

**Department of Veterans Affairs (VA)  
Advisory Committee on Women Veterans (ACWV)  
Meeting Minutes  
810 Vermont Avenue, NW  
G.V. "Sonny" Montgomery Conference Center, Room 230  
Washington, DC 20420  
February 18-20, 2009**

**Advisory Committee Members Present:**

COL Shirley Quarles, USAR, Chair  
CDR René Campos, USN, Retired  
PO2 Davy Coke, USN, Retired  
Yanira Gomez  
Velma Hart, USAR  
Marlene R. Kramel, USA

Mary Antoinette Lawrie, USAF  
COL Gloria Maser, USAR  
TSgt Barbara Pittman, USAF, Retired  
Celia Szelwach, USA  
Joanna Crosariol Truitt  
Barbara Ward, USAF

**Advisory Committee Members Excused:**

CMSgt Helena R. Carapellatti, USAF, Retired

**Ex-Officio Members Present:**

COL Denise Dailey, Military Director,  
Department of Defense (DoD), Defense  
Advisory Committee on Women in the  
Services (DACOWITS)  
Denise Jefferson, Competitive Grants  
Specialist, Veterans Employment and  
Training Service, Department of Labor

Cheryl Rawls, Director, VA Regional  
Office (VARO), North Little Rock,  
Arkansas

**Ex-Officio Members Excused:**

Dr. Lawrence Deyton, Chief Officer,  
Public Health and Environmental  
Hazards

**Advisors Present:**

Dr. Patricia Hayes, Chief Consultant, Veterans  
Health Administration (VHA),  
Women Veterans Health Strategic Health  
Care Group (WVHSHG)

Carolyn Bryant, Program Manager,  
Veterans Benefits Administration (VBA),  
Women Veterans Outreach Program

Lindee Lenox, Director, Memorial  
Programs Service, National  
Cemetery Administration (NCA)

**Advisors Excused:**

CAPT Angela M. Martinelli, Division of  
Treatment and Recovery Research,  
National Institute on Alcohol Abuse  
and Alcoholism, National Institute of  
Health, Public Health Service

**VA Staff Present:**

**Center for Women Veterans**

Dr. Irene Trowell-Harris, Director

Dr. Betty Moseley Brown, Assoc. Director

Desiree Long

Shannon Middleton

Juanita Mullen

Michelle Terry

**Other VA Staff:**

Jurita Barber, NCA

Tanya Johnson, Compensation and Pension  
Service

Dr. Mandy Krauthamer, WVHSHG

Dr. Laura Herrera, WVHSHG

Amy Hertz, WVHSHG

Stephanie Willis, Veterans Health  
Administration/Chief Business  
Office

**Guests:**

Alejandro Barberena, Government Business  
Development Health Net Federal Services  
(HNFS)

Sharon Hodge, Vietnam Veterans of America

Nancy Hogan, Senate Committee on Veterans  
Affairs

Rob McCashin, Director, HNFS

Blanca Mendez, Medill News Service

Teresa Morris, Veterans of Foreign  
Wars, (VFW)

Margo Sheridan, VFW

Denise Williams, The American  
Legion

Joy Willingham, HNFS

Kayla Woodring, VFW

**Wednesday, February 18, 2009 – Room 230**

***Meeting was called to order by the Chair.***

Items discussed included:

- Introduction of members and visitors.
- Agenda review.
- Approval of minutes from October 2008 meeting.
- Presentation of appointment Certificates to new members.

**Briefing: Greeting and Comments, The Honorable Eric K. Shinseki, Secretary of Veterans Affairs**

- Discussed 2008 Report of the Advisory Committee on Women Veterans, submitted to Congress on September 3, 2008.
- Discussed the importance of Advisory Committee's role in improving benefits/services for the growing population of women Veterans.
- Discussed the 2008 National Summit on Women Veterans' Issues.

**Update on 2008 ACWV Report, Dr. Irene Trowell-Harris, Director, Center for Women Veterans**

- Recommendations submitted by Committee are reflective of issues encountered by many women Veterans, are based on information and data presented during briefings at Committee meetings, and have implications for the entire women Veterans population.

- Committee offers rationales for each recommendation.
- Report submitted to the Secretary on July 1, 2008.
- Administrations, and Staff Offices crafted responses to recommendations.
- Report with VA response submitted to Congress September 3, 2008.
- Report also distributed to VA Administrations and Staff Offices, Members of Congress, and the general public.

**Updates on 2008 National Summit on Women Veterans' Issues, and Center for Women Veterans, Dr. Betty Moseley Brown, Associate Director, Center for Women Veterans**

- Provided information on outreach activities.
- Discussed VA's strategic goals, the Center's performance measures, and Center's recent and upcoming events.
- Follow-up on the 2008 National Summit on Women Veterans' Issues.

**Overview of Veterans Health Administration (VHA) Women Veterans Health Strategic Health Care Group (WVHSHG) Initiatives, Dr. Patricia Hayes, Chief Consultant**

- WVHSHG has adopted the following guiding principles for the delivery of services to women Veterans:
  - Comprehensive primary care by a proficient and interested primary care provider.
  - Privacy, safety, dignity, and sensitivity to gender-specific needs.
  - The right care in the right place and time.
  - State-of-the-art health care equipment and technology.
  - Gender parity in quality performance scores.
- Oversight of major focus areas to include:
  - Provision of primary and specialty care.
  - Environment of care, including inpatient and outpatient settings, residential and long term care.
  - Focus on privacy, security, and adequacy.
  - Planning for construction and remodeling, inclusion of women.
  - Development and implementation of appropriate services in all areas and departments.
  - Evaluation of health services provided to women.
  - Materials for VHA outreach to women Veterans.
- Demographic changes:
  - The number of enrolled women Veterans will double in the next 5 years.
  - Rapid growth will continue. Based on active duty and recruiting numbers, the percentage of female Veterans is projected to increase.
  - High enrollment and utilization rates by women who served in Operations Enduring Freedom & Iraqi Freedom (OEF/OIF):
    - Over 102,000 female OEF-OIF Veterans.
    - Over 44 percent enrolled, 43.8 percent use from 2-10 visits
  - Women Veterans are younger.

- Average age of VA users:
  - Female Veteran = 48.
  - Male Veteran = 61.
- Primary care challenges:
  - Women's general health care and gender-specific health care often handled separately.
    - Sixty-seven percent of VA sites provide primary care in "multi-visit, multi-provider model" — primary care at one visit and gender-specific primary care at another visit.
  - Few primary care physicians are trained in women's health.
  - More training in women's health planned for primary care physicians.
  - Inconvenient access to gender-specific care.
  - Need to ensure mental health care is not separate from primary care.
- VHA primary care policy revisited:
  - Gender specific care is primary care.
  - Defining comprehensive primary care for women Veterans:
    - The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs-- including acute and chronic illness, gender-specific, preventive, and mental health care.
- Goals for comprehensive primary care for women Veterans:
  - All enrolled women Veterans receive comprehensive primary care from a designated women's health primary care provider, who is interested and proficient in the delivery of comprehensive primary care to women, irrespective of where patients are seen (medical centers, community-based outpatient clinics [CBOCs], independent clinics).
- WVHSHG initiatives:
  - Implementing primary care enhancements.
  - Increasing education of providers on topics related to women Veterans.
  - Ongoing development of programs focused on major disease categories affecting women:
    - Cardiac health.
    - Lung cancer prevention.
    - Colon cancer prevention and interventions.
    - Focus on osteoporosis screening and treatments.
    - Birth defect prevention, pregnancy care.
    - Collaboration with radiology on follow-up of abnormal results.
    - Mammograms and timeliness to treatment.
    - Collaboration with mental health to assess and improve care.
- Discussed WVHSHG annual report summary.
- Discussed clinical inventory.
- Reviewed annual report for fiscal year 2008.

**Overview of Veterans Benefits Administration (VBA) Initiatives, Michael Walcoff,  
Deputy Under Secretary for Benefits**

- Recent media incidents:

- Putting procedures in place to regain trust and confidence of Veterans:
  - Three signatures will be needed on documents to be shredded.
  - If Veterans think they have already submitted documents to support their claims within a 1½ year, they can re-submit claims-- and VBA will take their word for it that the documentation was previously sent.
  - VBA has review teams visiting all of regional offices.
  - Working on being paperless by 2012, and allowing Veterans to be able to check their claims over the phone.
  - VBA needs to develop a system so that Veterans can check status of claims themselves.
- VBA changing the way that it does outreach:
  - Working on press releases.
  - Visits.
  - Looking into what might appeal to younger Veterans.
- Claims process improvement (CPI):
  - Reviewing business process, CPI model, how VBA organizes work.
  - Auxillary Power Unit– manager can come in and pull up records.
  - Map D– person on phone can see claim process.

**Update on 2008 Report (Recommendation 20), Gail Wegner, Acting Director, VA Office of Small and Disadvantaged Business Utilization, Center for Veterans Enterprise (CVE)**

- Leading the way in contracting with service-disabled Veteran-owned small businesses (SDVOSBs).
- Helping the federal government increase its efforts with SDVOSBs.
- Raising awareness of impediments.
- CVE will achieve the women-owned small businesses (WOSB) goals using woman-owned, VOSBs.
- Greater collaboration:
  - Social networking tools for outreach.
  - Manufacturing partnerships.
  - Intergovernmental support.
- WOSB set-aside authority:
  - Authorized in PL 106-554, signed in 2000.
  - Small Business Administration (SBA) proposed rule, issued December 20, 2007.
  - SBA final rule issued December 1, 2008.
    - Comment period ends March 13, 2009.
- P.L. 110-186:
  - Women Veterans business training:
    - Compile information on existing resources available to women. Veterans for business training, including resources for:
      - Vocational and technical education.
      - General business skills, such as marketing and accounting.

- Business assistance programs targeted to women Veterans.
- Disseminate the information compiled through Veteran business outreach centers and women's business centers.

**Overview of National Cemetery Administration Initiatives (NCA), Lindee Lenox, Director, Memorial Programs Service**

- Responsibilities:
  - Provide burial space for Veterans and maintain cemeteries as national shrines.
  - Administer federal grants program for construction of state Veteran's cemeteries.
  - Furnish headstones and markers.
  - Administer the Presidential Memorial Certificate Program.
  - First notices of death.
- First Notice of Death (FNOD) Program:
  - June 2008 - agreement between the Under Secretaries for Benefits and Memorial Affairs, to transfer responsibility from VBA to NCA.
  - First notices of death (FNOD) resulting in burial at a national cemetery, application for a Government-furnished headstone or marker, or application for a burial flag.
- Status of national cemeteries:
  - Open – 68.
  - Cremation only – 21.
  - Closed – 39.
  - Total – 128.
  - Under development – 3.
- Burial benefits:
  - Opening and closing of the grave.
  - Grave liner.
  - Headstone or marker.
  - Perpetual care of the grave site.
  - U.S. Flag
- State Cemetery Grant Program:
  - VA provides 100 percent of development cost.
  - Since 1980, \$344 million awarded in 172 grants.
  - 37 states plus Guam and Saipan received grants.
  - Five under construction.
  - in FY 2008, 24,823 Interments.
- NCA Outreach to women Veterans:
  - Participating in upcoming VBA women Veterans coordinator training conference in St. Louis.

- Coordinating with VHA and VBA to distribute burial/ memorial benefit information to women Veterans coordinators and women Veterans program managers (WVPMs).
- Demonstrated new Web site for women and minority Veterans.
- Watched revised DVD entitled, "A Sacred Trust: America's National Cemeteries."
- The ACWV reiterated its recommendation that NCA ensures the depiction of women Veterans in the Administration's outreach materials—specifically media tools like "A Sacred Trust: America's National Cemeteries." NCA indicated that the Administration would work to improve representation of women Veterans in its outreach materials.

### **Ethics Briefing, Jonathan Gurland, General Attorney, VA Office of the General Counsel**

- Provided information on ethics rules for advisory committee members who are special government employees.
- Discussed financial disclosure.
- Explained the federal criminal code:
  - Conflicts of interest.
  - Compensation for representational services.
  - Post-government employment restrictions.
  - Bribery.
  - Foreign agents.
- Explained standards of ethical conduct:
  - Appearance of a conflict of interest.
  - Gifts.
  - Charitable fundraising.
  - Teaching, speaking and writing.
  - Expert testimony.
- Provided information on how to get ethical advice.
- Other prohibitions:
  - Emoluments clause.
  - Foreign gifts.
  - Hatch Act.

### **Discussion: Wrap-up Dr. Shirley Quarles, Chair, ACWV**

**Thursday, February 19, 2009-- Room 230**  
***Meeting was called to order by Chair.***

Items discussed included:

- Capitol Hill visit logistics.
- Site visit to VA North Texas Health Care System scheduled for June 8-12, 2009.
- Preparation for the biennial report for 2010.

**ACWV Courtesy Visit to Capitol Hill, Cannon House Office Building, Room 340**

- Susan Lukas, VA Congressional Liaison, Office of Congressional and Legislative Affairs, facilitated meeting.
- ACWV members, Congressional staffers, Center for Women Veterans, and public attendees introduced themselves.
- Director of Center for Women Veterans gave an overview on the mission and activities of the Center for Women Veterans.
- ACWV Chair provided overview on the mission of the ACWV, discussed the focus of the 2008 Report, and answered questions from the audience.

**VA Claims Adjudication Process/ Update on 2008 Report (Recommendations 10 and 11) Christine Alford, Assistant Director for Veterans Services, Compensation and Pension Service, VBA**

- Discussed change in policy regarding in-service diagnosis of PTSD.
- Discussed benefits Delivery at Discharge program (BDD).
- Discussed going paperless.
- Discussed Vazquez-Flores v. Peake case.
- Training Responsibility Involvement Preparation (TRIP) training.
  - Three elements of a successful PTSD claim:
    - In-service event (stressor).
    - Current diagnosis.
    - Linkage statement (Nexus).
  - Three types of PTSD claims:
    - Combat-related PTSD.
    - Non-combat related PTSD.
    - PTSD based on personal or sexual assault, or sexual harassment.
- Grass root outreach effort:
  - State task force groups.
  - "Boot Camp to Veteran."
  - Stand downs.
  - Personal trauma development.
  - "Community dialogue with women Veterans."
  - "Everyday availability."
- Outreach materials:
  - Transition assistance state task force groups.

**Post-9/11 Veterans Educational Assistance Act of 2008/The New G.I. Bill, Shante Kinzie, Program Analyst, Education Service, VBA**

- Post-9/11 GI Bill (Chapter 33) benefits can be paid for training pursued on or after August 1, 2009. No payments may be made for training pursued before that date.

- Individuals who served on active duty after September 10, 2001 will be eligible for the Post-9/11 GI Bill if they:
  - Served for an aggregate period of at least 90 days.
  - Served at least 30 continuous days and received a disability discharge.
- Individuals will remain eligible for benefits for 15 years from:
  - Date of last discharge, or released from active duty of at least 90 continuous days.
- Post-9/11 GI Bill entitlement :
  - Individuals will generally receive 36 months of benefits.
  - Individuals are limited to 48 months of combined benefits under educational assistance programs administered by VA.
  - Individuals transferring to the Post-9/11 GI Bill from the Montgomery Bill (Chapter 30) will be limited to the amount of remaining Chapter 30 entitlement.
- Tuition and fees:
  - Individuals are eligible for:
    - Applicable percentage (based on aggregate active duty service) or the lesser of tuition and fees charged, or highest amount of tuition and fees charged for fulltime, undergraduate training at a public institution of higher learning (IHL) in the state the student is attending. (Determined by the State Approving Agency)
- Monthly housing allowance equivalent to the basic allowance for housing for an E-5 with dependents:
  - Amount determined by zip code of the IHL where the student is enrolled.
  - Prorated based on the percentage of the maximum benefit payable.
  - Active duty and anyone training at half-time or less, and those pursuing exclusively distance learning are not eligible for the monthly housing allowance.
- Stipend for books and supplies:
  - Up to \$1,000 per year. Prorated based on the percentage of the maximum benefit payable.
  - Paid proportionally for each quarter, semester, or term attended.
  - Active duty members are not eligible.
- Approved programs:
  - All programs approved under Chapter 30 and offered at an IHL.
  - Individuals who were previously eligible for Chapter 30, 1606, or 1607 may continue to receive benefits for approved programs not offered by IHLs (i.e. flight, correspondence, APP/OJT, preparatory courses, and national tests).
- Refund of contributions:
  - A proportional amount of the basic \$1200 contribution will be included in the last monthly housing allowance payment when Chapter 33 entitlement exhausts.
  - Individuals who do not exhaust entitlement under Chapter 33 will not receive a refund of contributions paid under Chapter 30.

- Refund of \$600 additional contribution is not authorized.
- Transfer of Entitlement (DoD benefit):
  - On or after August 1, 2009, DoD may allow an individual to elect to transfer entitlement to one or more dependents if he/she:
    - Has served at least 6 years in the armed forces, agrees to serve at least another 4 years in the armed forces.
  - Spouses may use transferred benefits after 6 years of service; dependent children after 10 years.
  - DoD determines eligibility for transferability and may, by regulation, impose additional eligibility requirements, and limit the number of months transferable.
- Yellow Ribbon Program:
  - IHLs may voluntarily enter into an agreement with VA to pay tuition and fees charged that are not covered under Chapter 33.
  - VA will match each additional dollar funded by the school.
  - The combined amounts may not exceed the full cost of the school's tuition and fees charged.
  - Only individuals entitled to the 100 percent benefit rate (based on service requirements) may receive this funding.
- Overpayment of benefits:
  - VA will determine the amount of overpayment for an individual in receipt of Chapter 33 benefits.
  - Tuition and fee payments are paid to the school on behalf of the Veteran; overpayments for tuition and fees will be charged to the Veteran.
- Claims processing strategies:
  - The application and payment process will be supported two ways:
    - In the short term (August 2009 to December 2010)-- minimal modification to existing IT infrastructure, and hiring significant additional term staff.
    - December 2010 onward-- automated processing using "rules-based" technology.

**Healthcare Effectiveness through Resource Optimization Governance/Project HERO, Sandi Jones, Chief Business Office, VHA**

- VA responded to the growing number of women Veterans by targeting programs to meet their unique health-care needs:
  - VHA office to address women's health issues created in 1988.
- P.L. 102-585, Veterans Health Care Act of 1992, authorized new and expanded services for women Veterans:
  - Counseling for sexual trauma on a priority basis.
  - Specific health services for women, such as Pap smears, mammography, and general reproductive health care.
- The Veterans' Health Care Eligibility Reform Act of 1996 expanded services to include reproductive benefits.

- Project HERO's genesis developed by VA in response to Congressional report associated with P.L. 109-114:
  - Congressional report called for VA to:
    - Implement care management strategies proven valuable in public and private sectors.
    - Ensure care purchased for enrollees from community providers is cost-effective and complementary to the larger VHA system of care.
    - Preserve and sustain partnerships with university affiliates.
    - Establish at least three care management demonstration programs through competitive award.
    - Collaborate with industry, academic and other organizations to incorporate a variety of public-private partnerships.
- Discussed Project HERO availability in Veterans Integrated Service Networks (VISNs) 8, 16, 20, and 23.
- Services available to women:
  - Humana Veterans health care services and Delta Dental offer.
  - Credentialed, quality providers.
  - Return of clinical information to VA.
  - Timely provider claims processing and sending claims to VA for reimbursement.
  - Monitoring and reporting of access to care, appointment timeliness, patient safety and satisfaction.
  - Appointment setting.
  - Additional patient advocate services.
- Benefits:
  - Facilities and providers meet VA-specified quality standards.
  - Clinical information returned to VA to improve continuity of care.
  - Improved access to specialty care services.
  - Timely payments to providers.
  - Claims to VA for reimbursement.
  - Cost savings with pricing comparable to or less than Medicare.
  - Centralized VA vendor coordinated referral and appointment process.

**Models of Care for Women Veterans, Dr. Elizabeth Yano, Researcher, VA Greater Los Angeles Health Care System, VHA**

- Considerable debate about how best to organize care for women Veterans:
  - Numerical minority creates challenges.
  - VA providers with limited exposure to women.
- VHA Handbook 1330.1 recommends specific primary care delivery models for women Veterans:
  - Separate women's health clinics.
  - Designated women's health providers in general primary care.
- Unanswered questions:
  - How are these models being implemented?
  - What do we know about what works?

- Women Veterans use VA differently than male Veterans:
  - Have substantial chronic disease burden.
  - PTSD, hypertension, depression, hyperlipidemia, chronic low back pain, gynecologic issues, diabetes.
  - Have substantial mental health comorbidities:
    - Medical and mental health conditions.
    - Diabetes comorbid serious mental illness, or substance use.
- More variation in the development of women's health clinics (WHC) within VISN than by region.
- Facilities with WHCs have greater caseload/workload.
- WHCs for primary care developed in facilities that:
  - Have primary care leadership distinct from subspecialty care (more autonomous).
  - Are less likely to contract out for care (build vs. buy).
  - Are more likely to be academically affiliated.
- Primary care is fragmented for women Veterans.
  - What would be routine primary care in community settings is referred out to specialists.
  - Women Veterans prefer one-stop shopping.
  - Receiving general and women's health care from the same provider or clinic rated very important for 55 percent of VA users.
  - Availability of women's health clinics rated very important for 44 percent of VA-users, 29% of VA-nonusers.
- Integrated Primary Care:
  - Percentage of facilities that have designated women's health providers in general primary care to whom women Veterans are preferentially assigned—42 percent.
  - Percentage that have one for whole primary care practice-- 56 percent.
  - Percentage that have one in each PC team—9 percent.
  - Percentage that have a women's health primary care team—18 percent.
  - Designated women's health providers only available six half-day sessions/week.
- Discussed breast and cervical cancer screening rates.
- Discussed care coordination.
- Women's mental health models:
  - Evidence from national organization's surveys of VA women's health programs:
    - Emerging women's mental health clinics to modest degree.
    - Increased proportion of these types of models nationally from 2001-2007.
  - Wanted to explore the implementation and sustainability of women's health models in VA:
    - Obtained VA Mental Health Queri Rapid Responsive Project funding.
    - Qualitative interviews.

- Discussed clinic manager interviews preliminary results.
- Women Veteran interviews:
  - Internal review board review underway for small single-site pilot.
  - Plan to interview women Veterans.

**Dr. Donna Washington, Researcher, VA Greater Los Angeles Health System, VHA**

- Women's primary care delivery options:
  - VAMCs and other large sites:
    - Primary care provider within general primary care clinic.
    - Designated women's health provider within general primary care.
    - Women's health clinic for annual exams.
    - Comprehensive women's health clinic.
  - Integrated primary care achievable when gender-neutral and gender-specific care delivered by the same provider or clinic:
    - Primary care provider within general primary care clinic.
    - Designated women's health provider within general primary care.
    - Comprehensive women's health clinic.
    - Alternative for gender-specific screening:
      - Women's health clinic for annual exams only.
- VA women's health clinics – scope of care:
  - Number of women's health clinics: 74 in 2001, 131 in 2007.
  - Of women's health clinics open in both 2001 and 2007, 73 percent deliver comprehensive women's primary care (remainder provide annual screening exams only).
  - Of women's health clinics that opened after 2001:
    - Forty-four percent deliver comprehensive care.
    - Modest change in number of gynecology clinics does not offset growth in number of primary care women's health clinics.
- VA sites are using direct primary care providers delivery to increase services to women Veterans in general primary care settings.
- Though for most services, women's health clinic currently predominant delivery mode.
- Women's health clinic are being established, however, scope limited to basic services.
- Decline in on-site availability of specialized women's health services.
- Challenges to high quality, coordinated comprehensive care.
- Models of care that community based outpatient clinics (CBOCs) and smaller facilities can support.
- Location of VA sites in relation to geographic distribution of women Veterans.
- Off-site contracts for specialized services:
  - Quality assessment.
  - Care coordination and communication.
- VA primary care providers continuing medical education in women's primary care.
- National Survey of Women Veterans

- Funding from WVHSHG, with supplemental funding from Health Services Research and Development.
- Population-based study of 3,500 women Veterans to:
  - Identify current demographics, health care needs, and VA experiences.
  - Assess how health care needs and barriers to VA health care use differ by period of military service (e.g., OEF/OIF vs. earlier periods).
  - Determine impact of VA women's health model of care on access, satisfaction, and quality of care ratings.

**Discussion: Wrap-up Dr. Shirley Quarles, Chair, ACWV**

**Friday, February 20, 2009 -- Room 230**  
***Meeting was called to order by Chair.***

Items discussed included:

- Assigning mentors to new committee members.
- Discussion of Hill visit.
- Discussed developing new recommendations for 2010.

**Update on 2008 Report (Recommendations 2, 4, and 7, 8, 15, and 18), Dr. David Atkins, Associate Director, Health Services Research and Development, VHA; Dr. Antonette Zeiss, Deputy Chief, Mental Health Services, VHA; Dr. Charles Anderson, Chief Consultant, Diagnostic Services, VHA; James Novorska, Director, Mammography Program, VHA**

- Discussed history of Quantity Enhancement Research Initiative (QUERI) program. Study how to speed up implementation of effective practice.
- Policy for uniform mental health services in VA medical centers and clinics:
  - Final version distributed September 12, 2008 as a Directive by the Under Secretary for Health.
  - Key principle: mental health care is an essential component of overall health care.
  - Defines minimum clinical requirements for VHA mental health services.
  - Expected full implementation of the requirements by the end of FY 2009.
- ACWV 2008 Report Recommendation 2—that general mental health care providers are located within the women's clinic during hours of operation to facilitate the delivery of mental health services; VA's Quality Enhancement Research Initiative/survey to be released in January 2009:
  - Office of Mental Health Services: Recommendations from the Uniform Mental Health Services Handbook concerning integrated care in all primary care clinics.
  - Integrating mental health in primary care:

- VAMCs and very large CBOCs (> 10,000 uniques per year) must have integrated mental health services that operate in their primary clinics on a full-time basis.
- These services need to utilize a blended model.
- Co-located, collaborative care model involves one or more mental health professionals who:
  - Are integral members of the primary care team.
  - Provide assessment and psychosocial treatment for mental health problems, which include depression and problem drinking.
  - Advise the primary care physicians on needs of patients with mental health problems.
  - Consult on referrals for mental health specialty care.
- Care management component based on approved evidence-based strategies.
- ACWV 2008 Report Recommendation 4—that women Veterans, upon their request, have access to female mental health professionals, and if necessary, use fee basis to meet the Veteran’s needs:
  - Data not routinely tracked, and there is no easy way to do this for all mental health providers.
  - Can report on:
    - Selected key mental health professions by gender.
    - Requirements in the Uniform Mental Health Services Handbook and plans in the evaluation process to track implementation (to begin at the end of FY 2009).
    - Training for mental health providers to provide gender-sensitive care.
  - Psychology Staff By Gender

	End of 2007	End of January 2009
Male staff	1,138	1,321
(%)	(51.4%)	(47.8%)
Female staff	1,077	1,442
(%)	(48.6%)	(52.2%)

- Facilities are strongly encouraged to give all Veterans being treated for MST the option of being assigned a same-sex mental health provider or opposite-sex provider, if the trauma involved a same-sex perpetrator.
- Veterans being treated for other mental health conditions are given the option of a consultation from a same-sex or opposite-sex provider regarding gender-specific issues, when clinically appropriate.

- Sensitivity to women Veterans in training for evidence-based psychotherapy:
  - National rollout of cognitive processing therapy: evidence-based treatment for PTSD.
  - Originally developed with sexual assault survivors.
  - Adapted for combat-related PTSD.
  - National conferences with a training manual:
    - Training materials specific to Veterans.
    - Training materials specific to women Veterans.
    - Specific components on MST-related PTSD.
    - Conference participants then see cases and attend ongoing case consultation calls.
    - Over 1,000 VA staff trained to date.
  - National rollout of prolonged exposure therapy: evidence-based treatment for PTSD:
    - Originally developed with sexual assault survivors.
    - Adapted for combat-related PTSD.
    - Similar in nature to national rollout for cognitive processing therapy, with special training components for women Veterans and MST.
    - Started last year; several hundred trained.
  - National rollouts of acceptance and commitment therapy (ACT) and cognitive behavioral therapy (CBT):
    - Evidence-based treatments for anxiety and depression.
    - National rollout similar in nature to Cognitive Processing Therapy, including special training components for work with women Veterans.
- ACWV 2008 Report Recommendation 18—That VA update its Web site to provide sufficient information for women Veterans to locate and contact the health care for homeless Veterans coordinator or alternate in their respective regions in order to find immediate shelter:
  - Mental health residential rehabilitation and treatment programs.
  - Measures in Residential rehabilitation and treatment programs (RRTPs) to improve therapeutic environment for women Veterans:
    - Staffing level and staffing pattern guidelines.
    - Physical plant access and safety/security improvements
    - Annual safety and security assessment.
  - Staffing levels and patterns must ensure:
    - Safety of Veterans.
    - Clinical care consistent with national best practices.
  - Staffing policy presented in RRTP draft handbook (awaiting publication).
  - Staffing must provide 24/7 on-site supervision of RRTPs.
- ACWV 2008 Report Recommendation 7—That the environment of care check list is included as a part of VAMCs, outpatient clinics, and CBOCs quarterly

environmental rounds; that local VAMC WVPMs be part of the environmental rounds inspections team:

- Safety and security of women Veterans in RRTPs:
  - January 2008: field mandated to implement:
    - Keyless entry for all RRTPs.
    - Locks for female bedrooms and bathrooms.
    - Use of closed circuit monitoring of public areas.
  - Approximately \$2.7 million allocated to the field for implementation:
    - Completed in December 2008.
- Annual Safety and Security Assessment in all mental health RRTPs:
  - Will be conducted jointly with the WVPM.
  - Will focus on the needs of women Veterans.
  - WVPM also encouraged to participate in regular environmental rounds, with special emphasis on improving privacy and security.
- Housing and Urban Development/VA Supportive Housing (HUD/VASH) provides:
  - Case management and supportive services to homeless Veterans and their families.
  - Housing choice of Section 8 vouchers for safe, decent and stable permanent housing.
- Program is particularly helpful for women Veterans, or women Veterans with children.
- HUD/VASH examples of case management services:
  - Assistance with Public Housing Authority process, agency which administers HUD/VASH vouchers.
  - Help secure safe, decent housing for which to use the voucher.
  - Referrals for health care services and social services from VA and community providers.
  - Basic mental health and substance use treatment services.
  - Money management training.
  - Psychosocial support.
  - Crisis intervention.
- ACWV 2008 Report Recommendation 8—That VA develops a formal program for tracking of mammography results and follow-up of abnormal mammograms to ensure that women Veterans receive consistent, timely, and high quality care; that office of quality and patient safety provide ACWV an annual report on the mammography tracking program to include data on timeliness to treat for abnormal results:
  - Mammography results that should be tracked:
    - An incomplete exam for which comparison studies should be located or additional views obtained, and results that probably benign, suspicious, and highly suggestive of malignancy.

- In August of 2008, VA mammography programs surveyed to learn how they were tracking and auditing incompletes and short term follow-up.
- Commercial tracking software:
  - Many software systems are available, but not used by VA.
  - Weakness is that they are not compatible with existing software.
- Plans to track in VistA:
  - Step 1 is to define national standard terminology and data fields in VistA to store BI-RADS codes as “Diagnostic Codes.”
  - Waiting on OI&T to send out software that will define these codes; perhaps June.
  - Once data field exists, basic audit reports can be run on patients that need to be tracked. Data is accessible but still not convenient.
- Tracking of BI-RADS 4 and 5 in women’s health package of VistA:
  - BI-RADS data could be passed to women’s health package
  - Caution: studies might be ordered by many different physicians, including primary care.
- Tracking of fee basis:
  - Refers to mammograms performed by outside radiologists and reimbursed by VA.
  - Facility can electronically track if outside report is entered in VistA.
  - New outside report capability allows these studies to be ordered and reports entered without assigning them to a VA radiologist.
- ACWV 2008 Report Recommendation 15—that the position of WVPM is established as a permanent full-time management position in a VA medical centers; update on goal to satisfy requirement by Dec 2008:
  - Implementation almost completed
  - 138 of the 140 WVPM positions have been filled.

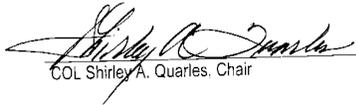
### **Importance of Women Veterans Health, The Honorable Michael Kussman, Under Secretary for Health**

- Discussed the status of the hiring of full time women Veterans program managers; almost completed.
- Discussed data on TBI, explained the definitions of TBI and concussive injuries; explained the difference between polytrauma injuries and TBI and concussive events:
  - Veterans are able to recover from mild TBI and from concussions.
- Addressed issues of homelessness and VA's major attempts to reduce the numbers of all homeless Veterans, and homeless women Veterans with children.
- Noted progress in total numbers of homeless Veterans.
- Stressed that VA is working towards preventing homelessness in the newest group of OEF/OIF Veterans.

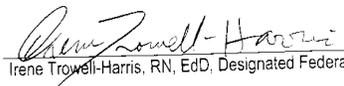
**Subcommittee Breakout Sessions**

- Health and Benefits subcommittees met with assigned ACWV members to discuss issues to be considered for upcoming report.

**Discussion: Wrap-up, Dr. Shirley Quarles, Chair, ACWV Meeting adjourned.**



COL Shirley A. Quarles, Chair



Irene Trowell-Harris, RN, EdD, Designated Federal Official