

**Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans (ACWV)
Meeting Minutes
Capital Hilton
Statler AB Room
1001 16th Street, NW
Washington, DC 20036
March 30 – April 1, 2010**

Advisory Committee Members Present:

COL Shirley Quarles, USAR, Chair
COL Martrice W. Browne, USA, Retired
CDR René Campos, USN, Retired
CMSgt Helena R. Carapellatti, USAF,
Retired

PO2 Davy H. Coke, USN, Retired
Valerie Cortazzo, USN
Karen Etzler, USAF
SFC Gundel Metz, USA, Retired
Barbara Ward, USAF
Kayla Williams, USA

Advisory Committee Members Excused:

Lindsay Long, USMC
COL Gloria Maser, USAR

Ex-Officio Members Present:

COL Emma K. Coulson, Military Director,
Defense Advisory Committee on
Women in the Services (DACOWITS),
Department of Defense (DoD),

Cheryl Rawls, Director, North Little
Rock VA Regional Office (VARO),
Veterans Benefits Administration
(VBA)

Ex-Officio Members Excused:

Denise Jefferson, Competitive Grants
Specialist, Veterans Employment and
Training Service, Department of Labor
(DOL)

Advisors Present:

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

CAPT Angela M. Martinelli, Division of
Treatment and Recovery Research,
National Institute on Alcohol Abuse
and Alcoholism, National Institute of
Health, Department of Health and
Human Services (HHS)

Advisors Excused:

Raynell Lazier
Chief, Executive Correspondence
Division, National Cemetery
Administration (NCA)

VA Staff Present:

Linda Bergofsky, VA Office of Inspector
General
Carolyn Bryant, Compensation and
Pension Service, VBA
Dr. Stacy Garrett-Ray, WVHSHG

Diane Johnston, VBA
Mehret Mandefo, Office of the Secretary
Candace Zfabiya, VHA
Nicholas Zolkowski, VBA
Tiffany Edwards, NCA

Center for Women Veterans (CWV):

Dr. Irene Trowell-Harris, Director
Dr. Betty Moseley Brown
Desiree Long

Shannon Middleton
Juanita Mullen
Michelle Terry

Guests:

Elijah Abram, Senate Veterans Affairs
Committee
Carla Abramcheck, QTC
Heather Ansley, United Spinal/Vets First
Alejandro Barbereno, Health Net Federal
Services
Denise Bullock, The American Legion
Leticia Cazares, House Veterans Affairs
Committee
Cynthia Dawkins, DOL
Dawn Jirak, Veterans of Foreign Wars
(VFW)

Sheila Jones, Vets Group
Richard Lawson, Associated Vets
Kathryn Monet, Senate Committee on VA
Teresa Morris, VFW
Alethea Predeoux, Paralyzed Veterans of
America
Brad Tobasco, Senate Veterans Affairs
Committee
Denise Williams, The American Legion

Tuesday, March 30, 2010 – Statler AB Room

Meeting was called to order by the Chair.

Items discussed included:

- Introduction of members and visitors.
- Agenda review.
- Approval of minutes from October 27-29, 2009 Advisory Committee meeting at the Capitol Hilton, Washington, DC.

Greetings and comments, The Honorable W. Scott Gould, Deputy Secretary, VA

- Thanks to work of this committee, women Veterans will receive the benefits they have earned.
- Women Veterans comprise 7.5 percent of the overall Veterans population and nearly 5 percent of all Veterans who use our health care services.

- Growing number of women Veterans demands decisive action.
- VA relies on this committee to advise the department's efforts to improve benefits and services for women Veterans.
- Many of this committee's recommendations have helped shape current policy and are catalysts for encouraging dialogue to address challenges facing women Veterans.
- Summary of VA's Transformation:
 - Veteran-centric-- change culture from adversary to advocate.
 - Results-focused-- deliver improved services and benefits to achieve high quality standards.
 - Future-oriented-- build strong and flexible management systems.
- 4 Strategic Goals:
 - Improve quality/access to health care and benefits.
 - Increase Veteran-client satisfaction.
 - Raise readiness to provide services, protect people, assets continuously in time of crisis.
 - Improve internal customer satisfaction.
- VA executing operating plan to achieve these four goals.
- Almost all aspects of our plan will affect women who have served our country with honor.
- Stressed the safety/security needs for female Veterans and female employees, as well as fairness/parity and equity.
- VA exploring pilots to address child care options.

Update on 2010 ACWV Report Process, 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, site visits and have implications for the entire women Veterans population.
- General guidelines for developing recommendations for 2010 report:
 - Review last two ACWV reports (2006 and 2008) for follow up on previously submitted recommendations.
 - Do not repeat prior recommendations.
 - Make recommendations specific, clear, appropriate, and include an adequate rationale that clearly defines the intent of the recommendation.
 - Make recommendations succinct, describing exactly what you are requesting VA to do. Make sure VA has Congressional authority to

- execute what the recommendation is requesting, or that the issue is under VA's realm of responsibility.
- Do not submit recommendations through VA that are intended for DoD, DOL, State Department of Veterans Affairs, or other agencies.
- Do not submit recommendations that require action for other VA committees, or ones that address issues covered by other VA committees, such as the homeless committee or the research committees.
- Submit a few good recommendations based on quality, not quantity, addressing a need for policy or legislation for an issue specific to women Veterans.
- Report to be submitted to the Secretary before July 1, 2010.
- CWV coordinates with the Administrations (VHA, VBA, NCA) and staff offices, who craft responses to recommendations.
 - Secretary mandated to submit report, to include VA responses, to Congress within 60 days of receiving the report.
 - Follow up on recommendations and matrix is maintained by CWV.
 - CWV processes report for design and printing, after report has been disseminated to the Secretary and Congress.
 - Final report will be distributed to VA administrations and staff offices, Congressional members, ACWV, various stakeholders and the general public.

Update on Center for Women Veterans Activities, Dr. Betty Moseley Brown, Associate Director, Center for Women Veterans

- Provided information on outreach activities.
- Discussed VA's strategic goals and the Center's performance measures.
- Discussed the Center's recent and upcoming events, such as the "Her Story" campaign to recognize women Veterans.

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

- Cross cutting issues for women Veterans:
 - The population of women Veterans is rapidly expanding, challenging VA's readiness to provide access to highest quality care.
 - VA must increase recognition of women Veterans.
 - VA must enhance privacy, respect, dignity, and sense of security for all Veterans.
 - Every level of VA – program offices, Veterans Integrated Service Networks (VISNs), and facility leadership and staff at every site – needs to be engaged in the enhancement of services to women Veterans.
- Priorities:
 - Expand enrollment and access for women Veterans:
 - Build capacity through infusion of basic clinic infrastructure and staff resources.

- Reduce barriers to care.
- Improve quality of health services.
- Engage in outreach with women Veterans through communication and advocacy.
- Engage women to be partners in managing their health.
 - Improve patient education aimed at women.
- Utilization by women Veterans:
 - Traditionally, women Veterans have under-utilized VA health care; majority receive health care outside VA.
 - Utilization data indicate current models of care delivery present barriers to women Veterans using VA.
 - High utilization of VA health care among women who served in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF):
 - Over 114,949 female OEF/OIF Veterans since 2002 enrolled.
 - Of the 47.3 percent of women who enroll, 45 percent have used from 2-10 visits.
- Needs of women Veterans:
 - Clinics to serve the needs of young, working women.
 - Access, flexible hours, use of technology.
 - Attention to reproductive health issues.
 - Many have childcare responsibilities and eldercare demands.
 - Many have difficulty in getting time off for appointments.
 - Adjustment and depression issues.
 - Homelessness, or at risk of homelessness.
 - Age-related health effects.
 - Cardiac risk, obesity and diabetes, lung cancer, colorectal cancer, breast and cervical cancer screening, osteoporosis screening.
- Ensuring primary care is not fragmented:
 - Women's general health care and gender-specific health care often are handled separately.
 - Many of VA sites (67 percent) provide primary care in "multi-visit, multi-provider model": primary care at one visit and gender-specific primary care at another.
 - Too few primary care physicians have training in women's health.
 - Inconvenient access to gender-specific care.
 - Mental health care is separate from primary care.
- Gender differences in quality:
 - Quality is high compared to the private sector.
 - Challenges: significant gender differences in clinical prevention measures and mental health screenings.
 - Cardiac risk measures lower for women.
 - Influenza immunizations lower for women than men.

- Homelessness:
 - Data received by VA's Homeless Program office indicates that, although the number of homeless Veterans is much lower in younger age frames, there is a higher percentage of women Veterans in younger age frames than men.
 - Risk factors:
 - Unrecognized mental health issues, such as post traumatic stress disorder (PTSD) and adjustment disorders; sexual trauma; undocumented combat stress; hidden substance use.
 - Lower income and earnings than men.
 - Homeless programs expanding to meet the needs of women with children.
 - Increased screening for PTSD, depression, and substance use.
 - Integration of mental health in primary care will allow evaluation for risk of homelessness.
- Rural women Veterans:
 - Limited information on:
 - How Veterans access rural healthcare.
 - What Veterans want regarding their health care.
 - Working with the Office of Rural Health and the CWV to identify barriers to care and outreach.
 - Partnering with VISNs 5 (Baltimore) and 6 (Durham) - funded by the Office of Rural Health - on initiatives that decrease barriers to care and improve access to women Veterans.
- Women Veterans Program Managers (WVPMs) ensure improved advocacy for women Veterans at the facility and VISN level.
- Full-time WVPM positions as of July 2008.
 - Increase outreach to women Veterans.
 - Facilitate improvements in the quality of care provided to women Veterans.
 - Help to develop best practices for women's health care delivery.
 - Educate women Veterans about VA benefits and how to apply for benefits.
- Comprehensive primary care for women Veterans is defined as complete primary care available from one primary care provider at one site.
 - Primary care providers are available to meet all needs, including acute and chronic illness, gender-specific, preventive, and mental health.
 - Increase focus on quality-of-care issues and comprehensive longitudinal care for women Veterans.
 - Raise the level of care delivered to women Veterans within the primary care setting.
 - Promote notion that gender-specific care is primary care.
- Policy that defines the scope of VHA services to women Veterans in concurrence:
 - Ensures equal access to high quality health care services in all sectors for women Veterans.
 - Ensures that care is provided in a safe and sensitive environment.

- Comprehensive primary care models:
 - Three potential models of care delivery that will:
 - Better meet the needs of women Veterans.
 - Decrease fragmentation.
 - Improve continuity.
 - The models are flexible:
 - Model 1: General primary care clinic.
 - Model 2: Separate but shared space.
 - Model 3: Women's health center.
 - Understand the population served to tailor the model of primary care delivery to each site.
- VHA handbook 1330.01 revision "VHA Services for Women Veterans:"
 - Defines the scope of VHA services to women Veterans.
 - Delineates essential components necessary to ensure that all enrolled women Veterans have access to appropriate services, regardless of VHA site of care.
 - Incorporates the new standard requirements for the delivery of health care to women Veterans.
 - Specifies services that must be provided at each VA facility and community based outpatient clinic (CBOC).
- Patient-centered medical home:
 - Patient-driven, team-based approach that delivers efficient, comprehensive, and continuous care through active communication and coordination of resources.
 - Key principles: Veteran-centric; access; continuity; comprehensive team-based care; improved coordination for all transitions.
- Women's health redesign and the patient-centered medical home.
 - The redesign of women's health care delivery conforms with the care platform concept discussed in VHA's universal services task force report: "Veterans Health Care: Leading the Way to Excellence."
 - The concept is to co-locate commonly used services and specialties, such as mental health and gynecology into one common care delivery process.
 - All three models focus on the core values to systemize the coordination, continuity, and integration of care for women Veterans.
 - The new definition of comprehensive care for women Veterans emphasizes improved coordination of care for women Veterans, continuity, and patient-centeredness.
- Delivery of comprehensive primary care to women Veterans:
 - Evaluation by outside contractor (started FY 2010).
 - Scoring methodologies and metrics to evaluate implementation of comprehensive care for all facilities.
 - Pilot sites.
 - Validation sites.

- Reporting process for ongoing evaluation and resource monitoring and tracking.
- Discussed preliminary July 2009 findings from GAO's review of VA provision of health care services to women Veterans. Final report posted March 2010.
- VA design and construction standards are being enhanced to address the physical and mental health care needs of women Veterans.
- Space planning criteria being adjusted for specific functions to be performed (mammography, outpatient clinics, radiation therapy, etc.)
- Privacy and security accountability/ measurement.
 - Facility-based environment of care rounds checklist:
 - Monthly assessment ensuring the dignity, privacy, sense of security, and safety of every Veteran in all care settings.
 - A review of structural, environmental, and psychosocial patient safety and privacy issues in VHA patient care settings will be conducted on an annual basis by the Director, Environmental Program Service, and incorporated into monthly environment of care rounds.
 - WVPMs included in the review process.
- Gender and health disparities:
 - Goal is to eliminate gender health disparities.
 - VA performance indicates high quality care delivery, but persistent gaps exist by gender.
 - Understand the provider, Veteran, and system factors.
 - Gender disparities in clinical performance not unique to VA.
 - Very complex interaction of factors; no identified source of problem.
 - Progress to date:
 - Since 2007, Office of Quality and Patient Safety has analyzed and released gender-specific clinical performance data.
 - Hospital quality report card, 2008 and 2009.
 - New: detailed reports by VISN and facility.
 - Allows sites to track measures that reduce performance gaps.
- Next steps:
 - Facility level evaluation of some cases to identify specific barriers to care.
 - Ongoing research to design better models of care for women Veterans.
 - Detailed outcomes analysis and ongoing oversight by program office.
- Provider education and development:
 - Develop a provider workforce to meet the needs of the increasing number of women Veterans.
 - Develop a provider workforce to meet the needs of women Veterans in a comprehensive care/patient-centered model.
- Outreach and communication:
 - VHA plans to utilize the OEF/OIF call center to reach out to women Veterans.
 - Branding developed for women Veterans health program.

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.
 - Emoluments clause.
 - Foreign gifts.
 - Hatch Act.

Overview of Women Veterans Initiatives, Diana Rubens, Associate Deputy Under Secretary for Field Operations, VBA

- Doing better outreach. In FY 08 briefed 300,000 at TAP and in FY 09 briefed 360,000.
- The backlog:
 - Thirteen percent to fourteen percent increase in claims.
 - Pension claims had an increase of 18 percent (partly due to the economy).
 - Recent changes for PTSD may take effect within 30 days; estimated increase once this is announced.
 - Nine new Gulf War presumptive illnesses.
 - Three additional presumptive illnesses for those exposed to Agent Orange (OMB currently in a 30-day comment period): Parkinson's, Leukemia B-cell, and schematic heart disease.
 - Initial estimates were 1 million new claims but it has been increased to 1.2 million as an estimate for new claims.
 - Biggest challenge at VBA facilities is space. Considering a 2nd shift.
- Post 9/11 GI Bill:
 - Fall enrollment period is coming.
 - VA initially considered using vendor services, but process became highly automated (manual).
 - VBA made a decision to advance payments of \$3,000 per eligible service member/Veteran.
 - Education Service trying to streamline the process in three phases:

- 1st Phase to begin in April.
- 2nd Phase at the end of June; converting processes,
- 3rd Phase in December 2010; will require lots of employees.
- Cross training at regional offices.
- Louisville leaders' conference:
 - Goal to lessen percentage of claims, with goal of less than 125 days by 2015, and 98 percent quality review and timeliness by 2015.
 - Guidance provided from VA employees and VSOs who have expertise.
 - Over 45 tasks on the list to do.
 - Pittsburgh RO doing pilot on letters for greater speed with claims (started in January 2010).
 - Discussed improved coordination with VHA and being able to prove claims with private doctor's records and DoD environment.
 - Veterans Benefits Management System (VBMS) to integrate better with VHA and private physicians. Managing different medical records at different sites; paperless but less holistic.
 - Trying to improve consistency among regional offices.
 - Discussed the possibility of specializing in mental health claims.

Women Veterans Coordinators Time Allotted for Workload /Update on Special Monthly Compensation Payments, Karen Gooden, Chief, Outreach, Compensation and Pension Service, VBA

- The duty assignment of Women Veterans Coordinators (WVC) is often an ancillary duty for VA RO employees.
- Most WVCs are employed full time as:
 - Veterans service representatives (VSR).
 - Rating Veterans service representatives (RVSR).
 - Public contact representatives or public contact outreach specialists (PCR/PCOS).
- On November 1, 2000, section 1114(k) of the United States Code was amended to allow special monthly compensation (SMC) for women Veterans who suffered service-connected loss of one or both breasts, including loss by mastectomy. On December 6, 2002, the criteria for entitlement to SMC k were amended to include loss of 25 percent or more of the tissue from a single breast or both breasts in combination (including loss by mastectomy or partial mastectomy), or radiation of the breast or breasts.
- SMC (k) data results:
 - Total of 683 women Veterans service-connected for a hysterectomy-related disabilities, and not coded for receipt of SMC (k).
 - Total of 1108 women Veterans service-connected for a mastectomy-related disabilities, and not coded as in receipt of SMC (k).
- VAROs were provided spreadsheet listings of cases that were to be manually reviewed to determine entitlement to SMC (k). As of August 2009, this review was complete.
 - Approximately 514 hysterectomy-related grants were made.

- Approximately 230 mastectomy-related grants were made.
- Thus far, approximately \$3.1 million dollars in retroactive benefits were paid to women Veterans.
- Fifty-three VAROs granted SMC (k) benefits to women Veterans.
- All eligible SMC payments have been made.
- The first draft pamphlet, VA Benefits and Services for Women Veterans, for women Veterans was unveiled in August 2009 at the WVC training conference in Minneapolis, MN. Additional revisions are being made.

Overview of VHA's Women Veterans Initiatives, Mr. William Schoenhard, Deputy Under Secretary for Management and Operations, VHA

- VHA is undertaking a major transformational agenda.
- Training for VHA leadership in healthcare utilizing the family as part of the care team.
- One out of 16 women Veterans enrolled.
- Will be one out of seven women Veterans enrolled in 15 years.
- Many women Veterans are childbearing age.
- Discussed items under development:
 - Guard/Reserve to find better access.
 - Telehealth.
 - Several ways to make OEF/OIF aware of their benefits and services.
 - Rural health.
 - Homelessness.
 - Childcare options at VA.
- Other VHA items discussed:
 - Quarterly reviews.
 - Full time WVPMS.
 - Mini-residencies.
 - Physical facilities.
 - Hiring more program managers.
 - Getting women Veterans to explain how better enhancements can take place at VA facilities.
 - Research.
 - GAO report on women Veterans health issues.

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

Wednesday, March 31, 2010— Statler AB Room

Meeting was called to order by the Chair.

Items discussed included:

- Chair opened the floor for comments and remarks.
- Discussed highlights from previous day.

VA Outreach to Women Veterans, Nathan Naylor, Deputy Assistant Secretary for Public and Intergovernmental Affairs, Office of Public and Intergovernmental Affairs

- Mr. Naylor provided an overview of Office of Public and Intergovernmental Affairs and highlighted the military contributions of the Honorable L. Tammy Duckworth.
- Mentioned the recent opening of the Tuscaloosa Alabama VA Medical Center's Women Veterans Clinic and described the opening from a public affairs perspective.
- Discussed how getting accurate consistent information out to our Veterans changes lives.
- Discussed the new VA staff for Twitter, You Tube and blogs, as well as the deliberate task to keep the VA Web site up to date with new national information.

Update on 2008 Report (Recommendation 7-- That the Environment of Care (Privacy) Check List is included as a part of VAMCs, Outpatient Clinics, and Community Based Outpatient Clinics (CBOCs) quarterly environmental rounds. Recommend also that the local VAMC WVPM be part of the Environmental Rounds Inspection Team), Jahmal Ross, Director, Environmental Programs Service, VHA

- One hundred percent of VHA facilities have reported adding the WVPMs to their environment of care administrative rounds and are using the checklist.
- Fifty four percent of total disparities identified are related to privacy curtains while 12 percent is related to access to proper fitting pajamas. The majority of these disparities requires minor retrofit for privacy and is expected to be closed this fiscal year.
- The latest completion date for all disparities is FY 2015.
- Estimated timeline:
 - 2011 – 71 percent completion of total disparities identified.
 - 2012 – 81 percent completion of total disparities identified.
 - 2014 – 95 percent completion of total disparities identified.
 - 2015 – 100 percent completion of total disparities identified.
- Actions to correct disparities range from as small as rearrangement of room furniture, to major reconstruction.

Contract Exam Overview, John R. Capozzi, Chief, Contract Management Staff Compensation and Pension Service, VBA

- Discussed the purpose of QTC Management, Inc. contract.
 - PL 104-275 authorized VA to conduct pilot program to contract for medical disability examinations from non-VA sources.
 - Enacted October 9, 1996.
 - Limited to 10 VAROs.
 - The authority has no sunset date.
- Contract awarded to QTC Management, Inc.
 - QTC began work Feb. 25, 1998.
 - Successor contract awarded for May 2003 through April 2008 to QTC.

- High marks on performance resulted in award years added to contract.
- ROs are located in Boston, Roanoke, Atlanta, Winston-Salem, Salt Lake City, Los Angeles, Seattle, Muskogee, Houston and San Diego.
- Forty benefits delivery at discharge (BDD) sites.
- Results are measured on three standards of performance:
 - Quality (required to be at least 92 percent).
 - Timeliness (cycle completed within 38 days).
 - Customer satisfaction (required to be at least 92 percent).
- Quarterly reviews conducted to determine if meeting acceptable level of performance
- Discussed the purpose of MES Solutions, Inc. contract.
 - PL 108-183 temporarily authorizes VA to expand the contract medical disability examinations from non-VA sources beyond the limitation of PL 104-275.
 - Enacted December 16, 2003.
 - No limitation on the number of VAROs.
 - The authority was extended to December 31, 2010.
 - Contract awarded to MES.
 - ROs located in Cleveland, Des Moines, Indianapolis, Lincoln, St. Louis, and Waco.
- Results:
 - Option year exercised (May 2, 2009 – May 1, 2010).
 - To date, MES Solutions, Inc. received high marks for customer satisfaction; timeliness and quality were both within acceptable levels of performance.

Update on 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; Update on Uniform Mental Health Services Handbook, Dr. Antonette Zeiss, Deputy Chief, Mental Health Services, VHA

- Gender-specific issues can be important component of care.
- Strongly encourage sites to give Veteran:
 - Treated for Military Sexual Trauma (MST) the option of same-sex provider, or opposite-sex provider if trauma involved a same-sex provider.
 - Treated for other mental health (MH) conditions the option of a consultation from same-sex provider regarding gender-specific issues.
- All VA facilities must accommodate and support women and men with safety, privacy, dignity, and respect.
- All inpatient and residential care facilities must provide separate and secured sleeping accommodations for women.
- Mixed gender units must ensure safe and secure sleeping and bathroom arrangements including, but not limited to, door locks and proximity to staff.
- Considerations:

- MST-related care is designated by use of the MST encounter checkbox in the Computerized Patient Record System (CPRS) and is not limited to clinic stop code 524, active duty sexual trauma.
- MST Support Team Reports, FY 2008:
 - MST screening report.
 - Summary of MST-Related Outpatient Care Report.
 - Report on MST Screening in Community Based Outpatient Clinics (CBOCs).
 - Summary of MST-Related Outpatient Care Report in Community Based Outpatient Clinics (CBOCs).
 - Special Report on Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans, MST Screening and Summary of MST-Related Outpatient Care.
- The MST support team will employ already established methods for identifying MST-related care to produce a MST-related care provider report.
- Report data sources:
 - PAID Database (VA Payroll data) is used to identify unique VHA providers and their gender.
 - MST Support Team MST Data Archive contains information on each patient's gender and MST screen status.
 - Outpatient Encounters File is used to identify encounters that are designated as MST-related, and to identify a provider ID.
 - Proposed MST-Related Care Provider Report will be able to examine the gender of providers of MST-related MH care to female Veterans and may include:
 - The proportion of all MST-related MH encounters that are attributed to a female MH provider at each facility, or
 - The proportion of female patients with MST-related MH encounters at each facility who were seen by female providers for at least one of those encounters.
- MST support team action Items:
 - Develop and refine methods to determine data quality and link new and existing data sources.
 - Develop procedures to resolve unique issues with provider data, such as resolving providers with encounters at multiple facilities, or identifying primary providers and trainees.
 - Develop draft reports to be reviewed by Office of Mental Health Services (OMHS), in the Office of Patient Care Services.
 - VA's Commitment: Quality Care.
- Our Nation's commitment to a new generation of Veterans, for their lifetime:
 - Treat returning Veterans early in the course of mental health problems.
 - Provide holistic, integrated care for physical and mental health problems.
 - Being there for the lifetime of all Veterans we are serving, from all eras.
 - Attrition of VA MH services in the late 1990s up to about 2003.
- Major Rebuilding and innovation since 2004, based on strategic plans.
 - VHA comprehensive MH strategic plan:

- Developed in 2003-04 and approved November 2004.
- Major rebuilding efforts for MH began with this document.
- Uniform MH services handbook:
 - Defines MH services that must be provided to all enrolled Veterans.
 - Completes implementation of strategic plan for patient services.
- Continuing transformation: Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics (UMHSH):
 - Implementation began September 2008.
 - Key principle: mental health care is an integral component of overall health care.
- Lays out minimum requirements for VA MH services:
 - Delineates essential components of mental health care that are to be implemented nationally.
 - To ensure that all Veterans, wherever they obtain care, have access to needed mental health services.
- Status of Implementation of UHSH:
 - Full implementation mandated by end of FY09.
 - Survey sent to facilities in August 2009 for thorough report on status of implementation.
 - Results obtained in September 2009.
 - Feedback sent to field in January 2010.
 - Second survey sent to field in January 2010 (just returned in early February).
 - Technical assistance planned following review of results of the second survey.
- Summary of findings:
 - Overall implementation in facilities (medical centers):
 - The overall implementation of the requirements of the handbook was 85.2 percent.
 - Although there were no statistically significant differences between VISNs in the extent of implementation reported, two VISNs reported implementation under 80 percent and two VISNs reported implementation over 90 percent.
 - System problem program areas in facilities:
 - For three of 12 of the program areas addressed in the Handbook, implementation across VISNs and facilities averaged less than 80 percent. These were requirements related to:
 - Mental health services for older adults with 79.9 percent implementation.
 - Serious mental illness with 73.7 percent implementation.
 - Residential care with 71.6 percent implementation.
 - Facility performance:
 - Across the VA system, VISNs reported performance in 144 facilities.

- Twenty seven of them, 18.75 percent, had overall implementation scores less than 80 percent.
- System problem program areas for CBOCs:
 - All CBOCs are required to deliver, or make available services in seven program areas:
 - Emergency Coverage.
 - Basic MH Services.
 - Inpatient.
 - Residential.
 - General Ambulatory.
 - Serious Mentally Illness (SMI).
 - Substance Use Disorder (SUD).
 - In addition, very large CBOCs are required to deliver services on-site in the following four program areas:
 - Primary Care Integration.
 - Older Adults.
 - Homelessness.
 - PTSD.
- Total implementation in CBOCs:
 - The overall total implementation rate of the requirements of the Handbook among the CBOCs was 90.8 percent.
 - No VISN differed significantly from the remaining 20 VISNs in the overall rate of implementation of handbook requirements.
 - All VISNs reported an implementation rate over 80 percent and 14 VISNs reported implementation over 90 percent.

Subcommittee Breakout Sessions

Health and Benefits subcommittees met with assigned ACWV members to discuss issues to be considered for the upcoming 2010 Report, and to develop recommendations.

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

Thursday, April 1, 2010— Statler AB Room
Meeting was called to order by the Chair.

Subcommittee Breakout Sessions

Health and Benefits subcommittees met with assigned ACWV members to discuss issues to be considered for the upcoming Report, and to craft recommendations.

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

Meeting adjourned.

Work on 2010 ACWV report recommendations.



Shirley A. Quarles, Ed.D., R.N., F.A.A.N.
Chair, Advisory Committee on Women Veterans



Irene Trowell-Harris, Ed.D., R.N.
Designated Federal Officer