV in disseminating information
# MVPC Outreach Statistics FY18

<table>
<thead>
<tr>
<th>Administrations</th>
<th>Number of Reports Submitted</th>
<th>Number of Activities</th>
<th>Number of Veterans Seen</th>
<th>Number Minority Veterans Seen</th>
<th>Percentage of Minority Veterans Seen</th>
<th>Average hours of Outreach Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCA</td>
<td>285</td>
<td>8,407</td>
<td>198,245</td>
<td>85,575</td>
<td>43%</td>
<td>12</td>
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<tr>
<td>VHA</td>
<td>530</td>
<td>14,931</td>
<td>296,442</td>
<td>118,693</td>
<td>40%</td>
<td>18</td>
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<tr>
<td>VBA</td>
<td>224</td>
<td>22,680</td>
<td>277,196</td>
<td>98,898</td>
<td>36%</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1039</strong></td>
<td><strong>46,018</strong></td>
<td><strong>771,883</strong></td>
<td><strong>303,166</strong></td>
<td><strong>39%</strong></td>
<td><strong>17</strong></td>
</tr>
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U.S. Department of Veterans Affairs
Center for Minority Veterans

202-461-6191
https://www.va.gov/centerforminorityveterans/
http://www1.va.gov/CENTERFORMINORITYVETERANS/index.asp
Please Transition to Breakout Sessions
&
Visit Vendors in Our Exhibit Hall
Thank You for Your Service