

Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans (ACWV)
Virtual Meeting, Washington, DC
April 27-29, 2021

The Advisory Committee on Women Veterans (the Committee) conducted a virtual meeting with VA Central Office Administrations and Staff Offices. Betty Yarbrough, Chair, presiding.

ACWV Members Present:

COL Betty Yarbrough, USA, Ret., Chair
FLTCM April Beldo-Lilley, USN, Ret.
Tiffany Daugherty, USA Veteran
CMDCM Linda Handley, USN, Ret.
CMDCM Octavia Harris, USN, Ret.
LTC Lisa Kirk, Maryland Air National Guard, Ret., Vice Chair, Health Subcommittee
MG Marianne Mathewson-Chapman, USA, Ret.
CW2 Moses McIntosh, Jr., USA, Ret.
LCOL Shannon McLaughlin, Massachusetts Army National Guard, Vice Chair, Benefits Subcommittee
Sandra Miller, USN Veteran
MSG Lachrisha Parker, USA Reserve, Ret.
COL Wanda Wright, USAF, Ret.

ACWV Ex-Officio Members Present:

Dr. Patricia Hayes, Office of Women's Health, Veterans Health Administration (VHA)
Nicole Neri, Veterans Employment and Training Service, Department of Labor (DOL)
Dr. Lawrencina Pierce, Outreach, Transition and Economic Development, Veterans Benefits Administration (VBA)
COL Elaine Freeman, U.S. Army, Defense Advisory Committee on Women in the Services (DACOWITS), Department of Defense

ACWV Advisor Present:

Faith Hopkins, Improvement and Compliance Service, National Cemetery Administration (NCA)

ACWV Advisor Excused:

CAPT Michelle Braun, U.S. Public Health Service, National Institutes of Health (NIH)

Center for Women Veterans (CWV) Staff Present:

Elizabeth Estabrooks, Acting Director/ Acting Designated Federal Officer (DFO)
Shannon Middleton
Ana Claudio
Julia Kelly

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Other VA Staff:

Jelessa M. Burney, Advisory Committee Management Office
Michael Dwyer, VHA
Kellye Kinnel, VBA
Jennifer Koget, VHA
Jessica Martinez, Office and Congressional Legislative Affairs
Eric Patterson, VBA
Dr. Janet Porter, VHA
Renata Scott, VBA
Trent Thomas, VBA
Elaine Westermeyer, VBA

Public Guests:

Nestor Aliga
Adrian Atizado
Dixie Banner
Tammy Barlet
Veronica Bauer
Dr. Cathy Bennet-Santos
Rene Campos
Sharon Cherrette
Chiquita (no last name provided)
Cynthia (no last name provided)
Irma Cooper
Rebecca Duberstein West
Maureen Elias
Cathy Ellis
Kara Fields
Cindy Garcia
Krystal Gilewski
DeAndria (no last name provided)
Patricia Harris
Kristina Keenan
Alexandra Logsdon
Tonya Maselli McConnell
Bridge Mulrooney
Bob Notch
Alexis Pierce
Donna Polichemi
Susan Price
Ethel Robinson
Xochit Rodriguez-Murillo
Clelia Taylor
Sheila Venson

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Public Comment:

Written public comment received from Dr. Cathy Bennett-Santos.

Tuesday, April 27, 2021

Open Meeting

The Chair called the Committee to order at 10:00 a.m. Eastern Standard Time (ET) on its first meeting day. The Committee members, ex-officio members, advisors, and public guests introduced themselves.

Approve Minutes

The ACWV approved the minutes from the September 21-24, 2020 virtual site visit to the Southern Arizona VA Health Care System.

Center for Women Veterans Update

Elizabeth Estabrooks, Acting Executive Director, Center for Women Veterans/Acting Designated Federal Officer, ACWV

Ms. Estabrooks welcomed the ACWV and the public. She mentioned new legislation that impacts the Center for Women Veterans and the ACWV. The Johnny Isakson and David P. Roe Veterans Health Care and Benefits Improvement Act of 2020 (Public Law 116-315) includes requirements for the ACWV and CWV to examine the impact of intimate partner violence (IPV) on women Veterans. She indicated that CWV is partnering with VA HSR&D to conduct a study and provided guidance to the ACWV members to ensure that they are especially mindful of the information shared during the presentation on IPV they will receive later during the meeting. Finally, she commented that the ACWV's work is impactful and is helpful in resolving issues for women Veterans.

Women Veterans Benefits Journey Map

Stephen Ellis, Sr. Customer Experience Strategist, Strategic Program Management Office (SPMO), VBA/ Angela Kendrix, Acting Deputy Director, Outreach, Transition and Economic Development (OTED), VBA

Mr. Ellis provided an overview of VBA's collaboration with the Veterans Experience Office (VEO) to better understand women Veterans' experience when accessing benefits and programs administered by VBA. The collaboration resulted in a women Veterans benefits journey map, creation of five women Veteran personas to illustrate the diverse perspectives of women who come to VA and eight key findings that can direct VA in identifying and prioritizing resources to address pain points for women Veterans.

He provided an overview of the key takeaways from the project: human centered design (HCD) research confirms that women Veterans have a different experience from their male counterparts. Knowing this, VA can take specific action to ensure women Veterans learn about and access VA benefits and services at times that are meaningful to them. VBA's immediate next steps include: sharing the insights and personas with women Veterans coordinators and other VBA staff to build empathy and understanding; sharing

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health care related insights with VHA and transition-related insights with DoD; identifying one to two priority areas to focus future design efforts in VBA to enhance outreach products and programs specifically for women Veterans and exploring strategic partnerships to develop a peer-to-peer women Veterans network.

Mr. Ellis explained the methodology VBA used for the women Veterans benefits journey map. VBA used HCD methodology to speak with male Veterans and women Veterans to map their benefits journey and to identify pain points and bright spots that they experienced. By interviewing Veterans and listening for bright spots and pain points, the journey mapping process allowed VBA to discover opportunities and take action to improve processes and services for women Veterans and to empower VBA staff to deliver benefits in a manner that honors their service.

Describing the journey map timeline, he noted that HCD planning took place from June to July 2020. From August to October 2020, staff conducted HCD interviews and data analysis. From November to December 2020, they created the journey map. This work resulted in the three deliverables: the journey map; five women Veterans personas; and an insight report.

The five women Veteran personas identified are a combination of characteristics and experiences heard during the research. They outline key perspectives shared about their unique experience as a Veteran and accessing VA benefits. Comparing personas reveals the diversity of women Veterans' attitudes and behaviors towards the military, VA and VA benefits. These women Veteran personas can be used as a tool for prototype development and design, providing insight into how certain Veterans may interact with different interventions.

Mr. Ellis explained that archetypes serve as a foundation for the development of the five personas. They outline contrasting attributes for the most clearly identified motivators, mindsets, needs and pain-points found in the user data. For women Veterans, the most prominent contrasting attributes were whether they faced equal treatment before and after leaving the military and whether they embraced their Veteran identity.

From the smooth sailor archetype--who embraces Veteran identity after the military and faces equal treatment before and after leaving the military--the Well-Off Wanda persona was developed. From the altruistic archetype--who embraces Veteran identity after the military and faces unequal treatment before and after leaving the military--the Advocate Anita and the Hesitant Heidi personas were created. From the progressor archetype--who faces equal treatment before and after leaving the military and disengages from all things military or Veteran related--the Moving on Mei persona was created. From the disenchanting archetype--who disengages from all things military or Veteran related and faces unequal treatment before and after leaving the military--the Untrusting Uma persona was created.

He explained that insights form the basis of design decisions. While all women Veterans may not experience every insight, each insight represents a major pattern heard in the

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women Veteran interviews, verified with project stakeholders, and in some cases, supported by findings from previous projects. The insights gathered from the women Veterans are that: they are being overlooked as a Veteran or personally not identifying as a Veteran; they are feeling too overwhelmed to find what they need; they have a desire to connect to others with similar backgrounds; they are hiding trauma to remain strong; and that their experiences tell them that the military and VA are not designed for women.

Mr. Ellis also discussed the key findings identified from talking with the women Veterans: they are seeing that male Veterans are treated better than women Veterans; being a VA employee means being part of a Veteran community; they are facing discrimination beyond gender; they are leaning on family and Veterans like themselves; they need more personalized outreach; they feel the life-long effects of MST; they want non-traditional health care services from VA; and they acknowledge that not all women Veterans have a negative experience.

Ms. Beldo- Lilley asked Mr. Ellis about how VBA will use the insight it gained to make women Veterans feel more understood and appreciated. Mr. Ellis said that VBA is sharing this insight with VHA and DOD to address issues, and VBA's national women Veterans program manager is sharing it with women Veterans coordinators (WVC) in the field. Additionally, this information may be used for building a peer to peer network.

Ms. Handley asked if the initiative is only for regional offices (RO). Mr. Ellis responded that this national project was taken to the 57 ROs.

Vice Chair Kirk asked if any specific health-related concerns surfaced from focusing on the five archetypes. Mr. Ellis mentioned that VBA is sharing any health-related concerns from the Insights report with VHA.

Ms. Harris asked why the majority of the northeast part of the country was not represented for this project. Mr. Ellis noted that District Offices throughout VA were included and the WVCs helped to identify women Veterans who would want to participate. Ms. Harris asked if there will be any follow-up on the data that was collected. Mr. Ellis VBA will follow-up on whatever comes from discussions with VHA and DoD.

The Chair asked if the journey map identifies any barriers to accessing VBA benefits and inquired about VBA's purpose for wanting to develop the journey map. Mr. Ellis confirmed that it did shed light on some barriers and other issues. Women Veterans represent a growing population of Veterans. VBA developed the journey map to help them access benefits and to better understand their journey. VBA wanted to understand the reasons they are not applying for benefits. The Chair expressed concern that the five personas do not adequately depict the diversity of the women Veterans population. She agreed, however, that VBA is at a good starting point. It can increase the value of the tool it is developing to capture other things that impact women Veterans' access, such as manpower.

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Ms. Harris noted that the ACWV needs to keep this on its radar, maybe submit a request for information or another recommendation, if necessary. She also noted that the northeast is a good area to tap into when illustrating women Veterans' journey.

Update on Women Veterans Research

Dr. Elizabeth Yano, Director, VA Women's Health Research Network, VA Health Service Research & Development, Veterans Health Administration (VHA)

Dr. Yano provided an overview of advances in VA's women Veterans research. She explained that the VA's Women's Health Research Network (WHRN) is comprised of the Women's Health Research Consortium and the Women's Health Practice Based Research Network (PBRN). The Women's Health Research Consortium conducts training and education, methods support; research development; and dissemination of information. The PBRN works to increase recruitment of women; increase multisite research; engage local clinicians, leaders to increase implementation/impact of research.

The goal of the WHRN is to use research to transform women Veterans' care in VA to better understand women Veterans' health needs, access to needed services, quality of care, and patient experience; increase inclusion of women Veterans in relevant VA research; examine gender differences in health and health care; and develop novel interventions to support women's care. It also seeks to determine what interventions need to be gender-tailored; engage women Veterans, VA providers, staff and leaders, and external groups (like ACWV) for input and ideas; build partnerships to increase implementation of research evidence in routine practice and policy; and disseminate VA women's health research.

The PBRN is now located in 73 VA medical centers (VAMC) and more than 300 community-based outpatient clinics (CBOC). More than 80 studies are currently underway.

Research on women Veterans' attrition from VA care, or whether a woman Veteran will stay in VA for their care, indicated that the odds of attrition from VA was almost four-fold higher for new patients than established patients. However, women Veterans who were new to VA were twice as likely to stay if they saw a women's health primary care physician (WH-PCP). Attrition rates from VA care among new users was similar for women and men Veterans over time, but women Veterans were less likely to leave VA care after VA's implementation of the comprehensive women's health care policy. Some of the experiences of VA care that positively influenced women's decisions to continue to use VA included affordability; the availability of gender-tailored care delivery in women's health clinics; providers' specialized knowledge of caring for Veterans (particularly in mental health); favorable patient-provider relationships; availability of virtual and online care delivery platforms; and convenience of centrally located, integrated care.

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VA reproductive health research shows a substantial growth in research on contraception and pregnancy (2019 systematic review), to include gaps in infertility, sexually transmitted infections, menopause, and gynecologic care research. Since the review, new VA research has been funded on other reproductive health issues, like menopause, infertility, and fibroids.

Dr. Yano identified cross-cutting themes in the literature to date, such as the negative impacts of sexual assault history and mental health conditions on reproductive health service use and outcomes across the life course, as well as a need for trauma-informed reproductive health care with integration of mental health services.

Additionally, she provided updated research findings regarding pregnancy, menopause and contraception that have been identified since the systematic review. Cesarean rates among women Veterans using VA maternity care are similar to those in the general population. Menopause symptoms increase the likelihood of chronic pain. Menopausal hormone therapy was associated with an increased risk of suicide attempt and increased risk of suicide. Among women Veterans with chronic pain, menopausal symptoms were associated with increased risk of long-term opioid use. MyPath, a patient-centered web-based reproductive decision support tool, is highly acceptable to women Veterans. More than half of women Veterans receiving contraception from VA report getting their ideal choice. The presence of a gynecologist at the primary care site was associated with increased odds of a match between ideal and actual contraception.

Dr. Yano shared that VA has significantly increased funding for reproductive research, focusing on maternity care, reproductive planning and menopause/mental health. VA also funded other major reproductive studies on contraceptive use, VA maternity care coordination, pregnancy outcomes, racial-ethnic disparities in uterine fibroid outcomes, sexual assault and combat-related trauma impacts on fertility. VHA is planning a virtual VA reproductive health research conference for summer 2021.

Dr. Yano summarizes findings from VA's research on harassment. Research indicates that one in four women Veterans are harassed in medical facilities. This is associated with delayed and missed care. Women who screened positive for MST, depression or PTSD were more likely to report feeling unsafe at VA. Men and women Veterans' harassment perspectives differ, with women expressing a clear understanding of behaviors constituting harassment and men expressing confusion on differentiating harassment, "harmless flirting" and general friendliness.

WHRN's evaluation of the effects of VA culture change initiatives is showing that most women Veterans report feeling safe (87%) and welcome (90%). Additionally, more VA facilities are adopting training and culture campaign activities. VA has several ongoing studies addressing gender-based harassment in VA; utilization of bystander activation intervention to address gender-based harassment and identification of staff strategies, barriers, and facilitators for intervening in Veterans' harassment. WHRN launched a harassment-focused research work group that is preparing several proposals.

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VA research has produced innovative care models for MST-related posttraumatic stress disorder (PTSD). VA is a leader in treatment for MST-related PTSD and trauma. Several VA randomized trials examined how gender and MST impact PTSD symptoms following cognitive processing therapy (CPT) and prolonged exposure (PE) therapy, showing a significant decrease in PTSD and depression.

Dr. Yano shared that VA is studying innovative approaches to treatment/engagement, such as trauma-sensitive yoga and mobile mental health (VA app “Beyond MST”) to offer resources and information to help survivors cope with MST-related challenges and improve their health, relationships and quality of life.

VA women Veterans suicide research shows that women Veterans’ suicide rates are higher than non-Veteran women. Her office launched a work group in 2017 to examine this and convened agenda-setting in 2018. Dr. Yano also oversaw a special journal issue on women and suicide in 2019-2020.

VA completed research on identifying novel opportunities for suicide prevention among women Veterans using reproductive health services. VA has ongoing research on women Veterans and suicide to address suicide prevention in women Veterans who utilize VA care and non-users, understanding suicide risk among LGBT Veterans in VA care, strengthening suicide prevention efforts through the Veteran Crisis Line and preventing firearm-inflicted suicides.

Dr. Yano concluded by noting that VA has significantly increased women Veterans’ research; increased their inclusion in research; increased emphasis on high-priority topics, such as women’s access, community care, trauma/MST/IPV, harassment, suicide, reproductive health; and increased its reporting of research on women Veterans’ health and gender differences at all levels. She further added that collaborative research enhances research impacts and accelerates evidence-based practice and policy, but there is more to learn and apply to ensure women Veterans get the care they need.

Vice Chair Kirk asked for copies of the research snapshots that Dr. Yano mentioned during her presentation. She noted that endocrine disruptions may look different in women Veterans than they do in non-Veteran women. She made mention of the importance of research on harassment. She acknowledged the finding that women Veterans do better when they use VA for health care, then inquired about the existence of research on bystander intervention to reduce instances of harassment. Dr. Yano responded that VA does not have enough information on that yet. However, there is evidence of bystander work outside of VA. More research is needed, to include how to train staff to address harassment when it occurs.

**Briefing: Expansion of Peer Support for Women Veterans
Dr. Jennifer Strauss, Acting National Director, Family Services, Women’s Mental Health and Military Sexual Trauma, Office of Mental Health and Suicide Prevention, VHA**

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Dr. Strauss presented information on VA's new women's peer support initiatives and updates on women's mental health. Women Veterans are more likely than male Veterans to experience a mental health condition. Compared to male Veterans, women Veterans have higher rates of depression and anxiety, higher rates of mental health and medical comorbidities, higher rates of life stressors and fewer resources and are clinically more complex.

Data from 2018 show that the rate of suicide in women Veterans is about 2.1 times higher than the rate for civilian women ages 18 and over. Among women Veterans, the rate is highest for young women Veterans, ages 18-34. Women Veterans have a greater likelihood of using firearms to commit than women non-Veterans.

Dr. Strauss gave an overview of several women's peer support initiatives for FY21. VA peer specialists are Veterans with lived experience recovering from mental illness and/or substance use disorders. They are members of a multidisciplinary treatment team that provide recovery-based services and they serve as role models for personal recovery. Their job is to assist Veterans in identifying and expanding their skills, strengths, supports and resources to achieve personal wellness and recovery goals; facilitate peer support groups; and provide crisis support.

Congressional House Report 7105/Megabus Act, Section 5206 requires VA to conduct a capacity assessment. Currently, there are approximately 1,200 peer specialists in VHA, of which 235 (19%) are women. VHA is developing a plan to hire more women peer specialists.

Congressional House Report 116-445 and the 2021 Joint Explanatory Statement directed VA to expand programmatic support for women's health care, including peer support for women Veterans; identify Women Veterans Network (WoVeN) for implementation within VHA; and provide \$1,000,000 in funding in FY21 to support these efforts.

Support groups for women Veterans provide a place for them to share their experiences in a supportive, recovery-oriented environment. Many face challenges during re-integration into civilian life, including challenges that are unique to women Veterans. Fewer resources are geared toward easing re-integration for women Veterans relative to male Veterans. Available resources for men do not always fit the needs of women Veterans.

WoVeN support groups are led by and for women Veterans (across services eras and branches of service). They offer eight 90-minute peer-led group meetings, with six to eight women per group. VA Women's Mental Health (WMH) and Peer Support Services is adapting WoVeN for VA to better serve women Veterans. VA WoVeN will include a team of women's mental health clinicians, trained peer specialists and peer specialist supervisors.

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In FY21, VA is offering several women peer specialist training opportunities, such as a webinar series for peer specialists and supervisors and a national continuing education effort. This multi-day training series will enhance knowledge and skills to provide gender-sensitive peer services that meet women Veterans' unique needs. It is adapted from the WMH Mini-Residency and VA's Annual Peer Specialist and Peer Support Supervisor Training Conference, covering issues that are relevant to serving women Veterans. National continuing education training is scheduled for fall 2021.

Dr. Strauss provided WMH updates and information on new WMH initiatives. VHA is establishing WMH champions, to ensure that there is at least one point of contact for WMH at each VA medical center. The VA WMH Champion is a mental health clinician with a specific interest and expertise in women Veterans' mental health and supports and expands local women's mental health resources and programming in support of gender-sensitive mental health care. The VA WMH Champion also partners with other local women's health stakeholders to identify and address local women-specific needs. The WMH mini-residency is a multi-day training that covers a broad range of topics related to the treatment of women Veterans and Service members. Nationally recognized experts lead sessions in gender-tailored psychotherapies and psychiatric medication management with a focus on the influence of hormonal changes and the reproductive cycle. The Department of Defense (DoD) partners with VA at least every other year to create a joint VA/DoD Mini-Residency; they are currently planning virtual 2021 conference.

Dr. Strauss discussed eating disorders in Veterans. Rates of eating disorders among all Veterans are at least as high as rates in the general population. Approximately 14% of women Veterans and approximately 4% of male Veterans who use VA health care have eating disorders. Among those Veterans, there are high rates of co-occurring mental health problems, serious medical consequences and increased risk of suicide. There are specialized VA Multidisciplinary Eating Disorder Treatment Teams in each VISN that provide direct care and clinical consultation. This gold standard, team-based treatment model includes evidence-based psychotherapy, psychiatric medication management, primary care, dietitian services and case management.

VA provides expert-led clinician training and consultation in STAIR (Skills Training in Affective and Interpersonal Regulation) and Parenting STAIR. These are cognitive-behavioral trauma treatments that teach skills for managing strong emotions and building healthy relationships, including parenting relationships. They are important areas of functioning that can be highly disrupted in women with histories of serious interpersonal traumas, such as sexual assault. Research indicates that emotion dysregulation is associated with suicidal ideation and behaviors.

VA is focusing on women's reproductive mental health, which is the functioning of a woman's reproductive system throughout her life. Elements of a woman's reproductive health, such as hormonal changes during pregnancy and menopause, can affect her mental health and influence treatment decisions, such as use of medications during pregnancy. In FY20, VA launched an innovative national reproductive mental health

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consultation program, which ensures that women Veterans everywhere can benefit from optimal diagnosis and treatment of reproductive mental health concerns.

The reproductive mental health consultation program includes a team of VA national subject matter experts that respond to requests for consultation from VA clinicians on issues such as premenstrual; pregnancy planning; pregnancy and the postpartum period; pregnancy loss (miscarriage, stillbirth); transition to menopause; breast and gynecologic cancers; contraceptives; and gynecologic conditions, including those resulting from sexual trauma.

VA offers dialectical behavior therapy (DBT), an evidence-based intervention for reducing suicide attempts and non-suicidal self-directed violence with extensive research support. The “full model” DBT includes weekly individual therapy; a weekly DBT-Skills Group (DBT-SG) for 6-12 months; phone coaching, as needed between sessions; and a weekly consultation group for patient’s providers to discuss problems that arise, coordinate care, and take care of each other.

In February 2021, WMH piloted an interactive, live virtual training in DBT-SG to teach patients to manage crises, emotions, and relationships. The DBT-SG, as an addition to regular case management or care, has been found to reduce suicidal behaviors in Veterans. For this initial pilot, teams from VA sites in Alaska, Caribbean (Puerto Rico), El Paso, Northern California, Southeast Louisiana, Tomah were selected. The DBT-SG is prioritized to include sites with little or no DBT programming that provide care to rural Veterans.

For the DBT-SG training pilot, 26 clinicians completed training with 100% retention. Training was virtual, experiential, case-based and highly interactive. It included weekly reading and practice; teams took turn demonstrating. Newly trained clinicians are beginning to offer DBT-SG. The training team is currently evaluating the training curriculum to see what needs to be revised. The second round of training will be conducted by end of FY21.

Ms. Wright commented that Arizona’s women Veterans have expressed concern about VA not having MST groups for support. She wanted to know if WoVen would be good for them to talk about sexual trauma. Dr. Strauss commented that WoVen is not good for addressing shared trauma, as it is focused on wellness and trauma would be more of an intervention. Ms. Wright followed up with a comment about a MST-focused WoVen group possibly being the next step to recovery. Dr. Strauss noted that there is no MST group yet; it is too early in the initiative. They may decide to form their own alumni group/their own community. Participation in WoVen may probably give them more tools to work through their issues.

Vice Chair Kirk inquired about mandatory training for the mental health realm. Dr. Strauss noted that in WMH, the mini residency is mandatory for all MH champions. For peer specialists, the annual national conference is mandatory. MST training is mandatory.

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Dr. Mathewson-Chapman inquired about how Dr. Strauss's office outreaches to women Veterans and women Veterans groups. Dr. Strauss noted that the MH champion's role is to do outreach to women Veterans providers, WVPMs and sometimes the communities.

Vice Chair McLaughlin asked about whether VA provided credentialing for the MH providers. Dr. Strauss shared that VHA provides a certificate of completion for all the trainings and offers continuing education credits.

Ms. Beldo-Lilley asked if WoVen is widely available in the community. Dr. Straus noted that they are bringing WoVen into VA with the expectation that peer support specialists will run WoVen in the facility. Six to eight will be a part of the pilot this year. In response to Ms. Beldo-Lilley's inquiry about where these six to eight peer support specialists will come from, Dr. Strauss indicated that there will be some geographic spread.

Ms. Parker inquired about how they will determine the age composition of the groups, considering age and service era gaps. Dr. Strauss indicated that VA is still figuring it out. The feedback is that a range of ages in the group is best. They will learn from each other.

Ms. Harris inquired about teams and how the Veterans Integrated Service Networks (VISN) coordinate at the local facility level to address eating disorders. Dr. Strauss noted that teams are a VISN level resources, but they are not in every facility. Each team should be conducting outreach on the local level. Ms. Harris also asked if each VISN has a list of MH champions. Dr. Strauss noted that VISN staff can use VA's intranet to learn of who and where they are.

Briefing: Women's Health Update/Reproductive Health and Coronavirus Dr. Amanda Johnson, Director, Women's Reproductive Health, Office of Women's Health, VHA/Dr. Alicia Christy, Deputy Director, Women's Reproductive Health, Office of Women's Health, VHA

Dr. Amanda Johnson provided an overview of Women Health's reproductive health program initiatives. The women Veterans population has characteristics that may put them at higher risk of severe maternal morbidity and mortality. A higher proportion of women Veterans are Black (31%) than in the general population. Generally, women Veterans who use VA for maternity care have MH comorbidities, are older and have hypertension. The number of VHA-paid deliveries increased more than 14-fold between FY2000–2015. VHA paid for approximately 6,000 deliveries in 2020.

VHA does not have perinatal care infrastructure. All maternity care (prenatal care and labor and delivery) occurs in the community. Maternity care coordinators (MCCs) play a vital role in care coordination. There is a MCC at every VA facility to support pregnant Veterans through pregnancy and postpartum. They help Veterans navigate health care services, both inside and outside of VA; connect Veterans to community resources; connect Veterans to care after delivery; and assist with billing concerns. To address reproductive MH, Office of Women's Health (OWH) collaborates with MH on several

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efforts, such as the Inpatient Perinatal Mental Health Workgroup, maternal mental health campaigns, dissemination of the National Reproductive Mental Health Consult. OWH also provides trauma-informed gynecologic care.

Dr. Johnson provided an overview of infertility services that VA covers in all women Veterans, to include fertility evaluation; surgical intervention, if necessary; ovulation induction; controlled ovarian hyperstimulation (ovulation induction with gonadotropins); and intrauterine insemination. For those who have service-connected infertility, VA also covers In-Vitro fertilization (IVF) and treatment for their spouses. To qualify for IVF, the Veteran must be deemed infertile by a provider and have the diagnosis verified by a VA provider; must be service connected for a condition that caused the infertility; must be legally married to an opposite-sex spouse; and have testicular tissue from which sperm can be retrieved (for the male Veteran) or have an intact uterus and at least one viable ovary (for the woman Veteran).

Dr. Johnson explained that VA has IVF interdisciplinary teams that track all couples seeking IVF services, approve eligible couples in a timely manner, review complex cases and complete and submit VHA Office of Community Care IVF approval. The team ensures bi-directional communication with Veteran couples. She then shared information on the availability of VHA's infertility resources for Veterans, as well as information on external grants, advocacy, and patient information addressing fertility.

She discussed VA's safe prescribing efforts, to include resources for providers on high-risk medications for women, such as anticoagulants and seizure control medications. She also discussed resources available to make women Veterans aware of preconception and contraception care options that VA provides, such as the Long-Acting Reversible Contraception (LARC) patient-facing brochure, the preconception care mobile application and emergency contraception materials.

Dr. Johnson provided information on OWH's education campaign on pelvic floor disorders, to include pelvic organ prolapse and urinary incontinence. She noted that VA offers peri/menopause management, to include vasomotor symptom management, management of genitourinary syndrome of menopause and sexual dysfunction.

She noted that 80% of VA's health care systems (HCS) or 140 HCSs had at least one gynecologist on staff in FY19. VHA provides ongoing initiatives to maintain the effectiveness of its gynecology workforce, for example a Gynecology Virtual Community of Practice; National Gynecology Virtual Grand Rounds; VA National Gynecology Needs Assessment (bi-annually); VA National Gynecology Meetings (bi-annually); the State of Reproductive Health Volume II.

Dr. Alicia Christy provided a summary of COVID-19 vaccine resources for women. OWH developed a reproductive health COVID-19 toolkit, focused an episode of the "She Wears the Boots" podcast to COVID-19 vaccination, provided a fact sheet on debunking myths and created a poster to motivate women Veterans to vaccinate. All Veterans are now eligible for the COVID-19 vaccine, regardless of age. Spouses and

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caregivers of Veterans are also eligible. OWH is focusing efforts on addressing vaccine hesitancy among women and ethnic minority Veterans.

Dr. Christy gave an overview of OWH's COVID-19 Vaccine Resource Toolkit, which was created to ensure that VA staff had the necessary resources to guide them when discussing COVID-19 vaccines with women Veterans. The toolkit's information focuses on gender-specific considerations. It also includes reliable resource links to CDC's and VHA's COVID-19 Web sites and offers printable resources that can be provided to the Veteran. More women Veterans came to VA to receive the vaccine than those who refused the vaccine, most of whom were between the ages of 45-65.

Ms. Daugherty inquired about how VA intends to address stigmatizing terminology used in reproductive health, for example the term inhospitable womb. Dr. Johnson noted that it is not a medical term. Dr. Patricia Hayes confirmed that she has heard it colloquially, but they could provide information on terminology used by the American College of Gynecology.

Vice Chair McLaughlin inquired about VA acquiring women-specific tools that are modeled after other VA initiatives or other women-specific groups. Dr. Christy noted that Dr. Hayes identified it as a need and requested it. Centers for Disease Control and Prevention (CDC) and VA information and messaging do not address gender-specific conditions. OWH communicated with VA and it is now in their tool kit.

Ms. Parker inquired about whether VA is providing information on vitamins in addition to the vaccine for fighting Covid-19. Dr. Christy mentioned that VA is focused on keeping Veterans informed about the vaccine but also offers information from CDC's wealth of information on Covid-19 topics. OWH's tool kit deals with gender-specific topics relevant to women Veterans.

Ms. Harris complemented OWH on the work of its Women Veterans Call Center. She asked if there are plans to expand and if it has been receiving enough callers. Dr. Hayes noted the call center's efforts to reach out to women Veterans who do not use VA and its monitoring of dropped calls. Of the calls received, maternity care and community care are the top issues addressed.

Adjourn

The Chair adjourned the Committee at 3:54 p.m. PT, on its first meeting day.

Wednesday, April 28, 2021

Open Meeting

The Chair called the Committee to order at 10:00 a.m. ET, on its second meeting day. The Committee members, ex-officio members, advisors and public guests introduced themselves.

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Greetings from VA Leadership

The ACWV viewed a recorded message from Secretary of Veterans Affairs Denis McDonough, where he discussed VA's commitment to Veterans and shared VA's priorities.

Briefing: Update 2020 ACWV Report Recommendation #2

Charmain Bogue, Executive Director, Education Service, VBA

Ms. Bogue provided an update on the ACWV's 2020 report recommendation two and gave an overview of the five programs Education Service manage. She explained that Education Service provides benefits and resources to help nearly one million Service members, Veterans and their families achieve their education goals. Education Service's two regional processing offices are in Muskogee, Oklahoma and Buffalo, New York. They consolidated to two stations last year, to provide better service to increase timeliness.

There is a dedicated call center in Muskogee, with 300 call center agents answering only education benefits calls. There is a special line dedicated for survivors only; the agents received special training on education survivor benefits and other benefits in VA, so they can help survivors navigate VA enterprise-wide. To promote efficiency, Education Service sets target days to complete education claims: 24 days for original applications and 12 days for enrollments (each academic term). They are currently processing original applications in under 20 days and enrollment applications under nine days. Payment accuracy is greater than 98%.

Ms. Bogue noted that the Post 9/11 GI Bill is the largest program utilized, representing more than 80% of the population served. They continue to see an increase of the Post 9/11 G.I. utilization; there was a three percent increase in number of women Veterans using the Post 9/11 GI Bill in 2019. By 2040, this percentage is expected to increase to about 17%. There is also an increase in utilization for other Post 9/11 GI Bill components. The Frye Scholarship Program had an 85% increase of children using program, since 2015, and the Dependent Education Assistance Program had a 40% increase utilization since 2015. However, Montgomery GI Bill utilization is declining, due to education about the buy-in and Education Service assisting individuals with benefits comparison. Public Law 113-315 included a mandatory sunset of the Montgomery GI Bill by 2023 and they are already working on a communications campaign to keep Veterans informed. The Vietnam Era Assistance Program has no one enrolled in the program. Education Service processed 3.5 million education claims totaling \$12 billion to 900,000 beneficiaries in FY20.

Ms. Bogue provided a scope of Education Service's education network. It includes more than 400,000 VA-approved education programs across 20,000 VA education institutions, at 43,000 campuses across the globe. It also includes on the job training programs and apprenticeship training programs. It launched new programs for Science,

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Technology, Engineering and Mathematics (STEM) field and other demand occupations. VA has paid \$114.7 billion to over 2.3 million beneficiaries (just for 9/11 bill alone), since 2001.

Ms. Bogue discussed Education Service's current modernization efforts. It received \$250 million from CARES Act fund to transform its systems, such as Digital GI Bill, to offer more self-service options for students to receive updates and get information and schools to better serve student Veterans. It is engaged in a project on outcome measures, to better capture demographic information on utilization to drive future projects on special populations. It is implementing several provisions from Public Law 116-315 this year. Customer service efforts are underway to get feedback from students to understand their needs. It is partnering with a third-party vendor to improve how it monitors schools.

Ms. Bogue provided an update on the 2020 ACWV report recommendation #2, in which the ACWV recommended that Education Service collaborate with the Veterans Experience Office (VEO) to examine barriers that women Veterans experience in accessing education benefits. It collaborated with VEO to map Veteran students' experience, identifying critical points for when they should provide the survey. It launched three V-Signals surveys in July 2020 to assess customer experience at moments that matter: applying for benefits, enrolling in school and receiving benefits. Based on surveys, Education Service has been able to enhance how it services Veterans.

Education Service is leveraging innovative GI Bill programs to provide additional flexibility and delivery in demand training opportunities. It established the Veteran Employment Through Technology Education Courses (VET TEC) Employer Consortium to accelerate hiring opportunities for participants. The employer consortium is looking to expand to allow for other students to leverage the opportunity. Education Service partners with Microsoft, Google and small tech companies to hire student Veterans. It also has an email distribution list of one million student Veterans and disseminates bi-monthly newsletters to keep student Veterans informed. Additionally, it serves as co-lead for the White House Office of Science and Technology Policy Interagency Working Group on supporting Veterans and military spouses to pursue science, technology, engineering and math (STEM) careers.

Ms. Bogue provided an overview of Education Service's initiatives to make STEM careers accessible for Veterans. VET TEC is a five-year pilot program for eligible Veterans to help them secure meaningful employment in the technology field. VA launched the Edith Nourse Rogers STEM Scholarship program for students training in high-demand STEM fields. The Veteran Rapid Retraining Assistance Program was enacted on March 11, 2021, as part of VA's continued effort to support Veterans seeking retraining and economic opportunities in response to the effects of the COVID-19 pandemic. VA, in partnership with the Department of Labor, published a list of high-demand occupation. The list includes healthcare, education, media, engineering, and high-tech opportunities.

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Ms. Bogue shared that VSignals data compared to the overall respondent population show that women respondents using GI Bill find their experience with VA to be simple and efficient but are less satisfied with the service they received in addressing their other needs. Outcome measures will expand demographic data collection and spur analytical and reporting opportunities for VA to better target resources and decision making. VBA is integrating direct feedback from women Veterans into Digital GI Bill and future communications efforts.

Ms. Bogue discussed the various tools that her office has available for Veterans and their eligible family members to educate them about their education benefits, such as social media platforms, Education Service's Website, GI Bill comparison tool, education call center and publications. From July 2019-February 2020, VA embarked on a national school tour to meet stakeholders where they are, travelling to nine different states. Other efforts included visiting three VET TEC providers, joining industry leaders to discuss workforce trends, Veteran initiatives and future collaboration and speaking at Student Veterans of American's National Conference.

The Chair asked about Education Service using the women Veterans journey map presentation to examine barriers for women Veterans accessing education benefits. She suggested that they look at how it impacts women Veterans and use it to inform Education Service.

Vice Chair McLaughlin inquired about how the education benefits utilization rates differ for men and women, the reason for the difference in rate and what the ACWV can do to address this. Ms. Bogue wants to dig deeper in examination of the rates. Vice Chair McLaughlin also noted that women are less satisfied about how their needs are addressed and indicated that the ACWV would like to know if their concerns are different from men and how they are being address. Ms. Bogue said she would look into it.

Ms. Handley noted that women are caregivers and may not be able to go to school, due to responsibilities, and that should be collected in the data. The ACWV would like to see this in the data. Ms. Bogue said that those needs are valid.

Vice Chair Kirk inquired whether the data presented on the VSignals survey results are specifically for women. Ms. Bogue will verify. If not, they will provide information by gender.

Dr. Mathewson-Chapman asked if Education Service separates data for National Guard and Reserve from those who are separating from active duty. Ms. Bogue confirmed that it does, as well as by branch of service, and can provide information on that population if needed.

Ms. Wright noted that women are always disadvantaged in the employment arena and VBA has programs that support employment after education. She inquired if Education Service has information on the gender breakdown of those utilizing the VET TEC

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program and how it compares to larger women Veteran population. She also asked about how the office outreaches to them, since technology tends to be not as attractive to women as it is to men. Ms. Bogue confirmed that Education Service can break down information by gender, as far as utilization. Outreach is evolving. They partner with groups in the private sector and schools to reach women. She welcomes any suggestions on how to reach populations of Veterans. Two teams in Education Service are dedicated to outreach and focus on strategies for how to reach certain populations in the GI Bill space.

Ms. Harris asked about the status of VA's implementation of legislative mandate to extend the housing allowance stipend to students pursuing online education so they will get the same amount as in-person learning students. Additionally, she wanted to know if it was implemented during the pandemic. Ms. Bogue said that the GI Bill space was drastically impacted by COVID last year. When schools increasingly moved to on-line education, they anticipated that it would impact the housing allowance and that school closures would also impact the housing allowance. School closures also impacted work study. Legislation passed last February allowing VA to continue paying students the in-person rate when schools went to online learning. It also allowed VA to pay up to four weeks if schools closed and to continue to pay work study students who were unable to continue at the work study sites due to school closure.

Ms. Harris asked if this change would be permanent for students taking online classes. Ms. Bogue said the fixes are not permanent; the authority will remain in place until the end of 2021. If there is no other legislative action, the benefit will go back to the regular online rate for those taking classes online. Education Service plans to partner with an education association to assess schools plans for 2022 and provide this information to Congress to possibly get the authorization extended.

Ms. Harris also noted that childcare challenges and women Veterans' increased utilization of the GI Bill may be helpful in justifying extension of the benefit based on the situational extensions. Ms. Bogue said that there is a larger issue with monthly housing allowance and online education. When Post 911 came online, most Veterans did in-person classes at brick and mortar locations. Education Service has seen a major shift in Veterans pursuing online education for various reasons. Veterans are generally nontraditional students with careers and families. Education Service been talking to the Hill about the need to address the online rates permanently (less than \$1000 now) to make it more meaningful to students who choose online education, as that is where it is headed.

The Chair thanked Ms. Bogue for always imparting important information regarding education benefits. She stressed the importance of revisiting the issue of adjusting the benefit for online education since it would be a hardship for many when it goes away.

**Briefing: Update 2020 ACWV Report Recommendation #3
Cheryl Rawls, Executive Director, Office of Outreach, Transition and Economic
Development, VBA**

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Ms. Rawls began with an overview of VBA's M27-1 Benefits Assistance Service Procedures (M27-1), which provides general guidance for the WVC position and duties but does not establish metrics for measuring success. The ACWV's 2020 biennial report requested that VA modernize the WVC position, by establishing it as a duty with measurable position standards to ensure that WVC duties are performed, while also allowing ROs the flexibility to meet the unique service needs of women Veterans. Measurable position standards provide the ROs the capability to monitor performance.

Ms. Rawls provided VBA's status on implementing the ACWV's 2020 report recommendation three. In January 2021, the M27-1 was rewritten to standardize the role of the WVC. VBA anticipates the manual update to be completed in the third quarter of FY21. Chapter enhancements include prescribing guidelines for numbers and/or hours of engagement (Implementation of results from Debra Sampson Act) and aligning duties with organizational goals. The manual is in concurrence. VBA started to put things in place but then decided to wait to ascertain how the Deborah Sampson Act will impact the manual. The Deborah Sampson Act mandated a study on the WVC role, which will likely impact what will go into the M27-1. State Directors of Veterans Affairs have also raised the issue of WVCs not having enough time to do jobs, not having enough specificity in their job and the need for discussion about making them full-time where needed. WVC Additional duties for outreach specialists who may or may not have had training or may or may not have access to the RO director for to say what they need. VBA will make recommendations about where full-time or part-time WVCs are needed.

Ms. Rawls shared that VBA updated the Outreach Reporting Tool Plus (ORT+), which is used by business lines and headquarters to pull data at any given point about Veteran outreach in the field. The update included the capability of capturing all data pertinent to the WVCs outreach efforts. VBA is continuing efforts to ensure the accuracy of the data by conducting quarterly field calls with the WVCs to get their input into this reporting mechanism.

Ms. Rawls summarized VBA's next steps in reviewing the WVC's role and updating the M27-1. VBA will complete the study of VBA's WVCs by July 2, 2021 as mandated. The Acting Under Secretary for Benefits will use the data to make determinations of full-time WVCs. Finally, VBA will publish an updated M27-1 chapter on WVCs, as informed by the study.

The Chair noted that the charge for the full-time WVC issue continues to be important for the committee. The primary concern is that it is a collateral duty for someone who works in a production type position. If supervisors are responsible for production, the WVC will be focused on the rate of production.

Vice Chair McLaughlin complimented Ms. Rawls on the organization of her presentation, making it easy to follow along. Ms. Handley asked about clarification of full-time versus part-time coordinators. Ms. Rawls clarified that full-time means 40 hours per week. The data may show enough to establish full-time positions. The field is

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production driven. Having the position be full-time would allow dedication of time to so the work. Ms. Rawls indicated that VBA would have to get additional funding for full-time coordinators, because it would have to replace staff removed from production. She noted that it may present an opportunity for a hybrid position, where the individual can also drive and move claims forward. The position description would specify the number of hours dedicated for outreach and specify that other time should be used to drive claims forward. VBA has taken a similar approach for military sexual trauma (MST) coordinators. The data may indicate that a few states will warrant a full-time WVC, some may warrant a hybrid version and some would warrant presence at the district level that will cover several states. The population of women Veterans continues to grow, and VBA is doing better at meeting their needs.

Ms. Handley inquired about the Debra Sampson Act, where the program manager would determine if the WVC could be flexible or standard and expressed a concern about how it would be measured. Ms. Rawls said VBA is also concerned about the concept of flexibility. Because VBA's recent reorganization gives her policy management and oversight, she can monitor how this aspect transpires in the field. She noted the importance of accountability. Ms. Handley recommended that Ms. Rawls conduct unannounced visits when she does her assessments.

Ms. Wright noted that unemployment is a low point for women; there should be some collaboration between the community and the WVC who is doing outreach. Part of the outreach can be helpful in communicating opportunities to inform women about education benefits. She asked if WVCs have a partnership with Education Service and the state women Veterans coordinators. Ms. Rawls indicate that there is no official partnership, but her office and Education Service now operate in the same Business Lane. They are examining some of the barriers and working on establishing a better communication channel.

Ms. Harris commented that the committee looks forward to updates on the WVC position and the Chair commented that the WVCs are always important because of what they do for women Veterans.

Briefing: Update 2020 ACWV Report Recommendation #6 Dr. Jeffrey Chenoweth, Acting Director, National Radiology Program Office, VHA/ Lisa Wall, Assistant Director, National Radiology Program Office, VHA/ Dr. Michael Kelley, VHA

Dr. Chenoweth provided an update on the ACWV's 2020 report recommendation six, which requested that VHA establish a national strategic plan for breast imaging services that covers the evolving needs of women Veterans. His office is actively working with OWH to develop the plan; it is in draft status.

He provided a brief overview of the Mammography Office, which is situated in VHA's National Radiology Program Office. All eligible Veterans are offered services, which are provided either inhouse or through community care. The Mammography Office is

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responsible for oversight and certification of all VHA inhouse mammography programs and makes recommendations to the Under Secretary for Health on mammography programs. All inhouse VHA mammography programs undergo triennial accreditation by the American College of Radiology and annual FDA inspection. The office is informed by VHA's Mammography Advisory Committee and subject matter experts in breast imaging. The office reviews clinical restructuring proposals to establish new mammography programs. It also works with OWH to encourage breast cancer screening for appropriate populations and to reduce no-shows.

Ms. Wall provided overview of inhouse mammography services. VHA has 67 inhouse mammography programs in 17 of its 18 VISNs. It offers 3D, 2D mammography capability and it has two mobile 3D units. Women participating in VA healthcare are more likely to receive timely breast cancer screening than women under private insurance or Medicare/Medicaid coverage.

Ms. Wall discussed VHA's Strategic Breast Imaging Plan. The National Radiology Program Office partnered with OWH, Primary Care and Community Care to establish a multidisciplinary workgroup to examine VA's existing breast imaging services and envision future priorities. During the review, four essential goals (access, quality, outreach and Veteran experience) for breast imaging services were conceived, based on evidence-based practice. The goals represent the fundamental pillars of the strategic plan. Objectives were identified to channel the lanes of effort in support of the plan. This plan supports the Department's overarching strategic plan, which identified customer service as a priority and women's health as an area of special focus. The plan will evolve as processes are reassessed, new information is gathered and best practices identified.

Vice Chair Kirk asked for clarification about the number of medical centers that offered mammography, given that 2019 data noted that 51 medical centers and Ms. Wall indicated that there are 67 facilities offering mammography. Ms. Wall clarified that the briefing included the number of actual programs (67); there are mammography programs located in several CBOCs too. Some of the programs fall under one HCS.

Vice Chair Kirk inquired about VHA's plans to put mammography in CBOCs and medical centers over the years. Although the numbers may not support having mammography at every CBOC, women have earned the right to get all of their care at VA. Ms. Wright added that mapping would be easier if all HCSs are depicted, to see how they had mammography programs in them. She then asked about the metrics they use to understand success in their goals. Ms. Walls circled back to Vice Chair Kirk and noted that they are establishing a minimum number of active women Veteran users needed to provide a quality program at every medical center. This will be used for the strategic plan; it is not finalized yet. Another important thing to consider is the competency of the radiologist. This person would have to be able to do readings all the time to maintain the continuing skill set. Space limitations have to be considered too. VHA is also trying to do some geo-spacing maps.

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Vice Chair Kirk noted her personal responsibility to women Veterans, that even if there is one Veteran, she deserves to receive care at VA. Policy may not support this personal altruistic view of giving it to everyone; instead we tend to limited because there are not enough resources. Ms. Walls affirmed that VA wants to offer quality of care and to do the right thing for women Veterans. There will be some facilities that will not be able to provide as good of service as others and VA is not able to have mammography everywhere, which is why coordination of community care is important. VA wants to do the right thing for women Veterans if it cannot do the best job at something.

Dr. William F. Arndt, Acting Executive Director for Diagnostic Services, clarified that VA wants to make sure it gets done right. Every radiologist must do 480 mammography readings annually. There are sites where, when they do not have the minimum number of enrollees to get two radiologists so they can cover each other, they have to do double reads. There are economic and efficiency considerations, but VA wants to offer the equivalent of large breast care centers in private sector. Outreach is important in getting the message out to get more enrollees. In addition, creating a welcoming environment, providing privacy when treating women Veterans and promoting dignity are important to get critical mass to expand. We can look at the possibility of using teleradiology support for screening mammograms; it leverages volume at multiple sites to funnel back to a breast imaging provider that may be off site, but diagnostic mammography requires in person appointments. Convenience is one part; VA has to be able to do a good job too.

Vice Chair Kirk reiterated Ms. Wright's question about measuring metrics for performance and what they are tracking to see if women are effectively receiving mammograms. Ms. Walls said they are using a dashboard to track outpatient procedure wait times for routine and urgent orders. They are monitoring no-show and cancelation rates. Mammography has a high no-show rate, even in the private sector. They are working with V-Signals to develop a survey to understand why patients missed appointments. They are also starting to examine the existence of racial and ethnic disparities, to learn what they can do better, working with geospatial staff to look at where the enrollees are located. For each objective, they will also create strategies for accomplishing the objective. These will be included in the final plan. Dr. Chenoweth said that they are now examining care coordination. If there is an issue with the community care consult, things fail. They are looking critically at the community care metrics too.

Dr. Kelley provided an overview of cancer in the women Veterans population. He noted that women Veterans are the fastest growing group within the Veterans population. Seven hundred women Veterans enrolled in VHA are diagnosed with breast cancer each year. One in eight women in the U.S. population will be diagnosed with breast cancer in their lifetime. Women Veterans between ages of 45-64 comprise largest group of women within the VA and are most likely to receive a cancer diagnosis. Localized breast cancer has a 99% survival rate, if detected early. The most common cancers in women Veterans are breast, lung and bronchus, colon and rectum, uterine, melanoma, and thyroid.

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Dr. Kelley provided an update on VHA's action plan task for the ACWV's 2020 report recommendation six, which indicated that the National Radiology Program Office would collaborate with the OWH to develop a strategic plan for breast imaging services. The mission of the strategic plan is to build the infrastructure necessary to provide cutting-edge cancer care to women Veterans that proactively screens and aggressively treats breast and other cancers affecting women Veterans. The goal is to establish a VA Women's Cancer System of Excellence, to enhance VA's breast oncology services through personalized care coordination; ensure best-in-class cancer care through precision oncology; build additional public-private partnerships to ensure greater access; and provide access to fully coordinated, state-of-the-art screening and diagnosis for earliest possible detection and treatment.

He further described the future state of VA's imaging program. VA wants to transform its program to provide coordinated, integrated patient-centered care; to transform prevention, treatment, outcomes and access capabilities in general through partnerships with national leaders in cancer care and research (e.g., NCI, Duke University, Baylor School of Medicine); and to innovate care through telehealth and decentralized clinical trials to women nationwide.

Dr. Kelley provided a summary of the next steps in accomplishing this task and the road ahead. In summer FY21, VA will Stand-up core staffing for Women's Cancer System of Excellence. By fall FY 22, VA anticipates beginning clinical pathways expansion into women's cancers, establishing a Women's Cancer National Tumor Board. By winter FY 22, VA anticipates establishing a breast cancer registry.

Vice Chair Kirk asked Dr. Kelley if there are plans to look at other cancers for women, such as ovarian cancer, and those that are due to environmental exposures. Dr. Kelley said they recruited a gynecologist from Duke University to help work with breast cancers but she will focus primarily on gynecological malignancies. The number of cases for gynecological malignancies is even smaller than breast cancer. They will work with a group to understand whether it makes sense to create pathways or personalized care. There is a care coordinator for gynecological malignancies that will have a physician review cases on regular basis, instead of having pathways. Pathways are designed for groups of providers and not one or two. The number may be small enough that pathways are not needed. They may be able to simply add on an expert or a group of experts and add to the care team where the patient is currently being seen.

Vice Chair Kirk asked about other cancers that women may be more susceptible to due to their endocrine systems and if those would be stratified by gender for the various cancers groups. Dr. Kelley said yes.

Vice Chair McLaughlin asked, if outside of types of cancers that women are more likely to encounter it is true that there are treatment practices that are different or more effective for women, or treatment concerns that are more women Veterans specific. Dr. Kelley said yes, there are malignancies that only women get, mostly gynecological

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malignancies, and women are the predominant group of Veterans affected by breast cancer.

What VA knows about treating men with breast cancer comes from treating women with breast cancer. Lung cancer is the second most common cancer among women and is the leading cause of cancer death in women Veterans. For decades, research has been looking at whether there should be differences in treatment for lung cancer in women and men. There is some biological rationale for why there should be some differences. but it is not clear if the treatment algorithms are different. Every study will break down by sex now, as opposed to past studies where there was not enough female representation. Most of the modern studies include enough women to allow for subgroup analysis of effects. Immune therapy and targeted therapies seem to be equally effective.

Dr. Kelley noted that women are more likely to get non-smoking related lung cancer and treatment would be different because they have specific genetic alteration in their tumors that can be treated with oral drugs versus chemotherapy; they are not responsive to immunotherapy. This is important for molecular diagnostic testing at time of diagnosis. Every Veteran, regardless of sex, should have molecular testing for lung cancer before starting systemic treatment. Women have better prognosis with small cell lung cancer; it is postulated to be due to estrogens, but this has not led to integration or modulation of humoral levels for treatment in men or women.

Briefing: Update 2020 ACWV Report Recommendation #7

Dr. Sally Haskell, Deputy Chief Officer, Office of Women's Health, VHA/Chris Mannozi, Director, Performance Measurement, VHA

Dr. Haskell provided an update for the 2020 ACWV report recommendation seven, which requested annual reporting on metrics pertaining to the care of women Veterans. The OWH reviewed the number of women Veteran patients in each year for FY00-FY19. The number of women Veterans using VA health care has tripled since the year 2000. Thirty percent of new VA users are women. Women aged 45-65 represented the largest population of women Veteran VHA Patients, between FY00 and FY19. There was a decline in utilization for women Veterans over age 80 during that same timeframe. They are closely following the racial/ethnic distribution by sex among FY20 Veteran VA Users. Forty three percent are women of color.

Dr. Haskell provided an overview of OWH's tools used to collect data on women Veterans, specifically the Women's Assessment Tool for Comprehensive Health (WATCH) and Women's Health Assessment of Workforce Capacity (WAWC) for FY 20. The WAWC initiative was administered as two separate online surveys completed by WVPMS for each HCS for FY10-20.

Dr. Haskell provided a demographic perspective of women Veterans who utilize VHA health care. In FY 20, 544,678 unique women Veterans received care from VHA. Of those women, 66,516 were from the Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND) cohort. The 10 most common diagnoses for women Veterans in FY20 fell into three categories: mental health

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conditions, cardiovascular risk factors and muscular skeletal disorders. Mental health conditions were the most common and at the top of the list.

Dr. Haskell explained that one of the important factors that WATCH monitors is how well the Women's Health Program is staffed. She provided information on the distribution of key Women's Health Program personnel across the 139 HCS. For FY20, reporting for the WATCH survey indicated that 130 HCSs had at least one full-time WVPM; one HCS had a part-time WVPM; and four HCSs had their WVPM position filled in an "acting/interim" capacity. One hundred and thirty-eight HCSs had a Women's Health (WH) medical director and/or a WH champion; 109 had the minimum of four hours of protected time per week; and 29 had no protected time. There were 136 HCSs that had a WH Liaison who helped coordinate with WVPM at the main facility, at each CBOC.

She shared that WH is focusing on care coordination, as it is a huge need for the women Veterans population. Sometimes care coordination is a collateral duty for the WVPM. However, some HCSs have separate full-time or part-time staff serving as coordinators for mammography, maternity care and cervical care.

Dr. Haskell provided an update on WH's model of care, as of September 30, 2020. Policy requires that women Veterans be assigned to a women's health primary care providers (WH-PCP), those who have special training or experience in women's health. They can practice in any of the three models of care. Model 1 is a gender-neutral primary care clinic, mixed gender. Model 2 is separate but shared space specific to women. Model 3 is a fully separate women's clinic with separate entrance. The 139 HCSs are comprised of 164 medical centers and 880 CBOCs. Most women Veterans are receiving care in a Model 1 setting, since that is the predominant model available in the CBOCs.

In FY 20, there was at one least 1 WH-PCP at each medical center. At CBOCs, there has been a persistent gap in coverage; small, rural sites may not have a designated WH-PCP, due to the small number of women Veterans served or the challenge in hiring a WH-PCP. WH is working hard to close the gap. Most facilities have more than one designed WH-PCP. Regarding primary care-mental health integration—presence of a mental health provider in a primary care setting—care can be provided in all three models face-to-face, tele-video in the clinic, or tele-video in the Veterans' homes. At the end of FY 20, 80% of HCSs have at least one gynecologist on staff. Smaller sites may not have a gynecologist due to the low number of women Veterans; some sites do not have a surgical program and thus do not have a system to support having one. Women Veterans would then be referred to community for care. Several of the HCSs can perform specific gynecological procedures. OWH has several projects to focus on pelvic floor care. Due to funding provided through Women's Health Innovation Staffing Enhancement, or WISE, several sites have already hired pelvic floor physical therapists. Infertility evaluation is done inhouse, but treatment is done in the community.

Dr. Haskell noted that it is WH's goal to have 85% percent of women in primary care assigned to WH-PCP, understanding that some women Veterans prefer to keep the

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provider that they have. Women Veterans assigned to WH-PCP have higher satisfaction with care and higher quality of care and are more likely to get breast and cervical cancer screening. They are twice as likely to stay in VA care than those not assigned to WH-PCP. VA continues to exceed the private sector in breast and cervical cancer screening. VA saw a slight decrease in breast and cervical cancer screening rates in 2020 and 2021, which may be due to women not coming in for face-to-face care because of COVID.

She also noted that WH has been tracking all performance measures by gender since 2008. Since then, it has seen almost all of the gender disparities disappear, except for a consistent gender disparity for immunization rates. There is no gender disparity in the COVID vaccination rates.

Dr. Haskell concluded by sharing that the population of women Veterans has tripled since 2001; over 30% of new VHA users are women. VHA is tracking capacity and services for women Veterans. While capacity has improved, there are still gaps, such as availability of WH-PCPs at CBOCs. Current legislation and recent funding to the field is providing opportunity for change. Women's Health Innovation and Staffing Enhancement funding is providing an opportunity for enhanced staffing of women's health programs with providers and care coordinators. WH training is expanding capacity and quality of care. VA exceeds private sector in preventive metrics. Gender disparity still exists in immunizations; VA is targeting this issue in 2020-2021.

Vice Chair Kirk inquired about whether the new legislation helped to identify gaps that her office would want to examine. Dr. Haskell noted that the legislation is helpful in requiring a women's health provider at the sites.

Dr. Mathewson-Chapman asked if there is any objective to track obesity in women Veterans. Dr. Haskell said yes, they have that data. Men and women are initially fit when they leave active duty. Over the next five years, there is a rise in obesity particularly among VA users, and obesity is higher in women. They can look up information on obesity in women during the transition to VA care and think about prevention strategies.

Ms. Handley asked if the WVPM position description is standardized. Dr. Haskell confirmed that it is and noted that it is an actual policy. The WVPM can be a nurse or social worker, as well other positions like psychologists and medical doctors. The vast majority of WVPMs are nurses or social workers.

Mr. Mannozi provided an overview of VHA's Performance Measurement (PM) Office, which supports high quality care and care equity for Veterans using clinical and patient experience performance measures aligned with industry standards. PM's Gender Report and its Transparency and Equity Report can both provide quarterly evaluation of gender differences in care. The Gender Report includes six clinical gender-neutral composite measures of quality geared toward preventive health (influenza, pneumonia, diabetes, smoking, cardiovascular, behavioral health). The Transparency and Equity

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Report is stratified by gender and other demographics to evaluate care equity through patient feedback on questions on items like overall satisfaction, access and care coordination.

Clinical Measures Composite Data show that measure performance between male and women Veterans is largely the same across composites. Women Veterans of all ages tend to have better controlled diabetic blood pressures than males. Women Veterans have lower utilization of statin therapy than males for both diabetic and cardiovascular groups, more notable at younger ages (50 and below). Approximately 10% more male Veterans have received pneumococcal vaccination than women Veterans.

Mr. Mannozi shared that a snapshot of COVID-19's impact on breast and cervical cancer screening indicates that the pandemic's impact is evident but not as severe as anticipated. There are small declines in timely breast and cervical cancer screenings during the pandemic, but the measures are sampled data that can have variability from quarter to quarter.

The Equity Report indicates that younger Veteran age groups of both genders generally return less favorable responses than older age groups. Although the women Veteran population is on average younger than the male Veterans population, they score similarly in the youngest bracket, with women Veterans rating their provider and overall satisfaction higher but lagging in self-management support compared to male Veterans. Overall, in the Primary Care setting both genders rate their experience similarly.

Ms. Daugherty asked if the new Veterans Experience Office's (VEO) chief experience officer is focused on harassment issues and White Ribbon Campaign. She also asked about his office's engagement with VEO and how that impacts the focus of his work. Mr. Mannozi said their offices are complementary; their performance measurement does similar work, but not the same. Surveys follow industry standard protocol, where as VEO's V-Signals are instant patient satisfaction reaction. They meet monthly with VEO to learn how they can share their experiences and expertise to holistically approach issues. They have not met to specifically discuss White Ribbon, but this may be on the table for discussion it this summer.

Dr. Mathewson-Chapman asked about where they are with measuring weight/body mass index (BMI) as a performance measure, which is almost the basis for the all the conditions that are measured. Mr. Mannozi indicated that they do not measure it, but they can provide the data to the ACWV. There is at least one MOVE-related measure that looks at BMI across the population. Dr. Mathewson-Chapman noted that women Veterans would like to see weight programs specifically for women and counseling, other than training in food preparation. Programs should be more customer friendly or highlight the health problems that are caused by weight.

Dr. Haskell shared that the OWH is collaborating with Office of Nutrition and Food Services and it sent funding to the field so facilities can do teaching kitchens to teach women about healthy food preparation. There are a number of sites that have women

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only MOVE programs. Dr. Mathewson-Chapman said it would be helpful if women are more cognizant of the health issues related to weight issues.

Ms. Beldo-Lilley asked if the ACWV can get information on where the surveys were conducted. Mr. Mannozi said these surveys measure experience less than satisfaction throughout their encounter journey. In general, the sampling method is disseminating over one million surveys annually that are sent out about three months after the specific encounter. VEO looks at a closure timeframe. Veterans would receive one survey if they are in the sample population for that year. It is not adjusted for geography; but they make sure individual Veterans are not over-surveyed. The survey is not conducted by facility; they want to know about experience, regardless of where the Veteran receives care.

Adjourn

The Chair adjourned the Committee at 2:30 p.m. ET on its second meeting day.

Thursday, April 29, 2021

Open Meeting & Introductions

The Chair called the Committee to order at 10:00 a.m. ET. The Committee members, ex-officio members, advisors, and public guests introduced themselves.

Briefing: Update 2020 ACWV Report Recommendation #8

Dr. Sally Haskell, Deputy Chief Officer, Office of Women's Health, VHA/Dr. Mary Driscoll, Consultant, Women's Health, VA Connecticut Healthcare System, VHA/Dr. Katherine Hoggatt, Research Health Science Specialist, San Francisco VA Health Care System; Associate Adjunct Professor, University of California, San Francisco/Dr. Friedhelm Sandbrink, National Program Director, Pain Management, Opioid Safety and PDMP (PMOP), Specialty Care Services, VHA
Dr. Haskell, Dr. Driscoll, Dr. Hoggatt and Dr. Sandbrink provided updates to the ACWV's 2020 report recommendation 8, which requested that VHA: (8a.) increase women Veteran-centric pain management training for providers and increase women Veterans' access to diverse modalities of treatment for co-occurring chronic pain and substance abuse for women Veterans and (8b.) continue to research how pain management impacts women Veterans differently than male Veterans, as well as the links between pain management and substance abuse in women Veterans.

Dr. Sandbrink provided a general overview of chronic pain in Veterans. According to the 2016 National Health Interview Survey (all Veterans in the country, not specifically Veterans who use VA), 9.1% of Veterans reported severe pain. About 30% of Veterans reported experiencing chronic pain. Younger Veterans reported experiencing pain more than older Veterans. Women Veterans reported more severe pain than male Veterans.

According to 2018 data, two million of the six million Veterans enrolled in primary care had at least one pain diagnosis. Only about 5.8% of Veterans with a pain condition

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attended a pain clinic; women Veterans represented 11% of these Veterans. In the higher capacity pain clinics, women Veterans were over-represented.

Musculoskeletal pain is the most common type of pain reported, with the most prevalent reported being joint pain (44%) and back pain (33%). Chronic pain is more often severe in Veterans. Pain clinic users had higher rates of muscle spasms, neuralgia, neuritis, radiculitis, and fibromyalgia, as well as major depression and personality disorders. Patients attending pain specialty clinics have more difficult-to-treat pain conditions and comorbid psychiatric disorders, use more outpatient services and receive more opioids. Mental health care is included in the specialized treatment of chronic pain, because of the very frequent comorbidity of pain and mental health conditions.

Dr. Sandbrink discussed how pain, medical and/or mental health comorbidities are often related to military service and that they require Veteran-specific expertise. Mortality rate for opioid overdose is 1.5 times greater in Veterans who use VHA than in the general U.S. adult population. The suicide rate is about 1.5 times greater in Veterans who use VHA than in the general U.S. adult population. Pain is the most common factor among Veterans who die by suicide; there is a close correlation between pain intensity, suicide risk and death rates.

Pain care requires a systematic coordination of medical, psychological and social aspects of health care (integrated care) and women's health. VA developed a stepped care model for pain management, with a whole health foundation to include patient self-care and self-management. For chronic care level, VA ensures that even at primary care level, all accessible modalities (rehabilitation, integrative, behavioral) are readily available.

The Comprehensive Addiction and Recovery Act (2016) mandates that every VA facility have a pain management team (PMT) or a pain clinic and access to specialty care that can support primary care-centered Veterans. Based on this, VA mandates that the minimum composition of PMT/pain clinics should include: a medical provider with pain expertise; integrated access to addiction medicine expertise for evaluation of Opioid Use Disorder (OUD) and access to Medication for OUD (MOUD); integrated access to behavioral medicine with at least one evidence-based behavioral therapy; and integrated access to rehabilitation medicine discipline. Optional team members can include: interventional pain, nursing, case/care manager and a clinical pharmacy specialist.

In a 2019 analysis of its execution of this mandate, VA realized that not every VHA facility had a fully high functioning PMT. In response to this analysis, the Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP) program office is providing funding to VISNs/facilities for opioid safety and pain management initiatives, beginning April 1, 2021--one that provides recurrent and sustained funding for a PMOP coordinator at every facility to assist with program development and one that provides temporary funding over the next three years to

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support Veterans Integrated Service Networks' (VISN) efforts to identify and close the most significant gaps in patients' access to PMTs in their respective facilities.

Beginning in fiscal year (FY) 2022, VHA will fund a separate initiative in all VISNs that provide a clinical resource hub (CRH) program for collaboration in pain management. The PMTs will be very comprehensive, following best practices identified by VA, the Pain Management Best Practices Task Force and Department of Health and Human Services. Medical providers are expected to have the ability to prescribe medications for opioid abuse disorder. There will be integrated access with behavioral therapy, physical therapy and pharmacy participation. The funding will have a three-year funding cycle. There is an ongoing pilot in VISN 20.

Dr. Haskell explained that pain is a women's issue because women—Veteran and non-Veteran—report higher prevalence of pain than their male counterparts. Women who experience pain have greater pain-related disability. Women experience a greater risk for sub-optimal patient-provider communication and stigma regarding care. It takes a longer time for women to receive a diagnosis and they are less likely to receive optimal pain treatment. Additionally, women are more likely to experience adverse medication side effects/complications.

Pain is common in active duty women and women Veterans. Back pain and joint pain are 40-50% higher in active duty women, relative to men. Rates of chronic pain are high among women Veterans using primary care. The most commonly diagnosed concern in Veterans using VA care was musculoskeletal; the rate was higher in women Veterans.

Certain types of pain conditions are more common in women than men. For instance, connective tissue diseases, rheumatoid arthritis and lupus may often cause chronic pain and are more prevalent in women.

The women Veterans population has high risk factors for chronic pain, to include: higher injury rates in basic training (BCT) and active duty compared to men; higher prevalence of depression and anxiety; combat trauma; sexual trauma, with 20% of women Veterans screening positive; and pre-enlistment physical/sexual trauma with 50% screening positive. Cumulative BCT injury rates may be twice as common in women relative to men. Approximately 75% of BCT injuries in women are "overuse" injuries, such as stress fractures, shin pain, and chronic knee pain syndrome.

Depression is associated with onset and maintenance of pain in women. In general, depression is more common in women. Among Veterans, it is almost twice as common in women Veterans relative to men. The presence of depressive symptoms is a strong, independent, and highly prevalent risk factor for the occurrence of disabling back pain. Women with pain report greater disability in the context of depression. Pain and depression frequently co-exist and have an additive effect on adverse health outcomes and treatment responsiveness.

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Sexual trauma is associated with onset and exacerbation of pain. It is estimated that one in four women report military sexual trauma (MST). Sexual trauma and resulting PTSD is strongly correlated with and predictive of pain. MST is associated with increased prevalence of pain and presence of more than one pain diagnosis. Childhood trauma can have an impact on chronic pain outcomes. Previous trauma is associated with greater pain intensity and/or pain interference.

Dr. Driscoll explained how VA is addressing chronic pain care through clinical programs and research. At the foundational level, 82% of facilities offer self-management programs of pain care that women can access. At Level 1/primary care, 80% of facilities offer pain care in primary care; 85% of facilities offer pain care in the specialty pain clinic/Level 2; and 65% of facilities offer tertiary pain care/Level 3.

VA offers gender-specific provider pain education initiatives, such as the annual National Veterans in Pain (VIP) conference, which includes gender-specific pain content, so providers can learn how to optimize care for women Veterans; the Women's Musculoskeletal Mini-Residency, a hands-on training where women's health providers can access tailored diagnostic assessments and treatment training in caring for women with pain; monthly Pain PACT community of practice (COP)/Post-Deployment COP, includes content on the care of women with pain; providers call in from all over the country.

OWH sponsors a Pain Management Best Practices page on its internal Web site. Additionally, Women's Health Innovation & Staffing Enhancements (WHISE) FY21-FY24 is soliciting proposals from the field for staffing enhancements, programs, pain coordination teams and equipment useful to optimize the treatment of women with pain. This allows facilities to identify their unique needs and apply for funding to address them. One of their internal reporting mechanisms identified that over 38% of VA facilities offer gender-specific pain programs.

VA is engaged in several observational studies designed to understand trends and patterns that can inform care. The Women Veterans Cohort Study examines gender differences in musculoskeletal disorders/chronic pain and its management. The findings will inform knowledge about patterns of utilization, complexity, psychosocial needs, and health and healthcare disparities. A National prospective study of Veterans prescribed long-term opioid therapy (LTOT) includes quantitative and qualitative monitoring for opioid reduction/discontinuation processes and outcomes with gender comparisons planned. Findings from the study will inform best practices and clinical guidelines, especially regarding gender differences. The Office of Rural Health funded a study to look at chronic pain care for rural women Veterans, to define the needs and gaps in care for rural-dwelling women Veterans with chronic pain. Findings will inform innovative pilot to address specific needs of this population.

VA and National Institutes of Health (NIH) have clinical trials that examine the effectiveness of non-pharmacologic pain interventions in women Veterans.

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VA and NIH, in conjunction with DOD, funded two collaborative trials: the Co-Operative Pain Education and Self-Management (COPEs) trial and the Learning to Apply Mindfulness to Pain (LAMP). Both will oversample women Veterans, with up to 50% of participants being women. COPEs is an asynchronous self-management program to manage chronic pain versus a traditional, in-person self-management of chronic pain. LAMPs will compare the mobile approach to address chronic pain versus group-based mindfulness for chronic pain. Project CONNECT is a small pilot created to examine the provision of peer support in pain care, specifically pairing women Veterans with pain together to learn self-management strategies and to participate in a graduated walking program. This will determine if the program is feasible, if women Veterans will like it and if it should be expanded.

Dr. Hoggatt discussed pain and substance use in women Veterans. Although women Veterans represent a small segment of VA patients in specialty care for substance use disorder (SUD). Women Veterans with chronic pain are less likely to receive prescription opioids for pain control, but women Veterans with prescription opioid misuse may be at increased risk for morbidity and mortality. Population data indicate that women Veterans may face a greater burden of prescription drug misuse, including opioids. Women Veterans who use VA tend to be younger than their male Veteran counterparts; prescription drug misuse is more prevalent in younger Veterans.

VA's clinical programs target the overlap between pain and SUD in Veterans. About 85% of VA facilities provide individual therapy for SUD. Access to treatment for opioid use disorder specifically has increased 162% between 2018-2020 and an expansion of clinics offering this is underway. Women Veterans report increased willingness to attend treatment for SUD when women-only groups are available. About 39% of VA facilities made women-only SUD treatment groups or programs available. A history of MST (37%) and sexual assault (45%) are common among these Veterans.

Substance use disorder in women Veterans with pain may convey greater risk than for men. Women comprised 6% of VA SUD specialty care patients on average in 2014 range: 0 to 20% across VA facilities. Epidemiologic research on women Veterans (2007-2012) shows that the burden of prescription drug misuse is greater than for men (crude estimates: 5.0% vs. 3.0% for women Veterans and men Veterans respectively).

Non-VA data support the escalating danger of opioids in women. A 9-year national (non-VA) study indicates that opioid-related inpatient hospitalizations increased faster among women. By 2014, inpatient hospitalizations for women outpaced men. According to the CDC, death rate secondary to opioid use increased 471% among women between 1999 and 2015.

VA researchers are studying opioid misuse and safe prescribing. To address gaps in understanding, VA is funding research addressing pain and SUD among women Veterans. VA Puget Sound Center of Excellence in Substance Addiction Treatment and Education (CESATE) and the VA Connecticut's Pain Research, Informatics, Multi-morbidities, and Education (PRIME) Center are collaborating to use VA administrative

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data to study characteristics and care needs for Veterans with SUD. The goal of the research is to be able to describe individuals, their medical and pain profiles, their VA treatment receipt, and utilization of acute care resources. The data will serve as a foundation for targeted, investigator-driven data collection to understand women Veterans' perceptions of their pain, opioid medication use, and OUD and to develop and evaluate interventions tailored to their specific needs.

Women Veterans are at risk for more frequent disabling pain due to service injury, depression, interpersonal trauma, and female-specific pain syndromes (headaches, fibromyalgia, pelvic pain). There is a higher burden of prescription drug misuse (e.g. opioids). VA is engaged in ongoing clinical, programmatic and research initiatives that prioritize the needs of women Veterans to optimize pain and co-occurring SUD care.

Vice Chair Kirk asked what the gender specific pain programs entail, Dr. Haskell responded that the women Veteran's cohort study is in its early stages and they will provide more information when it is available.

Vice Chair Kirk noted Dr. Hoggatt's reference to alcohol abuse in her presentation and wanted to know if there is any indication that women are turning to alcohol instead of opioids to manage pain at a greater rate than men. Dr. Hoggatt responded that qualitative research conducted by her team and others is showing that there is a high co-occurrence between alcohol abuse and opioid use, which can progress to more severe disorders. There is speculation on the substitution hypotheses during pandemic. Anecdotally, it is suggested that women are substituting other substances for prescription opioids if there is no access to opioids. They will conduct further research to examine how women's polysubstance use is contributing to exacerbation of pain and opioid use, and the progression to opioid use disorders and more severe consequences.

Dr. Kirk said that the ACWV is interested in learning if mental health disorders come before the opioid and/or alcohol use, before the pain or after of the pain and if there are co-lingering effects combined with pain causing more depression in women Veterans.

Ms. Wright asked about collaborations with VBA and their groups of disabled Veterans for the purpose of research, noting that not all who enroll in VHA continue to use VA; those who file claims may not be included. Dr. Haskell indicated that she is not aware of OWH reaching out to VBA to identify those who are service connected but not using VA. Dr. Driscoll clarified that they have only seen VA health care users, but they have used the service connection status data. VHA does have information about service connected (the data) Veterans in VA system. Dr. Hoggatt noted that she has seen research that included users and non-users and has measured users' status but says she has not seen research that looks explicitly at connection to benefits and VBA services.

The Chair asked about prevalence of musculoskeletal issues in women, given that the military opened positions to women, and the training pipeline is putting women in combat positions. She asked if there is any study to see how VA will address this when

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women present to VA in the future. Dr. Haskell said that VA continues to roll out musculoskeletal training to providers to make them well-versed in diagnosing conditions. However, VA needs to collaborate with DoD to discuss how to handle women who will come to VA, to get them diagnosed and better recognize overuse type injuries. Early recognition, getting them into treatment right away and prevention are very important; VA is working on that. The Chair said it is important as VA looks at how who to care for them in the future, because DoD will see an increase of women coming into these positions and it will impact services VA has to provide to them.

Briefing: Update on the Office of Transition and Economic Development Initiatives Dr. Lawrencia Pierce, Acting Executive Director, OTED, VBA

Dr. Pierce shared that the Office of Transition and Economic Development is now Outreach, Transition and Economic Development (OTED) and that she has resumed the deputy director position.

Dr. Pierce provided an overview of OTED's mission, which is to better facilitate Service members' transition from military to civilian life by serving as the first touch point to connect Service members and their families to VA. OTED supports transition through interagency partnerships with DoD, DOL, the Small Business Administration and the office of Personal Management. It also partners with States' Department of Veterans Affairs, Veterans service organizations (VSO) and other non-governmental organizations (NGO). OTED supports the economic development side, with the goal of holistic approach to transition. OTED aligns its mission and priorities with VA's and VBA's priorities to ensure that it is consistent, the information it provides is timely and accurate and that it identifies unmet needs and opportunities for partnering internally and externally to address the specific needs of Service members/Veterans.

OTED assists transitioning Service members, their families and their caregivers with the transition journey, pre-military separation to post-military separation, not just during a snapshot of time. Transitioning service members and their spouses receive the benefits information as part of the Transition Assistance Program (TAP). OTED engages VBA partners to make sure transitioning Service members apply for certain benefits within guidelines or letting them know they can leverage certain benefits. OTED buckets programs into life domains (housing, employment, mental health, etc.) so transitioning Service members can access information that is relevant to them; it tailors programs to meet Veterans' specific needs. OTED conducts proactive outreach calls to eligible service members through VA's Solid Start Program, which allows for a tailored conversation that is guided by the Service member. OTED participates in several other programs to expedite the sharing of information, such as Skill Bridge which focuses on economic development; Post Separation TAP or PSTAP, a survey conducted post-separation to enhance knowledge of existing programs; and the Women's Health Transition Training (WHTT), which helps to familiarize women with VA's health care services.

Dr. Pierce noted that OTED assumed responsibility for management of WHTT in early 2021. WHTT focuses solely on addressing women Veterans' gender-specific health

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care needs. As of February 22, an online, self-paced course is now available at TAPevents.org, the learning management system that hosts all of VBA's transition-related courses. This four-hour course, developed in collaboration with VHA and DoD, helps participants understand VA's health care services, enroll in VA health care as quickly as possible after separation and prepare to manage post-military health care.

OTED's economic development initiatives were designed to provide Veterans access to benefits and services to promote financial security and contribute to the community; foster a culture of collaboration between VA, communities and Veterans, to sustain long-term outcomes; identify and connect Veterans with local employment opportunities; and invigorate economies of local communities. OTED recently signed a memorandum of understanding (MOU) with Prudential to promote economic development. This MOU establishes a free, no solicitation, no endorsement financial literacy opportunity for Service members and their families that allows them to manage their finances and receive financial wellness education through tools and workshops to address various financial topics. OTED is looking to expand beyond Prudential over the next couple of months. Finally, OTED partners internally with VBA's Veteran Readiness and Employment and Loan Guarantee Service to promote Veterans' financial wellness.

Vice Chair McLaughlin asked Dr. Pierce if OTED looked at the differences in how women and men access benefits. Dr. Pierce said OTED does studies on transition experience for women Veterans, minority Veterans and other populations of Veterans, but it works closely with other VBA business lines to inform OTED. Vice Chair McLaughlin noted that it would be helpful if the ACWV had information on the rates of utilization and reasons for any differences in rate. Dr. Pierce, as the VBA ex-officio member, will take that request back to VBA for response. Vice Chair McLaughlin requested to have the link for the WTII course. Dr. Pierce said she would provide it.

Ms. Handley asked if it was a pilot program for a year before it came to VBA from VHA. Dr. Pierce clarified that it is a full fledge program, and that it transitioned to VBA. It was a pilot under VHA. Ms. Beldo-Lilley inquired if the course was available for all transitioning women and Dr. Pierce confirmed that it is. The team is advocating to make it also available for all women Veterans, so they can be informed about services no matter when they separated. Ms. Handley asked if the virtual tour included was for every facility. Dr. Pierce said that there is only one facility but that it gives the Veteran an idea about what to expect.

Ms. Harris asked about how the link is disseminated. Dr. Pierce shared that VBA leverages its partnership with DoD to get information out during the TAP structure, as well as other partnership opportunities like the Center for Women Veterans' March Partners Meeting with VSOs, and in leadership in presentations. The DoD fellow and DOL fellow also share with their respective networks.

Ms. Harris inquired if VBA delivers the briefing at the various bases through contracted staff or VBA staff. Dr. Pierce explained that VBA uses contracted staff but retains

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oversight. It reviews the curriculum and observes the TAP briefings to evaluate the quality of the training.

Dr. Mathewson-Chapman asked about VBA's access to the Guard and Reserve, women who are in the Individual Ready Reserve and women who are still drilling and if VBA tracks data to make sure these women are not forgotten. Dr. Pierce confirmed that VBA has them on its radar and makes sure they have information similar tailored to Guard and Reserve. Within the TAP governance structure, VBA works with the Department of Homeland Security to access the Coast Guard. VBA has a Friday workgroup where they provide information to the Guard and Reserve. It is one of VBA's pillars to make sure that they are not forgotten. In TAP briefings, there is information about the Guard and Reserve. If there are members in the audience, the presenter provides specific information for them.

Briefing: Intimate Partner Violence and Women Veterans

Dr. LeAnn Bruce, National Program Manager, Intimate Partner Violence Assistance Program, Care Management and Social Work, VHA/Dr. Katherine Iverson, Clinical Psychologist, National Center for Post-traumatic Stress Disorder, VA Boston Healthcare System, VHA

Dr. Bruce noted that VHA adopted the Center for Disease Control and Prevention's definition of intimate partner violence (IPV) and expanded upon that, recognizing that IPV can include physical violence, sexual violence, stalking or psychological aggression (including coercive acts) from a past or current intimate partner. VHA built its screening to capture the different forms of IPV, from verbal aggression at the beginning of relationship conflicts to more chronic psychological effects. IPV is not specific to cohabitation or sexual intimate relationships and can be present in both heterosexual and same sex relationships. VA uses a broader definition to be strategic, in order to mitigate risk and to be involved early to promote healthy relationships as well.

Providing the scope of IPV among women Veterans, Dr. Iverson said that women Veterans experience a higher prevalence of lifetime IPV than non-Veteran women. VA investigators analyzed the data collected by the Center for Disease Control and Prevention to compare the lifetime experience of IPV in women Veterans to those who have never served in the military. They found that 33% of women Veterans experience IPV compared to under 24% of women who have never served in the military. After controlling for known risk factors (such as age), women Veterans were 1.6 times more likely to experience lifetime IPV. It was the first population-based study to show that IPV may be an issue among women Veterans.

Dr. Iverson shared findings from a national sample of over 400 women Veterans who completed an anonymous, web-based survey on IPV; 55% reported experiencing IPV in their lifetime. This study used a wider definition of IPV that included measures of psychological aggression, which is most prevalent in both Veteran and non-Veteran women. Psychological violence tends to co-occur with other types of IPV, like sexual and physical. Although psychological aggression can occur in the absence of physical and sexual violence, the reverse is rarely true. In that same sample, 30% experienced

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one or more types of past-year IPV, with psychological IPV (threats, name calling, intimidation, economic control, isolation, for example) being the most prevalent.

Dr. Iverson provide a demographic view of women Veteran VHA users who experience IPV. Overall, 18.5% of women Veteran VHA primary care patients experienced IPV in the past year, with the highest percentage occurring in young women 30 years or younger, 26%. There were equally high rates of past year IPV in women Veterans over age 30 through 55, where it drops to 15.8% and then drops to 5% for women Veterans around age 65. Among subpopulations of women Veteran VHA users, 14% of pregnant Veterans using VHA maternity care benefits experienced past-year IPV; 11% of women Veteran VHA patients age 18-44 reported past-year reproductive coercion; and 60% of partnered Post-9/11 women Veterans reported IPV in the past 6-months.

Dr. Iverson discussed the factors associated with increased risk for IPV among women Veterans, which are: younger age; lesbian or bisexual orientation; financial hardship; homelessness; military sexual trauma; and childhood sexual abuse. These risk factors are the same for the general population. Several studies show that MST more than doubles the odds of women Veterans having experienced IPV. Childhood sexual abuse (both general and Veteran population) is another significant risk factor for IPV.

Dr. Iverson noted that VA funded research shows that health issues associated with IPV include injury and physical impairment, chronic pain and illness, reproductive health problems, mental health disorders, emotional pain and suicidality. Depression and PTSD are common among women with IPV experiences. She clarified that IPV is not a diagnosis, but an experience that contributes to and exacerbates other health conditions. Women Veterans who experience IPV are more likely to have housing instability, suicide ideation and more emergency department utilization. This has implication for VA services for suicide prevention and housing. VA is aware of IPV factors and uses this knowledge to integrate care and services.

Dr. Bruce discussed Veteran-centric factors that stress relationships and contribute to IPV, such as post-traumatic stress; military family life stress; separation and isolation, mental health concerns; alcohol and/or drug use; loss of trust/moral distress; traumatic brain injury; increased anger; and decreased frustration tolerance. These factors can lead to increased risk of divorce and disrupted families; loss of support; homelessness; joblessness; poverty; increased healthcare needs; justice involvement; suicide and/or homicide. VA takes these into consideration when providing services for IPV.

Dr. Bruce also highlighted the relationship between IPV and human trafficking (HT), which is a public health concern that can affect people of all ages, races, genders, nationalities, and sexualities. The Victims of Trafficking and Protection Act (2000), defines HT as the exploitation of another person for labor, domestic servitude, or commercial sexual activity by force, fraud or coercion. Veterans may experience risks that lead to exploitation including poverty, homelessness, unemployment, existing trauma, and other key social determinants of health. The COVID-19 pandemic lead to an increase of HT by more than 40% nationwide. VA's Office of Social Work developed

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a Human Trafficking Tiger Team to explore the intersection between HT and Veteran issues, including IPV and health care.

Dr. Bruce shared that VA has conducted training on and examined the relationship between IPV and strangulation, which is highly prevalent in IPV. Of women who experience IPV, 68% report near-fatal strangulation by their partner. For those who have been previously strangled, the risk of homicide increases 750%. Strangulation is the fastest way to cause death; if not death then it causes brain death, or brain damage can occur. VA is committed to making this a part of training and awareness for providers and Veterans.

Dr. Bruce provided background on VA's IPV Assistance Program (IPVAP), from chartering the DV/IPV Task Force in May 2012, program implementation in 2013, hiring the first National DV/IPV program manager in 2014, creating a few pilot sites in 2015 to currently mandating that every VA facility has an IPV program in 2019.

The IPVAP's mission is to implement a comprehensive person-centered, recovery-oriented assistance program for Veterans, their families and caregivers and VHA employees who use or experience IPV. Its five action areas are raising awareness through campaigns, training and education; building community partnerships; serving those who experience IPV and serving those who use IPV, by implementing a screening/identification plan and establishing an intervention plan and resources; and serving staff through internal collaborations with employee assistance programs.

Dr. Iverson reported that IPVAP partnered with the OWH and other VA researchers to develop tools that would help guide conversations between patients and health care providers and distributed them to facilities nationwide. They can be used in clinical encounters or made available in waiting area for patients to learn about IPV and how to seek services at their own pace. The tools are also available online.

Dr. Iverson provided information about Recovering from IPV Through Strengths and Empowerment (RISE), a new brief counseling intervention developed in VA specifically for women Veterans. It is an individualized, empowerment-based intervention. Women Veterans can have up to eight sessions, more if needed. Recognizing that those who experience IPV have different concerns, women get a menu of options at the beginning of each session and are allowed to select a topic that is most important to them based on their circumstances.

Dr. Iverson discussed ongoing IPV research initiatives. There is a IPVAP partnership to implement RISE at more VHA facilities (eight sites by end of FY21). Findings are under review and are already informing practice. IPVAP has a partnership with OWH and the Office of Research and Development to offer coaching interventions, in an effort to examine barriers and provide support to providers for implementation of IPV screening programs in Women's Health Model 1 and Model 2 primary care clinics, as well as to evaluate the coaching support effort. Additional research will address a secondary focus on IPV, for example, the Veterans Crisis Line and maternity care coordination. The IPV Center for Innovation and Research funded an IPVAP innovation hub to develop, disseminate, implement, and evaluate innovative, high-quality, Veteran-centered,

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trauma-informed, and recovery-oriented practices for IPV detection, prevention, and treatment, with particular focus on IPV use and bidirectional IPV.

Dr. Bruce discussed IPVAP's action item mandated by Public Law 116-315, Title V: Deborah Sampson Act 2020, Sub-section C: Eliminating Harassment and Assault. Section 5304 requires IPVAP to conduct a two-year pilot to assess the feasibility and advisability of assisting Veterans who experience IPV or sexual assault followed by report within 180 days of completion. Section 5304 also requires them to extend programming to all "former members of the armed forces;" extend services for sexual assault not occurring in the context of intimate relationship (non-IPV); extend services for sexual assault occurring at times other than during military service (non-MST); and extend service to those who experienced sexual assault in the past. IPVAP is mentioned in other sections of the act and they will consult as subject matter experts to support other offices' efforts to satisfy requirements. Planning to launch a pilot in October.

Dr. Bruce encouraged participants to visit and to share IPVAP's Web site (<https://www.socialwork.va.gov/IPV/Index.asp>) with others for access to information about IPV and resources for getting assistance. IPVAP is in the process of building a Spanish translated page; many of IPVAP's products have already been translated into Spanish.

IPVAP meets quarterly with an external stakeholder group. Some of the internal and external partners include VA's National Center for PTSD, Futures without Violence; Danger Assessment Inventory; DomesticShelters.org; National Coalition Against Domestic Violence; National Domestic Violence Hotline; and the Centers for Disease Control and Prevention.

The Chair noted that the committee will be working with Dr. Bruce and Dr. Iverson, since The Debra Sampson Act also added an item to the ACWV's reporting requirement to include IPV, which will add to the ACWV's charter and mission.

Vice Chair Kirk asked if there is research that examines the rate of IPV in women Veterans who have former military partners versus civilian partners and if there is any increase or decrease in IPV when there are two Service members or two Veterans. Dr. Iverson said there is concern about underreporting in Service members but there is a sense that Veterans are more likely to use violence and it is likely to show up in their relationships. But it is not because they are Veterans. They are seeing a connection with substance abuse in coping with trauma and other additional stressors that come with post military life.

Ms. Wright wanted to build on the same thinking, noting that knowing if there is a difference in IPV for two Veteran relationships and mixed Veteran-status relationships. would better inform DoD so they can work on the Service member as they separate from military service, before they come to VA. Dr. Bruce said that one of VA's close partners in DoD is Family Advocacy and agreed that know these things would provide greater insight into the dynamics.

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Vice Chair McLaughlin asked if it is true that women come into the military with many of the identified risk factors or if risk factors come from military service. Dr. Iverson said that it may be an intersection of a lot of factors. It may be that women come in with more risk factors. Data saying that childhood sexual abuse in individuals coming from violent homes may be higher for people in the military. Those are risk factors for experiencing IPV. Dr. Bruce agreed that it is complicated; they see it increasing with military service but it is not necessarily generalizable. The Section 5304 pilot study on IPV is an important issue in understanding how these factors impact quality of life and overall health.

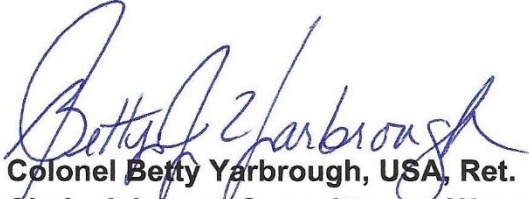
Ms. Beldo-Lilley noted how members of the military do not like to self-report, due to mental health stigma and asked how VHA gets the information out to individuals who need it, based on their background. Dr. Bruce shared that VHA used the trauma informed and patient-centric approach. They are careful about messaging on brochures, for instance using language about improving relationships and not anything that would cause “red flags” or the term IPV. Carrying a brochure home can increase risk for the people served. There is a lot of thought about messaging and taking a positive approach to how it is presented to reduce stigma. The vast majority are just trying to have healthy relationships but struggling with communication, relationship skills and conflict resolution, not so much with power and control. The IPV is overwhelmingly filled with people who were self-referred.

Ms. Harris said this issue is important to the committee because it overlaps other problems, such as homelessness and substance abuse. She expressed a concern that VA’s treatment for MST-related PTSD is the same treatment modality as for combat-related PTSD. She asked if it is going to change, given that they have had success in the community with other modalities of treatment. She also asked about the composition of the task force, will they request assistance from the ACWV and about the timeframe for getting started. Dr. Iverson indicated that she would share her comments with staff from the National Center for PTSD and the MST Program for consideration. VA has invested a lot on therapies like cognitive processing therapy and prolonged exposure, making efforts to tailor treatment to the individual’s problems. These two PTSD treatments were initially validated with women with sexual violence and IPV experiences. She appreciates the suggestion about not having a one size fit all approach and is open to discussing the ACWV’s thoughts.

Dr. Bruce responded that the task force and the study are different. The task force leans into the 5405, which they are not leading but will be part of the consult to the task force when it is assembled. CWV is working on that. They are looking at cross sections for communications and will assist the task force as VA’s IPV subject matter experts.

Meeting Adjourned

The Chair adjourned the Committee at 1:00 p.m. ET, on its third and final meeting day.



Colonel Betty Yarbrough, USA, Ret.
Chair, Advisory Committee on Women Veterans



Elizabeth Estabrooks, MSW
Acting Designated Federal Officer, Advisory Committee on Women Veterans