



**Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans
Virtual Site Visit: VA Portland Health Care System (VAPORHCS)
Veterans Integrated Service Network (VISN) 20: VA Northwest Network
August 24-27, 2021**

The Advisory Committee on Women Veterans (ACWV) conducted a virtual site visit with the VA Portland Health Care System (VAPORHCS) and Veterans Integrated Service Network 20 (VISN 20) via video-teleconference. COL Betty Yarbrough, USA, Ret., Chair, presiding.

ACWV Members Present:

COL Betty Yarbrough, USA, Ret., Chair

CMDCM Octavia Harris, USN, Ret.

CMDCM Linda Handley, USN, Ret.

LTC Lisa Kirk, Maryland Air National Guard, Ret., Vice Chair for Health Subcommittee

MG Marianne Mathewson-Chapman, USA, Ret.

CW2 Moses McIntosh, Jr., USA, Ret.

LTC Shannon McLaughlin, Massachusetts Army National Guard, Vice Chair for Benefits Subcommittee

Sandra Miller, USN Veteran

MSG Lachrishia Parker, USA Reserve, Ret.

COL Wanda Wright, USAF, Ret.

ACWV Ex-Officio Members Present:

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

Lawrencia Pierce, Office of Transition and Economic Development, Veterans Benefits Administration (VBA)

ACWV Advisor Present:

Faith Hopkins, Office of Finance and Planning, National Cemetery Administration (NCA)

Center for Women Veterans (CWV) Staff Present:

Lourdes Tiglao, CWV Executive Director/Designated Federal Officer (DFO)

Elizabeth Estabrooks, Deputy Director/ Alternate DFO

Shannon Middleton, Alternate DFO/Committee Manager

Julia Kelly

Other VA Staff:

Jeffrey Moragne, Advisory Committee Management Office (ACMO)

Jelessa M. Burney, ACMO

Christine Hamilton, NCA

Dr. Janet Porter, WHS, VHA

Jonna Brenton, WHS, VHA

Dr. Carrie Kairys, WHS, VHA

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Public Guests:

Kelly Fitzpatrick, Oregon Department of Veterans Affairs (ODVA)
Jessica Bradley, ODVA
Jennifer Donovan, ODVA
Rene Campos, MOAA
Saanjh Kishore
Jill Friedman
Dorothy Maloney
Abby Roubal
Andrea (Guest)
Antarah Crawley
Carla Spinelli-Moraski
EL (Guest)
Heather Durant-McEady
Jenny Richardson
Joy Langley
Kelly Edwards
Lacey Carter
Lisa Dean
Margie Anderson
Eve Holzemer
Minnie Garcia
Robin Hertert
Savannah Aseoche
Sharon (Guest)
Tori (Guest)
Wyndess James
Driayon Dickerson
Elizabeth Allen
Nancy Dailey
Nicole Woods
Rosalina Camacho
Matale, Anne
Kathie Warren

Tuesday, August 24, 2021

**Open Meeting/Introductions of Advisory Committee on Women Veterans (ACWV)
Betty Yarbrough, Chair, ACWV**

At 10:03 a.m., Pacific Standard Time (PST), the Chair called the first day of the ACWV meeting to order. The committee members, ex-officio members, advisors and public guests introduced themselves.

Welcome

Darwin Goodspeed, Director, VAPORHCS

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VAPORHCS Director Goodspeed delivered welcome remarks and salutations to the ACWV on the first day of the virtual site visit to VAPORHCS and VISN 20. He introduced himself and thanked the ACWV members for their service, affirming that the VISN welcomes and values the Committee's recommendations on ways to improve, modify and affect change in VA programs. By way of introduction, he remarked that the ensuing comprehensive review of local programs will highlight the efforts of VAPORHCS to serve women Veterans in the Portland catchment area.

The VAPORHCS Director also mentioned that the Portland Health Care System is in the middle of a Coronavirus Disease 2019 (COVID-19) surge and is taking patients from all across the state. VAPORHCS is actively planning how to increase its critical care delivery.

Purpose for Site Visit

Lourdes Tiglao, Director, Center for Women Veterans/Designated Federal Officer, ACWV

Ms. Tiglao stated that the purpose for the site visit is to provide an opportunity for the Committee members to compare the information received from VA Central Office (VACO) briefings with the activity in the field, as well as for the members to hear about the treatment programs and provision of benefits and services that are in place for women Veterans in VISN 20, Portland, Oregon especially. The presentations will address how program services and benefits relate to women Veterans. She anticipated the discussion to be candid, forthright, and respectful.

Overview of VISN 20 Facilities/Programs/Demographics

Dr. Chris Curry, Chief Medical Officer, VISN 20

Dr. Curry noted that the Northwest Health Network/VISN 20 is comprised of eight medical centers: Alaska VA Healthcare System in Anchorage, AK, Boise VA Medical Center in Boise, ID; VA Portland Health Care System in Portland, OR; VA Puget Sound Health Care System in Seattle / American Lake, WA; Roseburg VA Health Care System in Roseburg, OR; Mann-Grandstaff VA Medical Center in Spokane, WA; Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, WA; and VA Southern Oregon Rehabilitation Center and clinics in White City, OR. This network spans 23% of the United States' land mass, including 135 counties; two tertiary care hospitals in Portland and Seattle; three additional acute care inpatient facilities in Boise, Roseburg and Spokane; 53 outpatient clinics; four women's comprehensive primary care clinics in Boise, Portland, Seattle and American Lake; one clinical resource hub supporting telehealth services across the network in Boise; VA's only free-standing mental health residential rehabilitation treatment program in White City; and six community living centers in Boise, Portland, Roseburg, Seattle, American Lake and Spokane.

Services offered at all VA medical centers (VAMCs) in VISN 20 include women's comprehensive primary care, audiology, dental, pharmacy, lab, prosthetics, mental health and substance abuse, homelessness assistance, caregiver support/long-term services and supports, whole health, post-deployment transition services and care coordination. The VISN offers general surgery at Boise, Portland, Puget Sound and

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Spokane. Gynecology (GYN) is offered in-house at Boise, Portland, Puget Sound and Spokane and is provided at Anchorage via a sharing agreement with Joint Base Elmendorf-Richardson. Roseburg, Walla Walla and White City, however, utilize community care to provide GYN services. Transplant services include kidney and liver at Portland and bone marrow and lung at Puget Sound. VAMCs also offer residential substance abuse treatment, acute inpatient mental health, research, residency and internship training programs and spinal cord injury in Puget Sound.

In FY20, VISN 20 facilities had 3.9 million outpatient visits and 20,160 inpatient admissions. Its general purpose budget was \$2.39 billion with 13,474 full-time equivalent (FTE) employees. Of the 467,000 Veterans enrolled, about 9.7%, or 44,000, are women. The VISN has over 200 designated women's health primary care practitioners (WH-PCPs). Dr. Curry also presented the distribution of women enrollees across the eight centers and a projection showing a 38% increase in women enrollees by FY35.

Since the Northwest region covers a considerable amount of land mass, 33% of women Veterans on VISN 20 live in rural or highly rural areas. 67% of women Veterans served identify as white, with 14% self-identifying as belonging in one or more minority racial groups. 19% of women Veterans in VISN 20 are under the age of 35. 20% of women Veterans are age 65 and over versus 52% of male Veterans in the same category.

The Chair thanked Dr. Curry for the extensive breakdown in demographics and asked how the VISN uses the data projecting a 38% increase in women enrollees by FY35. VISN 20 lead women Veterans program manager (WVPM) Amy Reno replied that VISN 20's strategic plan for the Women Veterans Program uses women Veterans enrollment projections to forecast facility, staffing, and program needs into the future. The VISN uses this data to allocate real property and human resources in order to get ahead of the curve and be ready for when those women Veterans matriculate into VA.

The Chair opened the floor to the Committee for questions and comments. Health Subcommittee Vice Chair Dr. Kirk referenced a recently published OIG report which showed that VAPORHCS is above average compared with VHA overall regarding whether a Veteran would recommend the hospital to family and friends. She noted a significant difference between the male average (68% system-wide versus 76% regionally) and female average (51% system-wide versus 64% regionally) and asked whether that difference could be attributed to the rural population of women Veterans. Ms. Reno responded that market penetration and satisfaction levels tend to be lower among women nationwide, but that the VISN has been actively scrutinizing the effectiveness of programs for women Veterans when doing strategic planning.

VAPORHCS Chief of Staff, Dr. Sahana Misra, added that because VA's original infrastructure and program design was very male-driven and not catered to women Veterans, the VAPORHCS has engaged in providing separate spaces and additional care for women Veterans. The recent remodeling of the women's clinic segregated space from a preexisting space in just the past year is a testament to this effort. Dr.

Misra also mentioned some of the problematic intergenerational culture differences that need to be addressed in order for women to feel more comfortable in VA clinics. Toward making women feel more comfortable, VAPORHCS recently acquired several Mamava freestanding breastfeeding pods, which is a simple step toward gender equity in VA. VAPORHCS WVPM Dr. Sarah Suniga briefly remarked on the way that she has personally experienced gender inequity in the Army and how that has led her to be proactive in centering services around women Veterans.

Wanda Wright mentioned that while 9.7% is the average enrollment for women Veterans within a given VISN, minority enrollment in VISN 20 looks low compared to national trends. She asked what might be barring minority women's access to enrollment in the VISN 20. Ms. Reno replied that market penetration to minority women has been a struggle. To that end, VAPORHCS has been presenting public-facing materials and brochures that include minority women. There is a human resource effort toward diversity and inclusion. Ms. Reno did not have data regarding particular outreach to minority groups. Ms. Wright asked Ms. Reno to verify that such efforts were included in the VAPORHCS strategic plan.

Overview of VISN 20 Women Veterans Services

Ami Reno, Lead Women Veterans Program Manager (WVPM), VISN 20

Ms. Reno delivered the presentation. As of FY20, VISN 20 had 43,395 enrolled women Veterans, demonstrating a 23% growth since 2015. This growth is projected to continue. Of the main reasons women Veterans seek care from VA, 5 out of 10 diagnoses are mental health-related and roughly 12% of homeless Veterans are women. Ninety two percent of women Veterans in VISN 20 are assigned to a Women's Health PCP, well above the national average. There is less than a 5% disparity in wait times between women and men. Women tend to wait longer because they are waiting for a WH-PCP or they want to be seen in a standalone women's comprehensive clinic. In general, the longest wait times are for allergy/immunology and geriatrics. Breast and cervical cancer screening rates for women Veterans are lower than average at several locations within the VISN. A VISN-wide mammography standardization project is underway, although all mammography in VISN 20 is outsourced to community care providers. A VISN-wide cervical cancer process improvement is planned for FY22.

Data shows higher rates of COVID-19 vaccine refusal among women. Much of the concern among women is related to reproductive health (pregnancy and fertility). The VISN is actively working on education and messaging. On the other hand, the FY21 flu vaccine campaign successfully reversed gender disparity at most sites; data demonstrates more women than men received their flu vaccines. Real time feedback from Veterans, known as VSignals data, demonstrates that most women Veterans report high levels of trust and respect (91.1%), but their scores are still lower than men (93%). Data shows women trust their VAMC for health care needs at a rate of 87% versus 89.4% for males. The VISN is engaged in ongoing activities to understand and address the needs and preferences of women Veterans. FY20 SHEP data demonstrates that the highest rates of female Veteran satisfaction were in communication, comprehensiveness, and provider rating, and that the largest opportunity for improvement is in access.

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There is a full-time WVPM and a Women's Health medical director (WHMD) in place at every facility. There are also Women's Health Care Coordinators (or "Women's Health Navigators") at every facility to coordinate Pap smears, mammograms, and maternity care. There is a WH-PCP at every primary care location except Newport, Lincoln City, Portland CCRC, and Spokane Mobile Clinic. Recruitment efforts are ongoing for these vacancies.

Services that VISN 20 purchases exclusively through the community include mammography, reproductive health services (including intrauterine insemination / IVF / cryopreservation), and obstetrics (OB) care. Services that VISN 20 offers in-house include military sexual trauma treatment at all sites, with most sites offering women-only groups. Gynecology is offered at Boise, Portland, Puget Sound, and Spokane; reproductive endocrinology is offered at Puget Sound; and cervical cancer screening is offered at all VAMCs.

The VISN has invested \$4.3 million in new equipment, staff, and training. These investments include lactation pods/rooms at Anchorage, Portland, Puget Sound, Roseburg, and Walla Walla; lactation certifications at Anchorage, Puget Sound, and Spokane; pelvic floor physical therapy [PT] at Anchorage, Puget Sound, and Spokane; and colposcopy training at Portland. The VISN also acquired quite a bit of new equipment, including simulation equipment for female catheterization, breast and pelvic exam training, pelvic floor equipment, and equipment to support GYN exams for disabled women, including Hi-Lo/bariatric exam tables, knee crutches, lifts, and slings. VISN 20 was able to invest \$3.3 million in new full-time equivalent (FTE) employees through a WHISE grant. The new human resources include Women's Health Program Navigators at Anchorage, Puget Sound, White City, and Spokane; a Women's Health PCP in Walla Walla; a chaperone in Portland; a reproductive endocrinologist and a program assistant in Puget Sound; women's mental health providers in Roseburg, Anchorage, and Puget Sound; a Women's PACT Social Worker in Roseburg, Walla Walla and White City; a women's clinical pharmacy specialist in Spokane; a pelvic floor physical trainer in Spokane; a medical doctor for the eating disorders program in Puget Sound; and a women's peer support specialist in White City.

VISN 20 has been focusing on outreach and Veteran experience in conjunction with the Deborah Sampson Act. VISN 20 holds quarterly focus groups for women Veterans at all sites as well as bi-annual town halls for women Veterans. These assemblies are tracked quarterly to identify themes and issues. I Am Not Invisible (IANI) displays are at the forefront of all VAMC sites. VISN 20 recently stood up a Veterans Experience Committee and continues to work on the End Harassment/White Ribbon Campaign.

VISN 20 continues to emphasize ongoing women's health education. Its Women's Health Mini Residencies have trained 92 PCPs and 84 primary care nurses since 2017; VISN 20 is currently planning FY22 mini residencies for nurses and providers. To this end, the VISN developed a Maternal Hypertension Curriculum for emergency and primary care staff. Women's mental health and primary care national trainings are also routinely promoted.

VISN 20's overarching priorities include ensuring that WH-PACT teams are at every primary care site, providing women's health training/education, securing adequate resources (equipment, staff, space), ensuring that care is accessible, timely, and coordinated, managing

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employee accountability for Veteran experience (including trauma-informed care), engaging with Veterans to understand their needs, and maintaining a welcoming and safe environment.

The Chair thanked Ms. Reno for the extensive presentation and asked whether the quarterly focus groups were VISN-wide. Ms. Reno responded that because focus groups are designed to be small, intimate groups, the VISN supports advertising and idea generation while each facility conducts the groups themselves.

The Chair opened the floor to the Committee for questions and comments. Vice Chair Kirk asked whether mammography is offered at every medical center in the VISN. Ms. Reno responded that all mammography in VISN 20 is outsourced to community care. Dr. Mathewson-Chapman asked if VISN 20 was making a concerted effort to penetrate underserved and underinformed markets of women Veterans. Ms. Reno responded that many of these outreach efforts are done on a very local level, but the VISN does work with a contractor to conduct widespread marketing efforts such as robocalls and social media. Dr. Suniga added that the VAPORHCS Military to VA Office (formerly known as the Transition Care Management Office) has a mission to connect with guardsmen and women and Veterans returning from deployment so VA can push out information and provide opportunities for care. Ms. Parker asked for clarity regarding the less-than-30-day window for appointments across VISN 20.

Linda Handley observed that the VISN 20 mammography rates are lower than the national average and asked whether that was attributable to the outsourcing of mammography services. Ms. Reno replied that this is possible and added that the Northwest region has had difficulty getting women to have preventative care done. Ms. Handley replied that her VA in Pennsylvania also currently outsources mammography but that they have a plan to offer it in-house in the future. She added that she has a billing issue every time she goes out into the community for care. Ms. Reno stated that while the VISN has discussed offering mammography in-house, it is a substantial process to stand up such a program. Although Puget Sound offers the largest population of women Veterans, it is a landlocked facility with little space to develop. Furthermore, Ms. Reno added that community care billing as a whole is an area that needs improvement. Dr. Brenda LaFavor, Women's Health Medical Director, remarked that she would brief the Committee further on this issue in the near future.

Vice Chair Kirk advocated for adding mammography services to the VISN strategic plan considering the projected increase in the women Veteran population. Octavia Harris remarked that being landlocked is not an excuse for the VA to leave women Veterans out of strategic planning. More concerted efforts should be made to make space, personnel, and equipment available rather than outsourcing women Veterans' care. Ms. Reno agreed, stating that she continues to explore creative ways to progress the VISN. The Chair emphasized that community care billing is a problem across the country; the system should work seamlessly for both new and seasoned Veterans but it does not. The Committee is concerned that these billing errors burden Veterans who are not equipped to resolve such issues and thus lead to general dissatisfaction with VA care.

Overview of VAPORHCS and Strategic Partnerships

VAPORHCS Executive Leadership Team:

Darwin Goodspeed, Director; Karla Azcuy, Deputy Director; Bernard Deazley, Associate Director; Dr. Sahana Misra, Chief of Staff; Clare O’Geary, Chief Nursing Executive, Deputy Director for Patient Care Services; Brad Witke, Acting Administrative Director, Office of the Chief of Staff; Jenny Richardson, Deputy Chief Nurse Executive, VAPORHCS

VAPORHCS Director Goodspeed noted that VAPORHCS honors America’s Veterans by providing exceptional health care that improves their health and well-being. VAPORHCS is committed to being a patient-centered integrated health care organization for Veterans providing excellent health care, research, and education; an organization where people choose to work; an active community partner; and a back-up for national emergencies. VAPORHCS values Integrity, Commitment, Advocacy, Respect, and Excellence – together meaning “I CARE.” VAPORHCS has also deployed people across the country in support of the COVID-19 pandemic.

Director Goodspeed introduced the VAPORHCS leadership team, including VISN 20 Network Director Dr. Theresa Boyd, Deputy Director Karla Azcuy, Associate Director Bernard Deazley, Chief of Staff Dr. Sahana Misra, Deputy Chief of Staff Dr. David Kagan, Chief Nursing Executive Clare O’Geary, and Deputy Chief Nurse Executive Jenny Richardson.

The Director yielded the floor to Dr. Sahana Misra, Chief of Staff. Dr. Misra stated that the four top priorities for VA are customer service, response to the COVID pandemic, electronic health record and business system transformation. In response to COVID, VAPORHCS has had to pivot very quickly from a face-to-face to a virtual appointment modality and the leadership is hearing that the video delivery of mental health, in particular, is a very successful model.

VAPORHCS is replacing its aging electronic health record, CPRS, and migrating to the Cerner health information system. VISN 20 is the first in the country to be trained in Cerner. The new electronic health record will modernize VAPORHCS’s appointment system, automate disability and payment claims systems, and connect VA to the Department of Defense, private healthcare providers, and private pharmacies. Implementing the electronic health record will be an ongoing, iterative process to build a continuum of care that’s organized around Veterans’ needs. Dr. Misra commended VHA for taking the pulse and getting feedback from the field, anticipating that the next phase of the Cerner rollout will go much smoother than it had previously.

VAPORHCS is actively modernizing human resource management, finance and acquisition and its supply chain. COVID-19 brought the importance of supply chain continuity into relief. The goal with a more streamlined health care system is to provide more leeway to manage budgets, recruit, retain, and relocate staff needed to serve Veterans. It is also about more robust partnerships with state and local communities to address challenges, like Veteran homelessness and suicide prevention, VAPORHCS’s top clinical priority.

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Chief Nursing Executive Clare O’Geary discussed VAPORHCS’s priorities and initiatives, which includes increasing Veteran access to acute care services, increasing Veteran access to care through telehealth, keeping high cost, high complex care in-house, improving the Veteran experience, improving the employee experience, and building a high-reliability, zero-defect, zero-harm, highly-sustainable organization. These initiatives focus on the Access, Value, Experience, and Quality which lead to Veteran Advancement and Discovery, and serve as the foundation of the Whole Health and ICARE systems. VAPORHCS teaches its employees Lean and Lean Six Sigma in order to empower and enable them to change processes within VA to improve the experience for both Veterans and employees. VAPORHCS had submitted multiple innovations to and adopted multiple innovations from the VA’s Shark Tank. One of the most recent submissions for which VAPORHCS received recognition was their process for expanding lung cancer screening across the VISN.

The VAPORHCS Office of the Chief of Staff’s Acting Administrative Director Brad Witke continued the presentation with a review of VAPORHCS’s catchment area. It includes the main 1988 hospital building in Portland, which is physically connected to the hospital’s major academic affiliate, Oregon Health and Science University (OHSU), by a skybridge. VAPORHCS is one of two tertiary care referral facilities in the entire Northwest network. The Portland campus includes 167 Medsurge locked mental health and ICU beds. The Vancouver Washington campus includes a 76-bed community living center, a 35-bed residential rehab treatment program, and a transitional transplant lodging unit. In 2016 VAPORHCS opened a 16-bed Fisher House, and its catchment area also includes 10 additional clinics across 30,000 square miles and 26 counties of Oregon and Southwest Washington. VAPORHCS served about 98,000 unique Veterans in FY19. Portland and Vancouver are VAPORHCS’s the largest sites. There are 4,299 staff employed across the health care system, of which 29% are Veterans, 61% identify as women, and 7.6% are women Veterans.

Mr. Witke yielded the floor to Deputy Chief Nurse Executive Jenny Richardson. Ms. Richardson discussed the Women’s Health demographics. VAPORHCS serves a total of 13,542 women Veterans, with 7.6% of its employees being women Veterans themselves. VAPORHCS has a robust education and training mission. Its research funding level is the sixth highest in VA; it has 166 investigators, 570 active research studies in FY18, and nine National Centers of Excellence. It has received \$32 million in research grants from VA, National Institutes of Health (NIH), DoD, and others.

VAPORHCS’s education data shows that it has 716 graduate medical education slots (e.g., interns, residents, and fellows), 1300+ students trained annually (including medical students, nurses, psychologists, physician assistants, social workers, and chaplains), technical career field training in HR, facilities, fiscal and IT, and 228 academic affiliations, including Oregon Health and Science University (OHSU). Mr. Goodspeed shared some highlights from VAPORHCS’s women’s health research studies, including the MVP Gamma test predicting breast cancer risk for women Veterans, the VA women’s health research consortium practice based research network, implementation of tailored collaborative care for women Veterans, a clinical

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trial for women with methamphetamine use disorder, a randomized control trial comparing trauma sensitive yoga and cognitive processing therapy for PTSD and associated symptoms in women Veterans, and a women's enhanced recruitment program for research studies. VAPORHCS has achieved several other notable recognitions including being designated a Magnet in nursing excellence, being a Flagship for Whole Health, having a nationally regarded kidney and liver transplant program, receiving a William A. Nelson Award for Excellence in Health Care Ethics, and receiving certifications from the Primary Stroke Center and the Commission on Cancer.

The Chair thanked the panel for their extensive presentation and opened the floor to the Committee for questions and comments. Dr. Kirk asked how the 7.6% women Veteran employee rate compares across VA. Director Goodspeed responded that VAPORHCS does not have the other VAMCs' data with which to compare the rates of women Veteran employees, but he said that typically Veterans make up about 20-30% of the workforce at a given VA facility. The Vice Chair followed up by asking about the distribution of men and women generally, to which Mr. Goodspeed replied that the workforce is about 60% women. Vice Chair Kirk yielded the floor back to the Chair.

Vice Chair for Benefits Shannon McLaughlin sought further clarity on the data presented and asked if VAPORHCS had extrapolated a percentage of women Veterans enrolled in all VA. Ms. Richardson replied that the all-VA rate is about 7% as well. Ms. McLaughlin inquired into why discrepancies, if any, may exist in the rates, then yielded the floor to Linda Handley from the Benefits Subcommittee. Ms. Handley asked how many women Veteran employees use VA, to which Director Goodspeed replied that such data is not possible to gather. However, Dr. Suniga stated that she is a women Veteran employee who also uses VA. Vice Chair McLaughlin gave the floor to Lachrisha Parker.

Ms. Parker asked Ms. Richardson whether there was an increase in women Veterans utilizing the flagship Whole Health Program, especially in rural areas. Ms. Richardson replied that the Whole Health Program revolves around a wheel of care that includes medical, spiritual, physical environment, safety, sleep, noise and other parts of whole health care. VHA funded the flagship program in 2017 and VAPORHCS has been able to develop it at a considerable pace. VAPORHCS has educated its staff to practice whole health on themselves so that they can in turn use that model to care for Veterans. The health system is currently looking at how to incorporate whole health notes and terminology into direct patient care. However, VAPORHCS has not yet broken down the data by gender. He deferred to Dr. Dave Greaves, Clinical Director for Whole Health, who would brief the committee further on this issue. Director Goodspeed added that during the COVID pandemic, VAPORHCS has been able to stand up its yoga programs online.

Ms. Mathewson-Chapman asked what women's services in addition to mammograms are outsourced. Director Goodspeed replied that obstetrics is also outsourced. Dr. LaFavor added that VAPORHCS also outsources gynecological cancer and pelvic floor physical therapy at this time.

Overview of VAPORHCS's Women's Health Program/Primary Care

Dr. Sarah Suniga, Women Veterans Program Manager; Dr. Brenda LaFavor, Women's Health Medical Director; Dr. Phillip Dove, Deputy Clinic Director, Primary Care, VAPORHCS

Dr. Suniga delivered a presentation on the programmatic side of the Women's Health Program. The Women's Health Program team includes the WVPM, the Women's Mental Health Director and the Women's Health Program Navigator as well as about 53 women's health primary care providers (WH-PCPs). The WVPM does not have any collateral duties, with the exception of four clinical hours to maintain their psychology license. The WVPM participates in environment of care rounding, construction planning, and consults with various workgroups across the health care system. They also routinely collaborate with Public Affairs, the Office of Veteran Experience, Enrollment, and various care coordinators. The WHMD provides clinical expertise across the health care system, routinely collaborating with Primary Care, ED, Operative Care, and Mental Health.

VAPORHCS Women's Health Medical Director Dr. LaFavor delivered a brief on the clinical side of Women's Health Program. Their role is to provide clinical expertise across the health care system and help the VISN provide the best care possible to women Veterans, with their duties being 50% clinical and 50% administrative.

Dr. Suniga remarked that the women Veterans enrollee population is about 10% of total Veterans served. Some of the sites that are seeing the most women Veterans are Vancouver, Salem, and Portland. VAPORHCS continues to see growth in the woman Veteran population. The greatest distribution of women Veterans is in the 35-44 and 55-69 year age range. 62% of women Veterans identify as white-non-Hispanic and 25% live in a rural area. VAPORHCS's strategic priorities align with VACO's greater goals. Goal 1 is to ensure women Veterans receive high quality, patient driven health care and are assigned to designated women's health providers. Since fall of 2018, VAPORHCS has increasingly assigned women Veterans to WH-PCPs because doing so gets them higher quality care. Goal 2 is to ensure that women Veterans receive care that is seamless, holistic, and collaboratively delivered, and to expand and support virtual care. Goal 3 is to transform VA culture through employee accountability for women Veterans' experience and to promote visibility of women Veterans' contributions. Goal 4 is to ensure VA is a national leader in women's health, equipped to train interdisciplinary teams to target high complexity treatment.

Among its notable accomplishments, VAPORHCS received a Women's Health-Nutrition and Food Services grant to provide healthy teaching kitchen virtual classes, which even includes food supplies. VAPORHCS stood up its Stop Harassment Task Force, which is an integrated effort between VA Police, EEO, Women's Health, DEI program, Education, White Ribbon, Employee Threat Assessment Team, and the Veteran Experience Office. They offer psychosocial support for pregnant Veterans, as well as postpartum groups and lactation consultant support. VAPORHCS is also one of the first sites in the VISN to stand up an assistive reproductive technology/In Vitro Fertilization-Interdisciplinary Team (IVF-IDT). It is

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currently preparing to train an interdisciplinary team to address eating disorders. The I Am Not Invisible Campaign is on display at all sites of care.

Dr. LaFavor discussed VAPORHCS's Women Veterans Health Committee, whose purpose is to develop and implement a Women's Health program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans. The committee reports to a clinical executive board, and its goal is to open silos and have an integrated approach across the health care system. Some of the member stakeholders of the committee are mandated by VHA Directive 1330.01. Thus far the Committee has worked on outreach groups, strategic planning, and breast cancer screening.

Based on data from V-Signals, women Veterans respond to feedback surveys at a rate of 8% compared to overall Veteran feedback. Dr. Suniga shared key data points, including the survey questions "I trust VAPORHCS for my healthcare need," "I am satisfied with the service I received from VAPORHCS," and "During my most recent VA health care experience I felt respected and comfortable."

Some examples of VAPORHCS's outreach events include Oregon Women Veterans' Conference (ODVA), Portland Veterans Stand Down (Transition Projects), Women Veterans Appreciation Night (Portland Thorns), Annual Gathering of Warriors Veterans Summit (Office of Tribal Government Relations/Confederated Tribes of Grand Ronde/Native Wellness Institute), and Portland Women's Expo. These are both Veterans-focused events and community-focused events which result in more underserved women Veterans coming forward for care. Dr. Suniga and a Women's Clinic provider also published a YouTube video on cervical cancer screening and awareness. The Portland VA Women Veteran Health Program website is live and public-facing.

Primary Care Deputy Clinic Director Dr. Philip Dove continued the briefing with a presentation of the clinical side of the Women's Health Program. The total number of patients enrolled in primary care (PC) has significantly decreased while the ratio of women enrolled has significantly increased. Due to the COVID pandemic, access has become limited and VAPORHCS therefore maintains a slightly longer wait time than the VHA average. VAPORHCS has an embedded Primary Care Mental Health Integration (PCMHI) team available specifically to allow for warm hand-offs for immediate assistance within the Women Health Care program. Colposcopy is available within the PC Women's Clinic. There is integrated comprehensive trans-women care across the division and there is also highly effective contraceptive management available, including IUD and Nexplanon.

The Primary Care Division holds a monthly educational meeting featuring a quarterly Women's Health update. The Division has received special purpose funding through Women's Health Innovation and Staffing Enhancements (WHISE2.0) that allowed them to procure updated equipment, additional education resources for division providers and nurses, and a health tech/chaperone in Women's Clinic. 83% of PCP staff members are Women's Health Proficient, and comprehensive Women's Health Services are provided at 10 of 13 sites.

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Over the next year and beyond, all new provider recruitments to the PC division will be Woman's Health Proficient. Drs. Suniga and LaFavor organized a Woman's Health mini-residency which is offered to all PCPs several times a year. The Division recently appointed a lead nurse practitioner and Women's Health Provider and Educator. In the next fiscal year, VAPORHCS plans to open two additional Coastal Sites for Women's Health Care and expand Comprehensive Women's Health Care to Homeless PACT.

The PC Division has faced and continues to face several challenges, the foremost being COVID-related clinical staff turnover which has impacted access to care. Other COVID-related challenges include the pivot to virtual modality. Both Veterans and providers have struggled to grasp the technology. VAPORHCS is continuing to address the facility needs of the growing population of women Veterans and wants to expand into additional Model 3 sites at Salem and Southwest Washington.

Dr. Suniga offered the Committee a virtual site visit of the VAPORHCS facility and concluded her briefing. Vice Chair for Health Dr. Kirk expressed interest in attending the virtual site visit after this day of meeting, noting interest in the accommodations available to disabled women Veterans. Vice Chair Kirk expressed dissatisfaction with the outsourcing of women Veteran health services, inquired about comparative outsourcing for male Veterans as well as the ratio of WH-PCPs to the women Veteran population, and admired the expectation that all PCPs be trained in women's health. Vice Chair Kirk also inquired about the OIG report's comments on the Women Veterans Health Committee.

Vice Chair for Benefits McLaughlin asked whether the V-Signals surveys included questions about the level of satisfaction of women Veterans. Dr. Suniga replied that the survey is a five-question Likert scale model that provides real time Veteran feedback on trust, ease of schedule, and overall quality and experience. There are surveys specific to different departments of care, and a section for Veterans to submit their comments. The majority of such comments are characterized as compliments, and all comments are reviewed by the Women Veterans Health Committee. Dr. LaFavor added that while the Committee cannot control the questions, they do review the responses looking for trends.

Ms. Parker thanked the panel for their briefing and asked about VAPORHCS's future plans regarding homelessness, asking what the system does to bring homeless women Veterans in for care when they encounter them in the community. Dr. Dove replied that the homeless Veteran site is located downtown where homeless Veterans tend to congregate. It is an open door clinic with frequent walk-ins. Director Goodspeed stated that the VAPORHCS homeless program will brief the Committee on this topic in the near future.

Ms. Handley asked Dr. Suniga about her four hours of clinical practice and whether she has a staff to support her outreach program. Dr. Suniga replied that she has no direct reports although she is supported by the Women's Health team. Ms. Handley remarked that Dr. Suniga must be very busy as both the Women's Health Program Manager (WVPM) and a clinical practitioner, and asked whether her picture was posted publicly in the VAPORHCS facility, suggesting that if it were not, then women Veterans would not know who the Women Veterans Program Manager is should they need to contact her. Director Goodspeed

mentioned that Dr. Suniga needs to maintain a clinical practice in order to maintain her state licensure.

Dr. Marianne Mathewson-Chapman asked whether women Veterans were more comfortable getting their care at VAPORHCS or a CBOC. Dr. Dove replied that his experience shows that opinion is divided. While all CBOCs have primary care-mental health integration, the center on the Hill is more specialized because they only see women Veterans.

Ms. Harris remarked that the WVPM should be an FTE position and that H.R. 7105 mandates that VAPORHCS ensure the Women Veterans program is adequately staffed and supported. She expressed concern that the WVPM position is also a clinical psychologist without a supporting staff because the ACWV does not want the WVPM to experience burn-out. It is precisely because practitioners need to maintain their clinicals that the Committee mandated the WVPM be FTE. The WVPM is supposed to drive all of the women Veterans programs in her purview on behalf of the leadership, and she can't do that if she has collateral clinical duties. It is not fair to the practitioner and it is not fair to the Veteran. Director Goodwin replied that it would also be unfair of him to make career choices for Dr. Suniga, who desires of her own free will and volition to serve both women Veterans and her professional responsibilities. Ms. Harris emphasized that it is imperative for women Veterans to know their WVPM. As a point of privilege, Dr. Patricia Hayes, head of Women's Health Services (WHS) for VHA, remarked that VAPORHCS is in line with policy; the WVPM must be a clinical position, and it is necessary for state-licensed clinicians acting in any administrative capacity to maintain their state medical licensure through required practice. Dr. Hayes concluded by saying that just because a WVPM has a practice does not mean they have collateral duties or that women Veterans are not being served.

Breast and Cervical Cancer Screening Program

Dr. Brenda LaFavor, Women's Health Medical Director; Dr. Sarah Suniga, Women Veterans Program Manager; Alyssa Meyer, Group Practice Manager (GPM), VAPORHCS

Dr. Brenda LaFavor delivered the presentation on gender-specific health screenings, primarily cervical and breast cancer. Osteoporosis is also an important screening for women. Women face a number of barriers to getting screened, including trauma (MST, PTSD, et cetera), work and childcare conflicts, homelessness, and competing medical priorities, particularly mental health, chronic pain, and musculoskeletal conditions.

Dr. LaFavor discussed how women Veterans have been disproportionately affected by COVID. There have been many reports that women, particularly working mothers and women of color, are being disproportionately affected by the pandemic-related economic downturn. Women face a higher burden of unpaid work and they are more likely to leave their jobs due to childcare. Women make up about 70% of health care workers globally. Socioeconomic status is highly correlated with overall screening rates. Those without access to money are less likely to get cervical and breast cancer screening. Face-to-face cervical and breast cancer screenings have also been negatively impacted by COVID as there is no virtual modality for these screenings. These disproportionate effects on women Veterans must be addressed.

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At VAPORHCS all cervical cancer screening is done through the comprehensive primary care Women's Health Pap Teams. The few rural sites that do not have WH-PCPs do have Community Care Primary Care. VAPORHCS tracks all pap smear results using a locally designed tracking tool. It refers gynecology internally for those living in the Portland area, and through community care for those living in more rural areas. A higher number of women getting cervical cancer screenings come from the Portland metro area, which is generally a younger population.

Dr. LaFavor discussed trauma-informed pelvic exams and gynecological procedure, specifically using mindfulness during these procedures to improve patient outcomes. Patients were offered mindfulness interventions when they scheduled such screenings. All patients reported finding the intervention helpful and expressed gratitude. Four women voiced approval of what they perceived to be a Veteran-focused approach to care. Several Veterans declined the intervention but stated it would have been helpful to them in the past. Staff who utilized these interventions reported that they were an important approach to trauma-informed care by taking into account women's past experiences. Providers perceived that procedures went more smoothly due to provider stress relief and improved relaxation of cervix, and it allowed providers to focus on the procedure as there was a designated person to assist the Veteran with anxiety and relaxation.

100% of mammograms are completed through community care, and VAPORHCS reported 1228 mammogram consults from August 16, 2020, through August 16, 2021. VAPORHCS coordinates care with over 70 imaging centers across Oregon and Washington using a triage process: the Women's Health Navigator monitors patients due for mammogram; the Primary Care team places orders for mammogram; consults are reviewed by community care mammogram coordinator; a community care MSA authorizes mammogram to Triwest; an outside imaging center contacts the patient for scheduling; the outside imaging center faxes results to mammogram coordinator; the mammogram coordinator enters results in electronic medical record as if the test were done at VAPORHCS; and the Primary Care team notifies the patient of results. VAPORHCS breast cancer screening rates have been falling for the last five years due to anti-mammography culture in the Pacific Northwest.

Because VISN 20 breast cancer screening rates are below the national average VAPORHCS is focused on improving educational outreach and access to screening; it has even implemented a system-wide cancer screening workgroup run by the Women's Veteran Health Committee. Much of their activity is focused on town halls and other outreach events to raise awareness of importance of cancer screening. The Women's Health Navigator and Women's Health Liaisons conduct direct patient outreach and use motivational interviewing to help decrease barriers. Contracting options for outsourced mammography have not been successful and internal mammography faces multiple barriers including resources, space, funding, equipment requirements, and population limitations. VAPORHCS's highly rural catchment area also makes screening logistics difficult. Dr. LaFavor yielded the floor to questions from the ACWV.

The Chair thanked Dr. LaFavor for the presentation and turned the floor over to Vice Chair for Health Dr. Kirk. Vice Chair Kirk thanked Dr. LaFavor for the brief and asked about VAPORHCS's screening percentage goals. Dr. LaFavor replied that it is very hard to interpret the screening data due to their lag time, however, she stated that at 65% of women Veterans being screened for mammography, the VISN is not at her screening goal of 100%. Vice Chair Kirk also asked about the empanelment of 255 women Veterans per PCP and 1228 mammograms recorded in VAPORHCS, noting that the population of women Veterans will continue to go up in the coming decades. Dr. LaFavor replied that current recommendations for empanelment are at least about 100 women Veteran patients per PCP, and that ratio is projected to grow. VAPORHCS's staff gynecologists provide surgery on site one day a week, and all non-cancer surgeries are performed in-house. A lot of cancer surgeries are outsourced to OHSU, which is connected to VAPORHCS via skybridge. Hystograms, hysteroscopy, and other infertility workups are performed in-house, but care requiring IUI, IVF, and reproductive endocrinology are referred out to OHSU. Vice Chair Kirk thanked Dr. LaFavor and yielded the floor to Ms. Wright.

Ms. Wright asked about the positions of Women's Health Navigator and Women's Health Liaison. Dr. LaFavor replied that the Women's Health Navigator is a primary care/maternity care coordinator who helps monitor the system-wide approach to women's health cancer screenings. The Women's Health Liaisons are in each CBOC, and they help coordinate with the local PCPs, nurses, leadership, and Veterans. There being no other questions, Vice Chair for Benefits McLaughlin recognized the next presenter.

Maternity Care Coordination

Meghan Kauffman, Women's Health Navigator and Maternity Care Coordinator, VAPORHCS

Ms. Kauffman is also the maternity care coordinator for all of the pregnant Veterans within VA. Her role is to provide effective coordination between VA, community OB providers, and all relevant VA and community specialist providers treating the Veteran. Her role is also to collaborate with the Office of Community Care on referrals for care in the community; monitor the delivery of services and tracking of maternal and fetal outcomes; regularly communicate with the Veteran during their pregnancy; provide education, support, and information about local and community resources; ensure the EHR accurately reflects the Veteran's pregnancy or lactation status; and screen Veterans for depression, IPV/DV, MST and PTSD during pregnancy and postpartum, referring to appropriate specialists as needed. Ms. Kauffman stated that VA must not take a hands-off approach, but remain integral in the coordination of care for pregnant Veterans. Proactive care authorization helps avoid billing issues down the road. This year, VAPORHCS has had 58 viable and 15 non-viable pregnancies, with a total of 89 new pregnancies.

Maternity care services covered by VA include but are not limited to maternal fetal medicine, diagnostic imaging, lab work, genetic counseling and testing, education,

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prenatal classes, lactation consultants up to three months, postpartum contraception, and postpartum services for eight weeks. Excluded services include but are not limited to home delivery, doula services, direct entry midwives, any experimental procedures, elective and therapeutic abortion, and abortion counseling. Pregnant Veterans may also receive the benefit of the full lactation package, which includes a double electric breast pump with five different options, three nursing bras with seven different options, a pregnancy or postpartum support belt, 12 washable nursing pads, and a tube of Lanolin. VAPORHCS has a FTE lactation consultant.

Maternity support groups focus on the topics of lactation, sleep, nutrition, birth planning, and postpartum prevention planning. The focus groups have experienced some attendance challenges. Ms. Kuffman shared some positive feedback from women Veterans about the workgroups. At 20-weeks of pregnancy a primary care behavioral health provider performs a psychosocial assessment to review potential stressors, discuss feelings around being pregnant and becoming a mom, and provide resources and referrals as needed.

Ms. Kaufmann noted that many of her daily communications with Veterans and providers involve billing issues. These billing issues occur for such reasons as: lab work was sent out from the main OB clinic/hospital without insurance information; community providers may not understand the difference between TriWest Healthcare Alliance and Tricare (the assumption being that they are the same); the authorization may not be going to the right people; the clinic may assume the Veteran is paying out of pocket if there is no insurance listed; or, Veterans feel pressure from offices to pay out of pocket to avoid credit issues. Ms. Kauffman recommended establishing a position dedicated to coordinating maternity care between VA, TriWest, and PCPs.

In-Vitro Fertilization (IVF) community care referrals are managed internally by an interdisciplinary team comprised of the Chief of the Office of Community Care, a Service Chief designee, an Office of Community Care staff member, a Group Practice Manager, a Women Veterans Program Manager, a Primary Care Case Manager, a Urology Case Manager, and an Endocrine Case Manager. Ms. Kauffman shared some HIPAA-complaint IVF tracking information.

Vice Chair for Health Kirk opened the question session by asking whether VAPORHCS screens women Veterans for exposure to vocational or environmental toxins, and whether or not such data demonstrates any pass-through trauma to the mother or child. Ms. Kauffman replied that they are not currently tracking that information. The Vice Chair recommended that VA track environmental exposure data. Ms. Wright commended Ms. Kauffman for supporting her constituency of women Veterans, noting that they are disproportionately indebted to the health care system because they are referred out to the community for maternity care, thus resulting in billing issues. She then asked if IVF referrals result in the same kinds of billing issues to women Veterans. Ms. Kauffman said that they do, but not to the extent that other types of care incur because the IVF interdisciplinary team is so proactive in the process of referring the

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Veteran out to the community. Vice Chair Kirk echoed the comments of Ms. Wright and turned the floor over to the Vice Chair for Benefits.

Ms. Harris thanked Ms. Kauffman for the brief and asked whether VAPORHCS had any outstanding billing issues and how they are handling them. Ms. Kauffman replied that there are outstanding billing issues and she is wrestling with how she can help to resolve them from her position as a nurse. Often, VA and TriWest do not mutually communicate with the Veteran until the Veteran received a collections notice in the mail. Dr. Suniga added that she appreciated the attention the ACWV is paying to the systemic billing problem. Vice Chair Kirk concurred. The Chair recommended that the ACWV examine this topic more closely, and thanked Ms. Kauffman for her passion.

Committee Discussion

In lieu of committee discussion, Dr. Suniga gave the ACWV a virtual tour of the VAPORHCS facility.

Adjourn

At 2:00 p.m. PT the Chair adjourned the first day of the ACWV-VAPORHCS site visit.

Wednesday, August 25, 2021

Open Meeting/Introduction of ACWV Members

Betty Yarbrough, Chair, ACWV

At 10:03 a.m. PST, The Chair called the second day of the ACWV meeting to order. The Committee members, ex-officio members, advisors, and public guests introduced themselves.

Office of Tribal and Government Relations

Terry Bentley, Tribal Relations Specialist, Pacific District

The Office of Tribal and Government Relations (OTGR) was established in 2011 by an Executive Order that mandated all Federal agencies to develop written tribal consultation policies. Ms. Bentley introduced the regional specialists that work with tribes all across the nation: Director Stephanie Birdwell, Specialist Homana Pawiki, Specialist Peter Vicaire, Specialist Mary Culley, and Program Analyst Clay Ward. OTGR reports within VA's Office of Intergovernmental and Public Affairs. Its main goals are (1) to increase Native Veterans' access to services and benefits, (2) to improve economic sustainability, i.e. earned benefits such as education, vocational rehabilitation, direct loan, and compensation disability benefits, (3) and to implement VA's tribal consultation policy. Ms. Bentley highlighted a 2019 Yakama Nation outreach event honoring Native women Veterans.

Of approximately 158,217 American Indian/Alaska Native (AI/AN) Veterans, 65,749 use at least one VA benefit or service, at a rate of 88.5% male to 11.5% female. AI/AN Veterans tend to have lower incomes, are less likely to have advanced degrees beyond Bachelors, are more likely to lack health insurance, and are more likely to have a disability for service connection. AI/AN Veterans used Veterans Benefits Administration

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(VBA) benefits or services at a lower percentage than Veterans of other races, at a rate of 41.6% to 52.7%, likely because they take advantage of other tribal or Federal health benefits.

Ms. Bentley reported on the status of several recent pieces of legislation. The most significant is on reimbursements to Indian Health Service (IHS) and Purchase Referred Care (PRC) (HR 6237). A series of informational calls were held between VHA, IHS and members from IHS's PRC workgroup to gain an understanding of the PRC program, which would ultimately enable AI/AN Veterans to be seen in their tribal health programs and be referred out in collaboration with VA as necessary. VA and IHS's Offices of General Counsel are working together on details of the legislation. Co-pay prohibitions for Native American Veterans (HR 7105 section 3002) will eliminate co-pays for Native Veterans who come to VA for care. VHA Community Care is working on implementation by January 2022. State Veterans Homes Grants (HR 7105 section 3004) allows tribes to participate in that grant process where they had not been able to previously. HUD-VASH (section 4206) funding for 26 tribes to receive housing vouchers in and on reservations was secured and increased.

Per the Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships, OTGR and the Department of Veterans Affairs, U.S. Department of Treasury, Social Security Administration, and U.S. Small Business Administration participated in joint agency tribal consultation seeking input on ways to improve departments' and agency's tribal consultation policy. The Office is currently compiling its report and will send a draft consultation policy out to tribal leaders for further input. The VA-IHS memorandum of understanding is currently in the concurrence process and will be released soon; it has been in place since 2003 and continues to be an important partnership between the two agencies in the care of AI/AN Veterans. The VA Tribal Advisory Committee was recently established and is receiving membership recommendations from across the country. Its first virtual session is scheduled for October 2021. Ms. Bentley also discussed several outreach efforts targeted toward Native women Veterans.

In order to continue virtual outreach during the COVID-19 pandemic, OTGR developed WebEx Wednesdays to highlight key stakeholders in Indian Country and share information on a host of important topics within VA. Data from the VA-IHS/Tribal Health Program (THP) reimbursement agreement shows that \$142,194,208 have been reimbursed to tribes, impacting 13,440 unique Veterans.

Ms. Bentley shared some of the feedback she solicited from women Veterans and service providers within her region. They shared that the networking between tribal Veteran service officers and tribal Veterans representatives in the VISN has been very successful, especially since the CFR changed to allow tribes to be their own accredited Veteran service officer organization. Other successes include the Camp Chaparral Yakama cultural immersion camp, pre-COVID tribal outreach, the Joint American Indian Veteran Advisory Council (JAIVAC/AIVAC) out of VA Puget Sound, and partnerships with state DVAs, VBAs, VHAs, and NCAs. Some of the challenges reported from the

field were the VA phone system, the distance of providers from tribes, updating personally identifying information, the lack of Native American PCPs, and access to mental health counseling for Veterans and their families. Other feedback showed that women Veterans want more flexibility in choice of PCP, more tribal cultural education and competency, and a national virtual support group for Native women Veterans.

The Chair thanked Ms. Bentley for the briefing and asked for clarification about the statistic that AI/AN women serve at a higher rate than non-AI/AN women, at a rate of 11.5% to 8%. Ms. Handley noted that the inpatient claims for June 2021 seemed very low and asked why that was. Ms. Bentley replied that she would check on the data and respond at a later time. Ms. Handley followed up with a question about whether AI/AN Veterans experience the same kinds of billing issues that other women Veterans face when they are referred into the community for care. Ms. Bentley replied that billing is a structural issue that all women Veterans face. Ms. Handley replied that AI/AN Veterans are easily dissuaded from using VA if they experience any kind of inconvenience, raising a concern about Veteran trust in VA. She thanked Ms. Bentley for the briefing and yielded the floor back to the Chair.

Overview of VAPORHCS's LGBTQ+ Program

Dr. Aakash Kishore, LGBT Veteran Care Coordinator

Lesbian Gay Bisexual Transgender Queer and Associated Identity (LGBTQ+) Veteran Care Coordinator Dr. Kishore gave the report. Dr. Kishore is a staff psychologist at a Portland VA CBOC embedded within primary care. They also co-chair the local sexual orientation and gender identity advisory group. Dr. Kishore admitted that there is not a lot of great data on the demographics of LGBTQ+ Veterans because VA does not collect that data routinely. However, it is estimated that there are at least one million LGBTQ+ Veterans in the US and an estimated 268,000 transgender Veterans, or 0.6% of the Veteran population. A previous 2011 population estimate placed the transgender Veteran population at 0.3% of the population. Dr. Kishore stated that the numbers are likely underreported because of the way VA captures this information. Transgender individuals are nearly twice as likely as cis gendered women to serve in the military, and those assigned female at birth are nearly three times more likely. This makes VA potentially one of the largest providers of health care to trans individuals in the world, and VAPORHCS has one of the largest LGBTQ+ Veteran populations in the country.

There is a wide variety of services housed within women's health services that LGBT individuals may access, as well as wide diversity among women-identifying Veterans. The LGBTQ+ and Women Veterans Program are working jointly to provide care at this intersection. The role of the LGBTQ+ Veteran Care Coordinator is written into VHA directives 1340 and 1341. One of their roles is to co-chair the Sexual Orientation and Gender Identity Advisory Group, an interprofessional group of staff members who provide education and advocacy on LGBTQ+ Veteran health issues at the VAPORHCS CBOC. There is an LGBTQ+ Special Emphasis Program, which is a resource for LGBTQ+ staff members. Since 2014, the VAPORHCS CBOC has been acknowledged as a "Leader in Health Care" on Human Rights Campaign's Healthcare Equality Index.

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The facility has participated in local and community pride events in the catchment area, collaborating with Oregon Department of Veteran Affairs' LGBT Care Coordinator.

The CBOC offers LGBTQ+ Veterans such services as LGBTQ+ support groups, an alliance group for gender-expansive Veterans, primary and preventative care including medically necessary hair removal, mental health care, family planning, gender-affirming hormone therapy, gender-affirming prosthetics, gender-affirming voice training, pre-operative and post-operative care (though not currently able to cover gender-affirming surgeries), intra-facility transgender health e-consult, inter-facility transgender e-consult at Loma Linda, and CPRS-based support.

One of the major barriers to gender-affirming care for LGBTQ+ Veterans is the electronic medical record (EMR). The EMR does not appropriately capture a Veteran's affirmed name, gender identity versus sex assigned at birth, personal pronouns and salutations, sexual orientation, or organ inventory. There is a general lack of data collection of LGBTQ+ identities on customer surveys and LGBTQ+ Veteran health outcomes are not connected to SAIL measures. There are also no hospital-wide or system-wide minimum standards for proficiency of care for LGBTQ+ Veterans.

Some of the facility's improvement efforts include collaboration with the Women Veterans Program Manager, IPV coordinators, and MST coordinators to address cross-cutting issues and to educate at the intersection of LGBTQ+ and women's health. One such effort was the Trans Dudes with Lady Cancer CEU event. The LGBTQ+ program participated in the mammography workgroup to ensure that the solutions developed work for all Veterans. The program hosts in-service trainings to increase familiarity with the LGBTQ+ population (e.g., with HR, patient advocates, and prosthetics), and is currently collaborating with the Chief of Staff and division directors to increase baseline competencies for primary care and mental health. The Sexual Orientation and Gender Identity Advisory Group has been implementing a Veteran needs assessment in order to gather data directly from Veterans who both are and are not utilizing VA health care services.

The Chair thanked Dr. Kishore for the briefing and asked whether two LGBTQ+ Veteran care coordinators were enough to serve the large Veteran population in the Portland catchment area. Dr. Kishore replied that it was not due to the size and spread of the population, and stated that they allocate eight hours a week to perform the duties of the position while the other coordinator has four hours. The Chair gave the floor to Vice Chair for Health Kirk who also remarked on the part-time nature of the LGBTQ+ Veteran care coordinator. Vice Chair Kirk asked if there was a position description, to which Dr. Kishore replied that the duties are all listed in VHA Directive 1341. Vice Chair Kirk asked whether H.R. 7105 recommended anything for LGBTQ+, which Dr. Kishore did not know. Finally, Vice Chair Kirk remarked that VA has not benchmarked women Veterans in terms of socioeconomic status, health outcomes, age, minority status, and other public health measures, and therefore has not been able to develop metrics for tracking and other measures, so she asked Dr. Kishore whether they had been tracking such metrics. Dr. Kishore replied they were not, but went on to say that the EMR only

tracks sex assigned at birth, which needs to change because trans individuals within VA may not be informed of access to women’s health care services they may need. The Vice Chair yielded the floor to the Chair, who thanked Dr. Kishore and proceeded to the next item.

Overview of VAPORHCS Mental Health (MH) Services

Courtney Covey Lewis, Associate Chief Nurse Executive, MH & Clinical Neurosciences Division; Dr. Odessa Cole, Women’s MH Program Director, VAPORHCS

Mental Health Associate Chief Nurse Executive Courtney Covey Lewis gave the presentation. The VAPORHCS Mental Health (MH) Division covers 10 sites of care across the geographic region and runs multiple programs to address needs of diverse groups, including group and individual therapy both in person and virtual. Although the COVID-19 pandemic has led to a predominance of virtual care, VAPORHCS has a number of services that can be offered at home to often under-served populations. MH Division also has nurse care management and offers psychopharmacotherapy and medication management services. It also offers residential and inpatient programs, homelessness and community services, and programs for substance abuse, PTSD, suicide prevention, and robust integration with primary care. Some of the residential and inpatient programs include an acute inpatient psychiatry unit providing crisis stabilization, short term care, care coordination, medication management in Portland and a residential recovery treatment program offering substance abuse and homelessness services, individual and group treatment, and case management in Vancouver.

Male patients represent the vast majority of total mental health patients served over the last three years, although women Veteran MH patients demonstrated 15% growth between FY19 and 21, despite an overall decrease in MH services offered in FY20 due to COVID. Over the last three years, data shows a sustained increase in encounters with women Veterans. Ms. Covey Lewis gave the floor to Women’s Mental Health Program Director Dr. Odessa Cole.

Dr. Cole reported that she was trained by VA Central Office (VACO) as a Women’s Mental Health Champion, which includes a full week of training on Women’s Mental Health. The Women’s MH program director is a clinician embedded in the Women Veterans Health Clinic. She has one day a week of designated admin time to consult with MH clinicians and programs, make recommendations to MH Leadership, lead the Women’s MH Workgroup, and lead the Women’s MH Workgroup subgroup projects.

Dr. Cole is a member of the Women’s Mental Health Workgroup, a committee of MH clinicians and other support and wellness staff across VAPORHCS who are dedicated to improving mental health services for women Veterans. The workgroup invests in projects which are usually administrative in nature. Group members act as the “point person” for Women’s MH topics on their designated clinical team. Workgroup mission and projects are motivated by VACO Women’s Mental Health recommended topics for

improvement and attention, including women's reproductive mental health, complex trauma, women and suicide, and eating disorders.

The Women's Specialty Mental Health team has just received two new psychologists and a part-time (PT) psychiatrist dedicated to treating women's specific mental health concerns, including reproductive mental health, eating disorders and complex trauma (e.g., LGBTQ+ and race-based stress). The PT psychologist and PT psychiatrist primary care mental health providers are embedded in the Women Veterans Health Center. Other women specific groups such as stress management, seeking safety, peripartum education/support, PTSD group, and IPV group are embedded in all Women's Health Clinics. Dr. Cole opened the floor up to questions.

The Chair thanked the presenters and gave the floor to Vice Chair for Health Dr. Kirk. Vice Chair Kirk yielded to Ms. Wright, who asked about the offering of military sexual trauma (MST) group services. Dr. Cole said that they do not currently have an MST group, but that Aysha Crain would provide more information on that topic.

Ms. Harris asked how many inpatient beds, if any, are available specifically for women. Ms. Covey Lewis replied that there is a 21 bed acute inpatient unit in which VAPORHCS has developed safe spaces for women Veterans. A number of rooms have privacy locks that can only be opened from the inside. VAPORHCS has also been increasing the number of private rooms, which are prioritized for women Veterans. The residential program includes a women-designated lounge and rooms. Ms. Harris asked whether the women's health psychiatrists provide medication management or ongoing one-on-one sessions as well. Ms. Covey Lewis replied that the program of care depends on the individual Veteran. There is an evidence-based, goals-based number of sessions set initially for the Veteran and their progress is assessed as care is administered. The Primary Care Mental Health Integration program has psychologists, social workers, and providers embedded within primary care that can provide on-the-spot interventions to Veterans in need. Partners like The Vet Center also provide additional services. Ms. Harris yielded back to the Chair, who thanked the presenters.

Military Sexual Trauma (MST) Program Aysha Crain, MST Coordinator, VAPORHCS

MST Coordinator Aysha Crain is a licensed clinical social worker and one of two MST coordinators at VAPORHCS and also works on the PTSD clinical team. The definition of MST used by VA is "psychological trauma, which in the judgment of a VA professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training" (Title 38 U.S. Code 1720D).

VAPORHCS's two MST coordinators are allocated ten hours or .25 FTE each. VAPORHCS is currently hiring for the second coordinator position. MST coordinators provide support for VHA locations at Portland, Vancouver, Salem, The Dalles, Fairview, West Linn, Hillsboro, North Coast, and Bend, and VHA Directive 1115 prescribes their primary tasks. The MST Coordinator monitors systems and processes within the facility

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to ensure that MST-related policies are implemented properly (i.e. MST screening, connecting Veterans to appropriate care in a timely fashion, etc.). With regard to consultation, the facility MST Coordinator is a point person for Veterans and staff to contact when they need assistance with MST-related care issues. The MST Coordinator directly provides or ensures other mechanisms are in place to provide education to improve staff members' awareness of MST and knowledge and skill in working with those who have experienced MST. Lastly, the MST Coordinator plans, directs, and conducts outreach within the facility, with nearby VET Centers, and in partnership with community stakeholders. Ms. Crain reported on the prevalence of MST, with the caveat that MST is not reported as much as it is happening. Women Veterans are 15 times more likely than male Veterans to report having been sexually assaulted or harassed, yet make up approximately 15% of the Portland VA population. Ms. Crain shared data on the number of women Veterans screened for MST by fiscal year and the positive screening results. On average, 38-40% of women Veterans report a positive screening even though the number of women Veterans screened appears to be decreasing over time. About 2% of male Veterans screen positive for MST.

The MST coordinator works together with VAPORHCS facility point of contacts (POCs) and clinics most commonly working with woman Veterans, including the Women Veteran's Program Manager, Intimate Partner Violence Coordinators, LGBTQ Coordinators, Women's Health Clinic, mental health clinics, and primary care mental health integration. MST coordinators train staff about the difference of working with women Veterans who have experienced MST and track screening of women Veterans who have experienced MST. The national MST team has an extensive database that helps track this information. MST coordinators also work with and train community organizations about MST and military culture, discuss trauma-informed practice, and build a close relationship with VBA to assist with service-connected questions and concerns. VAPORHCS has developed a fruitful relationship with the local organization Returning Veterans Project.

Ms. Crain remarked that VAPORHCS can improve by offering more training to staff around trauma-informed care and consideration for women Veterans, especially those who have experienced MST. VAPORHCS could also offer more mental health and primary care mental health integration for women Veterans, especially for female Black Indigenous People of Color (BIPOC), LGBTQ+ Veterans, and those who have experienced MST (e.g., MST-related groups and individual treatments). Finally, VAPORHCS can provide more outreach to the female Veteran community to share resources and offer care options of which they might not be aware.

The Chair thanked Ms. Crain for the briefing and opened the floor to Vice Chair for Health Dr. Kirk. Vice Chair Kirk agreed with the need for more outreach and appreciated the training outreach to the National Guard. The Vice Chair expressed concern about the decrease in screening during the previous fiscal year and asked whether the MST program was coordinated with the Vet Center in offering MST care. Ms. Crain replied that VAPORHCS has a 99% screening rate of Veterans coming into the system, but that COVID may have impacted the lower overall patient numbers. In her role as the PTSD

clinical social worker, Ms. Crain has seen an overall increase in women Veterans engaged in care because they can use the virtual modality, being more comfortable not going to a VA facility. The Vice Chair remarked that it may be a more systemic problem of getting women Veterans to come to VA. Ms. Crain remarked that the VET Centers are VAPORHCS's main partner for MST-related groups and resources. Dr. Mathewson-Chapman asked how difficult it is to go through the disability process for MST. Ms. Crain replied that it is difficult for women Veterans to go through the process due to their burden to produce evidence, but this burden has changed over the years to allow fact-finders to reach conclusions through more nuanced circumstances. The hospital administration works with MST-positive Veterans to first validate their experience and then connect them with service providers and VBA representatives. Being asked to relive traumatic experience in testimony when they are not emotionally prepared also deters women Veterans from going through the process. Lastly, having multiple instances of MST can deter women Veterans who are limited to referencing one particular instance.

The Chair gave the floor to Vice Chair for Benefits McLaughlin who yielded the floor to Ms. Parker. Ms. Parker asked whether reservists who experience MST can report it after they re-enter civilian life. Ms. Crain replied that reporting MST is challenging for reservists because they have to report through the DoD sexual assault response team, which is a different process from VA. VAPORHCS, alternatively, offers MST care whenever a Veteran screens positive for MST.

Ms. Handley asked if the 10 hours per two MST coordinators was a full load of work. Ms. Crain clarified that each coordinator is allotted 10 hours, but she believes VAPORHCS could use more resources to more appropriately address the incoming needs of those who have experienced MST. Ms. Harris asked about the barriers preventing women Veterans from getting in for treatment. Ms. Crain replied that wait times for trauma-informed care providers is a barrier to women Veterans getting care. Ms. Harris followed up by asking whether women Veterans receiving a particular modality of care in the community can continue to receive that modality when they return to VA. Ms. Crain replied that she is able to act as an advocate for particular modalities of care that may be more comfortable or appropriate for a woman Veteran than those offered in VA. She can also inform the woman Veteran about appropriate options that are offered in-house. The Chair thanked Ms. Crain for the brief.

Interpersonal Violence and Assistance Program (IVAP)

Andrew Goodwin, IVAP Coordinator, VAPORHCS

Intimate Partner Violence Assistance Program (IPVAP) coordinator Andrew Goodwin is one of two IPVAP coordinators at VAPORHCS. He began by acknowledging VA stakeholders and defining "intimate partner violence" (IPV). IPV describes any violent behavior including, but not limited to, physical or sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner that occurs on a continuum of frequency and severity which ranges from one episode that might or might not have lasting impact to chronic and severe episodes over

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a period of years. It can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation.

In May 2012, VACO chartered the Domestic Violence/Intimate Partner Violence (DV/IPV) Task Force, leading to the finalization of the VHA Plan for Implementation of the DV/IPV Assistance Program (IPVAP) with 14 key recommendations in December 2013. A rapid implementation pilot site project began in 2015 at Baltimore, Salem, Cincinnati, Portland, Philadelphia, and Kansas City and concluded in the summer of 2017. The first National DV/IPV Program Manager was hired in January 2014. In January 2017 Dr. LeAnn Bruce became National Program Manager, which led to Directive 1198 entering concurrence in the fall of 2017. The Directive mandates every VA across the country to have an IPVAP on-site. In March 2018, IPVAP received \$17 million in funding, and in January 2019 Directive 1198 was published.

IPVAP's guiding principles are person-first, Veteran-centric, recovery-oriented and trauma-informed, in order to create a non-judgmental, stigma-free treatment program. The IPVAP has five main objectives. To raise awareness, the IPVAP conducts IPV campaigns, awareness events, materials, and staff training and education. To build community partnerships, IPVAP holds outreach events to build partnerships with domestic violence and sexual assault organizations within the catchment area. To serve those who experience IPV and those who use IPV, IPVAP implements routine screening and establishes intervention plans and resources. To serve VA staff, IPVAP builds internal collaborations with the Employee Assistance Program, Workplace Safety, and other entities.

Strength at Home (SAH) is an intervention developed by Dr. Casey Taft and others to reduce and eliminate violence and aggressive behavior in a Veteran's intimate partner relationships. It is a 12-week therapeutic group intervention with follow-up that uses "motivational interviewing" to support a Veteran's change process. In randomized controlled trials (involving 135 male Veterans/service members and 111 female partners), SAH participants had greater reductions in use of physical and psychological IPV compared to enhanced treatment as usual (ETAU). SAH participants also had greater reductions in controlling behaviors (e.g., isolation and monitoring their partners) as compared to ETAU. Veterans may be twice at risk to experience IPV due to a number of Veteran-centric factors, putting them at higher risk for various adverse physical, social, and emotion health outcomes. IPV manifests not only physically and sexually, but also emotionally (e.g. stalking). IPV intersects with women's health, suicide prevention, and geriatric care. 85% of individuals who experience IPV are women-identified, resulting in increased health consequences and health care utilization cost. IPV is also the most common cause of non-fatal injury in women. Two-thirds of elder abuse patients are women. Mr. Goodwin shared some statistics which emphasized the urgency with which VA should address IPV violence against women-identified persons.

Mr. Goodwin reviewed VAPORHCS's pilot implementation of Directive 1198 in 2018. VAPORHCS has established a two-coordinator, two-campus model in which one IPVAP coordinator acts as the front-facing provider for Veterans, Veterans' caregivers,

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partners, and spouses, and VA employees who experience IPV and the other acts in the same capacity for those who use IPV. Over 830 VAPORHCS staff members have received training on a range of IPV-related subject matter, including but not limited to the prevalence of IPV, the bio-psycho-social impact of IPV, the intersection of IPV and racism/discrimination and the experiences of marginalized/oppressed populations, trauma-informed screening practices and documentation, trauma-informed safety planning and assessment, and clinical nuance in supporting Veterans, Veterans' caregivers, partners, and spouses, and VA employees. IPVAP conducts outreach events throughout the year to educate the public on the intersectionality of IPV with other health care phenomena and populations and its impact. For the past few years, IPVAP has been strategically implementing the relationship health and safety screening, but there has been discomfort around asking questions about relationship health and safety as well as the emotional burden associated with this work. Several VA-partnered clinics and providers have volunteered to pilot the new instrument and provide resource brokerage.

VAPORHCS has offered a wide range of services for Veterans, Veterans' caregivers, spouses and partners, and VA employees who experience IPV. Recognizing that IPV was exacerbated during the COVID stay-at-home order, IPVAP implemented a "soft" screening which deployed during the May 2020 COVID-19 Outreach. IPVAP Services transitioned to 100% telehealth virtual service delivery in April/May 2020 due to COVID-19. In January 2021, Michelle Davis, LCSW, Regina Rizo, LCSW, and Dominique Sebastian, LCSW, developed and implemented Courageous Voices, a 10-week support group for IPV Experiencers. Since April 2019, over 365 Veterans, partners, caregivers, spouses and VA employees have received individual intervention (e.g., crisis intervention, safety planning, etc.), assessment, resource brokering, and follow-up.

VAPORHCS also offers a wide range of services for Veterans who use IPV. To date, 18 Cohorts of Strength at Home (SAH), including one-on-one individual therapy and group psychotherapy cohorts, as well as three cohorts of newly developed SAH couples intervention have been completed. Chaplain Services has facilitated two cohorts of the Warrior to Soul Mate relationship workshop.

As of February 2020, VAPORHCS has been an early adopter for the White Ribbon VA initiative which aims to eliminate sexual harassment, sexual assault, and domestic violence in VA health care settings and communities. It performs annual virtual pledge campaigns, and hosts trainings throughout each fiscal year. VAPORHCS is currently organizing the Green Dot Bystander Intervention, which equips staff with skills to disrupt harassment related behavior. Mr. Goodwin and Michelle Davis, LCSW will be the designated site coordinators.

VAPORHCS IPVAP has been selected to launch a Data and Analytics Innovation Hub to support the implementation of the Megabus Section 5304 Two-Year Pilot Program. The pilot aims to assess the feasibility and advisability of providing services related to IPV and non-MST related/non-IPV related sexual assault to Veterans. VAPORHCS will assist in providing oversight and support for the ten selected pilot sites, including clinical

and administrative consultation, training, data collection and analysis, and will assist in synthesizing recommendations for a congressionally mandated report.

The Chair thanked Mr. Goodwin and remarked that the ACWV was also included in H.R. 7105 at Section 5302, legislation which changed the law that established the ACWV and added the effects of intimate partner violence on women Veterans to its reporting purview. The Chair gave the floor to the Vice Chair for Health. Vice Chair Kirk commended Mr. Goodwin on the public health measures he presented and emphasized tracking metrics on the whole woman Veteran population, particularly with MST and interpersonal violence. She asked if Mr. Goodwin was a full time coordinator for IPVAP, to which he replied that VAPORHCS has two FTEs but that he is currently on detail with VACO. Vice Chair Kirk asked how much of his IPVAP time is allocated to research, to which Mr. Goodwin replied 50% of coordinators' job is clinical and 50% is administrative, to include remaining abreast of current research. Vice Chair Kirk asked if VAPORHCS would add an FTE to accommodate the H.R. 7105 work, to which Mr. Goodwin replied VAPORHCS has established a memorandum of understanding with the national IPVAP office and received funding for several additional FTEs to support that work. Finally, the Vice Chair asked for clarity regarding the statistics on IPV screening, and yielded the floor to Ms. Wright who asked how coordinated VAPORHCS IPVAP is with the community when it comes to IPV care. Mr. Goodwin replied that IPVAP sits on a local family violence coordination council comprised of batterer intervention partners and builds relationships throughout the catchment area.

Vice Chair for Benefits McLaughlin asked whether the IPVAP has supports for parenting skills as it related to those affected by IPV. Mr. Goodwin replied that the program does not currently offer that specific service, but that there is a program called STARE that is used throughout VA. The Vice Chair yielded back to the Chair who thanked Mr. Goodwin for the presentation on the newest reporting topic of the ACWV.

Suicide Prevention Program

Monireh Moghadam, Suicide Prevention Coordinator, VAPORHCS

Suicide Prevention Coordinator Monireh Moghadam is a licensed clinical social worker in addition to being one of the suicide preventions coordinators at VAPORHCS. She shared data from the National Office of Mental Health and Suicide Prevention's annual suicide data report. Suicide is a national issue, with rising rates of suicide in the general population. In addition, suicide rates are higher, and are rising faster, among Veterans than among non-Veteran adults. Societal factors such as economic disparities, race, ethnicity, LGBTQ disparities, homelessness, social connection and isolation, and health and wellbeing play additional roles in suicide. The coronavirus disease 2019 (COVID-19) pandemic has also placed additional strain on the nation and on individuals and communities. In the context of the COVID-19 pandemic, VA is monitoring trends in suicide-related behaviors. Thus far, findings do not indicate increases in suicide-related behavior among Veterans in VHA care. The 2020 National Veteran Suicide Prevention Annual Report was released last October and reports on trends in Veteran suicide deaths from 2005–2018, focusing on suicide counts and rates among various Veteran subpopulations. State data sheets also

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examine state level Veteran suicide deaths and compare them to national and regional trends. 53 data sheets are available for all 50 states, D.C., Puerto Rico, and U.S. territories.

The Annual Report shared some “Anchors of Hope.” Anchor 1: From 2017 to 2018, adjusted suicide rates fell among Veterans with recent VHA care, while rising among other Veterans not receiving VHA care. Anchor 2: The rates of Veterans in VHA care with depression, anxiety, and substance use disorders fell from 2005 to 2018. Anchor 3: In 2018, suicide rates decreased for specific Veteran populations engaged in VHA care. Anchor 4: The Veteran suicide rate did not increase significantly between 2017 and 2018. Anchor 5: There is a groundswell of support for coordinated efforts at the local, regional, and national levels to implement a public health approach to end suicide.

According to the CDC, over 6,000 of the 46,000+ Americans who died by suicide in 2018 were Veterans. Suicide rates for Veterans are 1.5 times higher than for non-Veteran adults, and particularly higher for women Veterans. Younger Veterans, women Veterans, those in a period of transition, and those with exposure to suicide have a higher risk for suicide. Ms. Moghadam shared some specific data around suicide rates for women Veterans. Among women Veterans in VHA care, suicide counts decreased from 94 to 81 from 2017 to 2018, and age-adjusted rates decreased from 15.7 per 100,000 to 14.0. The counts and rates for these years represent an increase over the count and rate in 2005 (56 and 13.8 per 100,000). From 2005 to 2018, suicide rates rose significantly faster among men than among women, both for Veteran and non-Veteran populations.

Access to lethal means puts Veterans at a significantly higher risk for suicide. In 2018, firearms were the method of suicide in 69.4% of male Veteran suicide deaths and 41.9% of female Veteran suicide deaths, compared to 50% for the general population. The percent of suicides that involved firearms was greater among Veteran men and women than among non-Veteran men and women. Women Veterans are more likely to commit suicide by overdose.

From 2018 to 2028, VA's National Suicide Prevention Office will implement a National Strategy for Preventing Veteran Suicide as a public health approach to end suicide. Goal 6 of the strategy promotes efforts to reduce access to lethal means. The Lethal Means Safety Strategies for 2020-2021 include: 1, disseminate lethal means safe storage information to primary care, women's health services, VET centers, and mental health clinics during the COVID-19 pandemic; 2; implement a one-time mandatory lethal means safety training for all VHA providers, including those in mental health, pain, emergency departments, primary care, women's health services, and VET centers; 3, train MISSION act (community care) providers in lethal means safety; and 4, increase integration of lethal means safety materials and goals into community-based coalition work.

In 2019 VA partnered with the National Shooting Sports Foundation and American Foundation for Suicide Prevention (AFSP). The partnership is a community-level

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program that delivers messaging to Veterans, their families, and communities about putting time and space between a Veteran in crisis and a firearm. A toolkit for “Safe Firearm Storage in Your Community” was released and Suicide Prevention Coordinators at all local VA Medical Centers can now offer cable gun locks with Veterans Crisis Line branding to secure firearms in the home.

Historically, VA has not had a consistent approach for screening, evaluation, or documentation of suicide risk, but in 2018, the Veterans Health Administration (VHA) Office of Mental Health and Suicide Prevention (OMHSP) launched an effort to develop and implement a national, standardized process for suicide risk screening and assessment using high-quality, evidence-based tools and practices. In November of 2020, the process was revised from three stages to two stages, to include an initial risk screen using the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener, which, when positive, prompts a VA Comprehensive Suicide Risk Evaluation. All Veterans in VHA care are to be screened for suicide risk annually. There are also specific settings where screening is required at intake (e.g., Mental Health, Emergency Department, Sleep Clinic, Pain Clinic, Inpatient Medical/Surgical, and VA nursing homes).

There are currently three Veterans Crisis Line (VCL) centers across the nation. VAPORHCS provides local follow-up to VCL callers and is currently 12th highest in the nation for VCL referrals, with 4325 since October 2020. Suicide prevention coordinators broker a wide range of services to Veterans calling in need. VAPORHCS facilitates Wise Warriors, a weekly support group for Veterans who experience thoughts of suicide. It has existed for five years, and due to COVID-19, all five Wise Warriors groups have transitioned to virtual modality. VAPORHCS has supplied 4000 cable gun locks since vaccine sites opened in February 2021. Gun locks are also offered at all community outreach events. VAPORHCS also partners with Chaplain Services to provide support to facility providers and Veteran loved ones after a suicide loss. Furthermore, VAPORHCS collaborates with other VA consultants/programs, including MST Coordinator, IPV Coordinator, LGBTQ Care Coordinator, Housing Program, and Vet Centers.

VAPORHCS trains facility staff on the newly standardized national suicide risk identification protocol and safety planning and participates in monthly case consultation meetings with Women’s Health Clinic. The Women’s Mental Health/Suicide Prevention sub-workgroup has developed a suicide prevention training based on VA research on women Veterans. VAPORHCS has also provided training to several facility programs as well as the Returning Veterans Project, a community partner. In partnership with the VAPORHCS LGBTQ Care Coordinator, the Suicide Prevention Program hosted listening sessions for female and male-identifying Veterans to seek feedback on the national suicide prevention program outreach campaign.

Some of VAPORHCS’s ongoing goals are to provide suicide prevention training on women Veterans to more of the facility Mental Health and Primary Care clinics and to work with facility and community partners to identify more targeted opportunities for outreach to women Veterans. Finally, Ms. Moghadam provided a list of resource links

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for Veterans and suicide prevention. The Chair thanked Ms. Moghadam for the in-depth brief and gave the floor to the Vice Chair for Health.

Vice Chair Kirk thanked Ms. Moghadam for providing specific detail through data and yielded the floor to Ms. Wright, who asked for data on local death by suicide for women Veterans. Ms. Moghadam replied that there are about 25 to 30 Veteran suicides per year, of which the portion of women Veterans is generally less than five. Ms. Wright asked if women Veterans were overrepresented in suicide statistics locally and how VAPORHCS engages the community in support, stating that they only know of the women Veteran suicides of those in VA, not outside of its system. Ms. Moghadam replied that she doesn't see an overrepresentation of women Veterans in VAPORHCS compared to the national data. At times there have been shifts in access to Veteran suicide data from the Oregon health authority. This data includes Veterans who are not in VA health care, but access to this data has gone away for the time being.

There being no other questions, the Chair recessed the meeting at 1:30 p.m. PT and returned at 1:39 p.m.

Healthcare for Homeless Veterans

Carolyn Bateson, Director Community Reintegration Services (CRS)

Community Reintegration Services (CRS) Director Carolyn Bateson, LCSW, gave the brief. Ms. Bateson manages the VAPORHCS homeless program. She discussed VA's nationally funded programs for homeless Veterans, which include Health Care for Homeless Veterans (HCHV), Homeless Primary Care Teams (HPACT), four coordinated entry specialists at VAPORHCS, community resource and referral centers (CRCs), street outreach through CRCs, Emergency Transitional Housing (ETH), Grant and Per Diem (GPD), Supportive Services for Veterans Family Grants (SSVF), Veterans Justice Outreach (VJO), Homeless Veterans Community Employment Services, and the Department of Housing and Urban Development and VA's Supportive Housing Program (HUD-VASH). Ms. Bateson presented some women Veteran-oriented data around emergency transitional housing, grant and per diem and the RRTP program in Vancouver. Recently, several programs in the VISN 20 region have received additional grant funding to support social distancing and infectious disease control in order to make shelters safer during the pandemic.

The Grant and Per Diem (GPD) program provides grants to community-based organizations to develop and provide transitional housing and supportive services to homeless Veterans. GPD also provides grants to community-based organizations to provide case management to support housing retention to formerly homeless Veterans and Veterans at risk for homelessness. Community based organizations include non-profits, state/local governments, and Indian Tribal governments. GPD was authorized to offer grants in 1992, with its first grants awarded in 1994. GPD offers a variety of grants based on funding availability. Capital grants provide funding for construction, acquisition of real property, and renovation to develop transitional housing or service centers. Van grants support purchase of vans to support service offered by GPD transitional housing or service centers. Per Diem Only (non-capital) grants provide per diem payments per

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Veteran per day for transitional housing or service centers. Special Need grants target populations authorized by statute for these grants (e.g., women, Veterans in the care of minor dependents, chronic mental illness, frail/elderly, terminally ill). Case Management grants support housing retention for formerly homeless Veterans and Veterans at risk for homelessness.

The Supportive Services Veterans Families Grant is a time limited program that leads to permanent housing by resolving housing crises. It offers a mix of case management and financial assistance, and aims to serve Veteran households with income less than 50% of AMI. Case management includes assistance with housing search, benefits, employment, legal services, health care access, and transportation. Non-profit corporations receive these types of grants to serve homeless and at-risk Veteran families throughout the U.S. and its territories. Ms. Bateson shared the grant program's partnership organizations and service population demographics. Out of 1,069 Veterans served by the Rapid Re-Housing (RRH) program, 126 have been female.

The primary goal of the HUD-VASH program is to move Veterans and their families out of homelessness and into permanent supportive housing while promoting maximum Veteran recovery and independence in the community. This is accomplished by providing rental assistance through HUD's Housing Choice Voucher Program (Section 8), pairing rental assistance with clinical case management and supportive services designed to assist Veterans in obtaining and sustaining housing, and utilizing the principles of Housing First. The original HUD-VASH program was started in 1992 with 600 vouchers at 15 sites. The scope of the program subsequently decreased until it was redesigned and expanded in 2008 in its current model. More than 105,000 HUD-VASH vouchers are now allocated nationally. Ms. Bateson said that 135 Female-Head-of-Households are currently enrolled in the HUD-VASH program. Next year will bring legislation that expands the HUD-VASH program to serve Veterans who are not necessarily eligible for VHA benefits.

Coordinated Entry Specialists work with multiple communities to find and reach out to Veterans who are struggling with housing instability and link with appropriate services. They are currently reaching out to Continuums of Care (CoCs) to develop a Veteran-by-name list in order to track homeless Veterans on the street and develop the best programs to solve the homelessness. Mr. Cole Schnitzer added that it is challenging to track this data because VA does not own the Veteran-by-name list and accessing all homeless services in those CoCs can also be challenging. Mr. Schnitzer stated that VAPORHCS's goal is to bring Veteran homeless to "functional zero," and to pilot such a policy for the general homeless population.

Ms. Bateson reported that more vulnerable populations such as women Veterans are prioritized for the HUD-VASH program. She said that the Portland area has experienced a tumultuous year in terms of keeping homeless Veterans safe from the environment and infectious disease. Through CARES Act funding, VAPORHCS has been able to expend the use of motels to create social distancing and keep homeless Veterans safe. A Homeless Smart Phone initiative provides digital devices to homeless Veterans so

that they can connect to virtual care during the pandemic. VAPORHCS created two all-day COVID-19 vaccine clinics for Veterans in the Per Diem and HUD-VASH program.

The Chair thanked Ms. Bateson for the brief and gave the floor to the Vice Chair for Health. Vice Chair Kirk sought clarity on the CoC Coordinated Entry data which appeared to show 77 total homeless women Veterans in the VAPORHCS catchment area. Ms. Bateson replied that the CoC data refers to the Veteran-by-name list and does not represent homeless Veterans exclusively, but rather those in queue for some kind of related service or shelter. Dr. Kirk asked if there was a women-and-children-exclusive temporary shelter, to which Ms. Bateson replied that the Beaverton Oregon Salvation Army is a Veterans with family facility. Furthermore, she stated, there is a wider range of supportive services in the community for women and children in general than for males, Veteran or otherwise. Dr. Kirk asked if women Veterans with MST with children can have access to transitional housing with no men around. Mr. Schnitzer replied that one of the goals of the CoCs is actually to avoid transitional housing altogether, opting instead for women Veterans and their families to enter the SSVF program and then progressively engage them with HUD-VASH services as necessary.

Vice Chair Kirk gave the floor to Ms. Miller, who asked how many grant and per diem beds VAPORHCS has. Mr. Schnitzer replied that VAPORHCS has about 270 units across the catchment area, in addition to Transition-In-Place grants. Ms. Miller acknowledged that the COVID-19 pandemic did not make it any easier to manage an already challenging and at-risk population, and asked how VAPORHCS plans to manage bad-conduct discharge Veterans who are now eligible for GPD. Ms. Bateson replied that VAPORHCS works with all Veterans on the disruptive behavior board and works with the grantee to help support that population if they're struggling with behavior. Mr. Schnitzer added that through the process of engaging with VAPORHCS a particular bad-conduct-discharge Veteran was able to graduate to a more productive and independent life. Ms. Bateson added that a lot of people also appeal their bad conduct discharge. Ms. Miller thanked Ms. Bateson for her service. The Chair thanked the presenters and proceeded to the next brief.

Whole Health

Dr. Dave Greaves, Clinical Director, Whole Health, VAPORHCS

VAPORHCS psychologist and Whole Health Clinical Director Dr. Dave Greaves gave the brief. The objective of Whole Health is to build a healthcare system that is designed to empower and support Veterans as they make healthy lifestyle choices. The health care system focuses on the values and aspirations of each person and provides expert medical care to help Veterans reach personal health goals. The default model of care, on the other hand, is a deficit model of care that seeks to find and fix adverse symptoms that a patient may experience without providing a paradigm for maintaining personal health and wellness. Strategic Objective 2.2 of VA's draft 2022-2028 Strategic Plan directs VA and partners to tailor delivery of benefits and customize Whole Health care and services for the recipient at each phase of their life journey, including end of life, to ensure equity and address their unique needs, preferences, challenges and goals. The January 2021 VHA Modernization aims to transform health care delivery with integration

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of Whole Health principles into primary care and mental health, improved chronic pain care, and improved employee wellness. The Comprehensive Addiction and Recovery Act (CARA) expanded research and education on and delivery of CIH to Veterans. VAPORHCS was one of the 18 flagship sites that piloted a program on integration of CIH and related issues for Veterans and family members.

Dr. Greaves shared data showing that the United States spends more money than any other country on health care but is #69 in the world for healthy life expectancy. Dr. Greaves concludes that the prevailing U.S. health care model is flawed, and instead advocates Whole Health to foster a personalized, proactive, and Veteran-centered approach to health. Mission, Aspiration, and Purpose make up the “MAP” of a Veteran. A Personal Health Inventory (PHI) is used to draw up a MAP which then drives the circle of Whole Health. Instead of asking “What is the matter with you,” a Whole Health practitioner asks “What matters to you,” thus putting the Veteran first. Veterans are able to take advantage of such approved CIH approaches as acupuncture, meditation, Tai Chi, yoga, massage for treatment, guided imagery, biofeedback, and clinical hypnosis. Whole Health puts Veterans in charge of their own health, empowers and equips them to make healthy choices, invites them to pursue their passions, and partners with them in health care choices. VAPORHCS is also currently developing women-specific nutrition classes.

From a Whole Health perspective, VAPORHCS promotes employee health and well-being through grassroots programs, encourages everyone to work on self-care, and promotes team wellness. When it comes to women Veterans, VAPORHCS has invested in upgrades to environment of care (e.g., salt lamps in exam rooms), Whole Health coaches assigned to support the Women’s Clinic, and yoga classes for women. VAPORHCS also offers regular MAP class, introduction to Whole Health class, and “Taking Charge of my Life and Health” class.

Dr. Greaves remarked that the Whole Health program has had over 16,000 encounters with Veterans in total, and that women may be overrepresented in Whole Health services; women Veterans seem to seek out Whole Health services at a higher rate than men. The program struggles at times with getting Veterans to engage in whole health principles, but once they begin to recognize these principles it makes a huge difference in their lives.

The Chair thanked Dr. Greaves for the brief and opened the floor to the Health Subcommittee. Dr. Mathewson-Chapman asked if there is a different Whole Health approach for dealing with male Veterans than women Veterans, noting that men seem to be less knowledgeable and receptive of Whole Health and nutrition principles. Dr. Greaves replied that the male lifespan is an average of five years less than that of women, owing to their generally poor nutrition decisions, but a Whole Health approach to care enables the Veteran to take control of their health on a day to day basis, not a reactionary basis.

Ms. Parker thanked Dr. Greaves for the brief and asked if he had seen a trend in Veterans coming off of prescription care opting for Whole Health care. Dr. Greaves replied that Whole Health enables Veterans to sustain and maintain quality functioning without medication, or lower rates of medication utilization than other forms of care. National data shows Veterans with high rates of opioid utilization have made a huge change with Whole Health. Ms. Parker asked about the administration of vitamins and minerals in the Whole Health program, especially in response to COVID-19. Dr. Greaves replied that the Food Service program has been sharing the benefits of vitamins with Veterans. Lastly, Dr. Greaves said that Veterans can self-refer to many Whole Health programs, with the exception of chiropractic and acupuncture. The Chair thanked Dr. Greaves for the presentation and proceeded to the next brief.

Veteran Justice Outreach (VJO) Overview

Matthew Byrge, Social Worker, Veteran Justice Outreach Program, VAPORHCS

Matthew Byrge is one of three VJO social workers at VAPORHCS, all of whom are licensed clinical social workers. The Veterans Justice Programs were established in 2009 to identify justice-involved Veterans and contact them through outreach to facilitate access to VA services at the earliest possible point. Veterans Justice Programs accomplish this by building and maintaining partnerships between VA and key elements of the criminal justice system. Research found that a barrier to ending homelessness among Veterans was the justice system. According to Bureau of Justice Statistics data, on any given day approximately 8% of the inmates in the country's prisons and jails are Veterans, of which an estimated 2-3% identify as female. A large majority of incarcerated Veterans are eligible for VA services. VJO takes a three-pronged approach to the legal system by focusing on courts, law enforcement training and education, and direct jail outreach. VJO educates people at the entry point to the justice system to convey the needs specific to Veterans and to connect justice-involved Veterans to VA services. VJO gets referrals for facilities and Veterans in need from local trainings such as Conflict Intervention Training (CIT). The number of women Veterans involved in the justice system is underreported and VJO is working with counties to report Veterans booked in their facilities to the national database. VJO's sister Veterans Justice Program is the Health Care for Reentry Veterans (HCRV) program. HCRV focuses on prison reintegration and meets with Veterans within six months of discharge in order to connect them with the medical center to which they will be returning.

The Chair thanked Mr. Byrge for the presentation and asked how many, if any, incarcerated women Veterans VJO is currently working with, to which Mr. Byrge replied that it is hard to say at the moment. There has been a lull in the Veteran court referrals due to COVID, however three of 52 Veterans currently involved in Veterans treatment court programs are women. The Chair thanked Mr. Byrge again.

Committee Discussion

The ACWV discussed some administrative matters.

Adjourn

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At 3:10 p.m. PT the Chair adjourned the second day of the ACWV-VAPORHCS site visit.

Thursday, August 26, 2021

Open Meeting/Introductions

Betty Yarbrough, Chair, ACWV

At 10:00 a.m., PST, the Chair called the third day of the ACWV meeting to order. The Committee members, ex-officio members, advisors, and public guests introduced themselves.

Overview of the Oregon Department of Veterans Affairs

Kelly Fitzpatrick, Director, Oregon Department of Veterans Affairs

Oregon Department of Veterans Affairs (ODVA) Director Kelly Fitzpatrick remarked that ODVA's vision is for Veterans and their families to thrive in Oregon. ODVA serves and honors Veterans through leadership, advocacy and strong partnerships. They rely on supportive partners such as the Federal VA, Oregon Health Authority, Oregon Housing Community Service Department, and counties and local entities. Slightly more than 13% of Veterans in Oregon are Black Indigenous People of Color. Women Veterans approach 10% of the population and continue to grow. More than half of Oregon Veterans are over 65. ODVA spent \$3.18 billion in FY19. In 2018 Oregonians passed a ballot measure to allocate 1.5% of state lottery fund proceeds toward Veterans; this funds a considerable portion of grants and pass-through funding, statewide Veteran services, and aging Veteran services. Director Fitzpatrick went on to discuss ODVA's four major service programs.

ODVA's most foundational program is the Veteran's Home Loan program, established after World War II. Oregon citizens voted in 1945 to create the Veterans' Home Loan program, established in Article XI-A of the Oregon Constitution. This historically self-sufficient program provides low-interest rate mortgages on single-family owner-occupied homes to eligible and qualified Veterans. Oregon state benefit is separate and distinct from the Federal VA Home Loan Guaranty and one of only five states with its own home loan program. Families may borrow up to \$548,250, the Fannie Mae limit as of 2021. ODVA is the lender and servicer of 1,777 home loans totaling more than \$347 million in portfolio, and has made more than \$8 billion in low-interest home loans available to more than 335,000 Veterans since 1945.

Next, Director Fitzpatrick discussed Statewide Veteran Services, ODVA's largest and most diverse division. ODVA provides training and certification to all Veteran service officers (VSOs) representing Oregon Veterans under ODVA's Power of Attorney, including county tribal VSOs. They perform claims advocacy and adjudication for Veterans' appeals filed under ODVA's Powers of Attorney and submit Oregon claims to the Federal VA for state, county, and tribal Veteran service offices. ODVA administers several grants to Veterans and partners, including Veteran Services Grant, Campus Veteran Resource Grant, Rural Veteran Healthcare Transportation Grant, Veterans Educational Bridge Grant, Emergency Assistance Grant, and USDVA Highly Rural

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Transportation Grant. ODVA has special advocacy programs for traditionally underserved Veterans, including women, LGBTQ, incarcerated, houseless, students, and tribal Veterans. ODVA maintains key partnerships with Federal VA, VHA, and VBA facilities in Oregon, state agencies like Oregon Health Authority, Housing and Community Services, Department of Transportation, and Department of Corrections, and counties and tribes. Since 2019, ODVA has been appointed as a State Approving Agency to approve and monitor institutions eligible to participate in Federal Veterans' education benefits.

Next, Director Fitzpatrick discussed the relatively new Aging Veteran Services division, which provides oversight for the two Oregon Veterans' Homes as well as programs providing direct services to aging and vulnerable Veterans. This division provides claims assistance and advocacy focused on the needs of aging Veterans, and in the conservatorship program, ODVA serves as a court appointed conservator to protect and manage Veterans' financial assets. Representative Payee services also ensure the timely payments of monthly expenses on behalf of vulnerable Veterans to ensure their basic living needs are met. ODVA's specialized volunteer and outreach advocates conduct local outreach to aging Veterans to educate and connect Veterans to benefits.

Next, Director Fitzpatrick discussed Oregon's award-winning state Veterans' homes located in The Dalles (1997) and Lebanon (2014), which are staffed by contractor Veteran's Care Centers of Oregon (VCCO). These Veterans' homes are an earned benefit providing skilled and long-term nursing care, endorsed memory care, and rehabilitative care to Veterans, spouses and Gold Star Parents. Veterans live in an environment with a culture of camaraderie and understanding from fellow Veterans who have shared military experience and staff who are trained to meet their unique needs. The homes provide access to claims representation and benefit assistance by service officers who focus on the needs of Veterans who served during the Vietnam, Korean and WWII wars. This self-sustaining program offers lower cost skilled nursing care to Veterans and their families.

Director Fitzpatrick discussed the negative impacts of COVID-19 on outreach programs, the greatest outreach casualty being the aging Veteran volunteer program. A total of 13 residents have died of COVID since March 2020. The greatest financial casualties have been the ORVET home loan programs and Oregon's Veterans' homes. The greatest positive effect of COVID on ODVA programs has been learning to serve Veterans in new ways using remote work tools. Incarcerated Veterans coordinators performed their first remote hearing for a Veteran in custody and the first virtual Women Veterans Conference took place on Whova. There have also recently been virtual town hall outreach events focused on women Veterans, LGBTQ+ Veterans, and Vietnam War Veterans, training events for VSOs and campus resource coordinators, quarterly public meetings with Veterans Advisory Committee, and a webinar for aging Veterans on the Family Caregiver Program. Overall, COVID proved that the agency can serve Veterans and their family members remotely, and underscored the need to modernize IT systems to enable employees to perform their jobs remotely as well as the value of leveraging partnerships.

Lastly, Director Fitzpatrick discussed ODVA's LGBTQ+ program, which was created by the legislature in 2015. The Director respectfully requested the Secretary of Veterans Affairs to create an LGBTQ Advisory Committee. She also respectfully requested the Secretary to expedite changing VA policy on gender-confirming surgery for transgender Veterans. ODVA is very excited to work on its five-year strategic plan in order to adapt and evolve into an agency that Veterans need and want, and diversity, equity, and inclusion is at the center of that plan. The Chair thanked Director Fitzpatrick for the briefing, noting that besides Ms. Wright, it had been the first time the ACWV had been briefed by a state VA director.

Ms. Handley asked if any tribal VSOs were located on the reservation, to which Director Fitzpatrick replied that all three are in fact located on their respective reservations. CWV Director Tiglao applauded ODVA in leading the way in the LGBTQ Veterans programs and remarked that CWV is examining the feasibility of having an LGBTQ advisory committee. Vice Chair for Health Kirk thanked ODVA Director Fitzpatrick for the brief and asked about the number of women currently living in Oregon's Veterans homes, to which Director Fitzpatrick replied that only a couple of women Veterans were living in each of the homes, but that ODVA is looking into how to more proactively market the homes to women Veterans. Vice Chair Kirk replied that women Veterans often do not want to be in the homes, but women who chose that option for elder care should be provided appropriate geriatric care and accommodations. The Vice Chair gave the floor to Ms. Wright who lauded ODVA's LGBTQ and Aging Veterans programs. Director Fitzpatrick thanked Ms. Wright for the accolades. Ms. Harris thanked Director Fitzpatrick and recommended that other state VA directors reference ODVA's benchmark programs because it is a cutting edge state VA. The Chair thanked the ODVA Director for the briefing.

**Greetings from the Oregon State Women Veteran Coordinator
Jessica Bradley, State Women Veterans Coordinator (WVC), Oregon Department
of Veterans Affairs (ODVA)**

Ms. Bradley described the establishment of the Women Veterans Program in Oregon. In 2015 the Oregon Legislature passed HB 3479, funding a full-time permanent Statewide WVC within the ODVA. The goal of ODVA and the Women Veterans Program is to improve advocacy and outreach to women who have served in the military, gather better data and research on the diversity of women Veterans in Oregon, participate in policy important to women Veterans, and work with county, state and Federal partnerships to advance the level of care that women Veterans receive in Oregon, helping them access the benefits that they have earned. At a population of 27,749, women Veterans make up almost 10% of Oregon's Veteran population. Ms. Bradley shared demographics of the women Veteran populations. Although COVID has restricted travel, the Women Veterans Program has conducted outreach through focus groups, town halls, Women Veterans Conferences, the "I Am Not Invisible" campaign, local media outreach, website, and social media. The I Am Not Invisible campaign originated in Oregon as a partnership with Portland State University as a tribute to the diversity, service, and contributions of women Veterans, and continues to serve as an

iconic platform for outreach and awareness efforts to bring women Veterans who may not be aware of their benefits into VA.

The Women Veteran Program has state and local partnerships with 36 county Veterans service offices (VSOs), 3 Tribal VSOs, national service organizations, non-profits, the Oregon Health Authority Veterans Behavioral Health Liaison, Campus Veteran Coordinators, and the Department of Labor Veterans' Employment & Training Service (VETS). The Program's Federal partnerships include VAHCS Women Veteran Program managers in Portland and Roseburg, the VISN 20 Women Veteran Program Manager, the Center for Women Veterans, the Center for Minority Veterans, and the National Association of Statewide Women Veteran Coordinators (NASWVC). Within ODVA, the Program partners with the Aging Veterans Services Program, LGBTQ Program, Tribal Veterans Program, Incarcerated Veterans Program, Homeless Veteran Program, the Education Program (Campus Veteran Coordinators Program), and Grant Programs.

ODVA'S Women Veteran Coordinator position is a Department of Veterans Affairs-accredited Veteran Service Officer. They serve to connect women Veterans to their earned benefits and facilitate service connection claims processing, to include MST related claims. They also support county and tribal VSO's in their work to represent Oregon's women Veterans. Homelessness and mental health care, especially surrounding MST, continue to be forefront concerns of the Women Veterans Program.

The Chair and the Vice Chair for Health thanked Ms. Bradley for the thorough briefing. There being no questions, the Chair proceeded to the next presentation.

Overview of Willamette National Cemetery

Jared Howard, Director, Willamette National Cemetery

Willamette also manages a rural cemetery in Idaho as part of the National Cemetery Administration's (NCA's) initiative to serve rural Veterans as well as Fort Stevens National Cemetery and Vancouver Barracks National Cemetery. Mr. Howard discussed the history of the NCA and the omnibus bill of 1862, which authorized President Lincoln to purchase grounds for use as national cemeteries. Fourteen national cemeteries were established in 1862, whereas previously soldiers were buried where they fell. The mission of the NCA is to honor Veterans and their families with final resting places in national shrines and lasting tributes that commemorate their service and sacrifice to our nation. Its vision is to be the model of excellence for burial and memorials for our nation's Veterans and their families. Willamette was built in 1951 and features many references to the Korean War. Nearly 185,000 Veterans and eligible dependents are interred in the cemetery.

The NCA has approximately 2,122 NCA employees, about 85% of which work outside Washington, DC. Over 74% of NCA employees are Veterans, 40% are disabled Veterans, 12% are women Veterans, and 6% are disabled women Veterans. The Willamette National Cemetery (WNC) Team has 49 full time employees, of which 95% are Veterans. Five staff members are women: one assistant director who is a Veteran,

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one administrative officer and three program support/cemetery representatives, two of whom are Veterans.

Those eligible for a burial in a VA national cemetery include any member of the U.S. Armed Forces who dies on active duty, any Veteran who was discharged under qualifying conditions (other than dishonorable), National Guard members and Reservists with 20 years of qualifying service who are entitled to retired pay and spouses, minor children and certain adult dependent children.

The benefits of being interred at a national cemetery include the opening and closing of the grave, perpetual care, a government headstone or marker, a burial flag (for Veterans), a Presidential Memorial Certificate and zero cost to the families. Some Veterans may be eligible for burial allowance, and women Veterans are entitled to the same benefits listed above. Veterans who are married to Veterans are entitled to their own adjacent gravesites if they choose, their own Presidential Memorial Certificate, and a headstone with the Veteran's name inscribed on the front.

VA implemented the pre-need burial eligibility determination program to assist anyone who would like to know if they are eligible for burial in a VA national cemetery. VA is promoting pre-need eligibility determinations to encourage Veterans and their eligible family members to plan to use VA burial benefits that Veterans have earned through their military service. Planning for a Veteran's or loved one's final resting place can eliminate unnecessary delays and reduce stress on a family at a difficult time. Veterans' families will have increased confidence that their loved ones are eligible for burial in a VA national cemetery at their time of need. Willamette is among the top 10 busiest national cemeteries in the country, and there are currently 2,769 known women Veterans interred at WNC. In 2012 Willamette was the first National Cemetery to inter a same sex couple, driving a national policy change on the burial eligibility of same sex Veteran couples.

WNC participates in such outreach efforts as the monthly VAMC community meeting, Vietnam commemorations, Carry the Load, partnership with local VSOs (AL, VFW, Lady Marines, DAV, etc.), Boy Scouts and Girl Scouts, local churches, and tribal and state Veterans' cemeteries. WNC also participates in the Veterans Legacy Program (VLP), a national partnership that engages students, educators, and the American public with their local history through the diversity of the Veteran experience enshrined in our 155 national cemeteries. The Veterans Legacy Memorial online database was recently enhanced to provide a tribute page for each of the nearly 3.8 million service members and Veterans interred in our National Cemeteries across the country. With this tool, anyone can search for a loved one who served on the Veterans Legacy Memorial and leave a comment as a lasting tribute on their memorial page. Lastly, Mr. Howard discussed WNC's educational outreach and strategic partnerships, emphasizing the motto "modernizing how we memorialize."

The Chair thanked Mr. Howard for the brief and remarked that the ACWV has not been to a single national cemetery that has not been a tightly run organization. Dr.

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Mathewson-Chapman thanked Mr. Howard for the briefing and asked if a Veteran can receive burial benefits, such as their headstone, even if they are not buried in a national cemetery. Mr. Howard replied that Veterans not buried in a national cemetery can still receive a government-furnished headstone and Presidential Certificate, as well as bronze medallions. The best call to make is to one's local national cemetery. Dr. Mathewson-Chapman asked whether Mr. Howard could communicate with local funeral directors on new requirements for receiving benefits. Mr. Howard replied that WNC puts every funeral home it comes in contact with on a distribution list to receive further benefits updates.

Overview of the Portland VA Regional Office (VARO) Business Lines

Renaye Murphy, Director, Portland VARO

Portland VA Regional Office Director Renaye Murphy introduced herself, some members of her team, and the Portland VARO's organizational structure. The VARO includes the Veteran's Service Center, Veterans Readiness and Education (formerly known as Vocational Rehabilitation and Education), and the Support Services division within its organizational structure. Portland currently has a FY21 RAM supporting 214 FTE and an FY21 Budget of \$505,288 with \$224,994 in overtime.

Portland is one of five regional offices processing Military Sexual Trauma claims. Due to COVID-19, nearly the entire workforce is teleworking, although productivity is better than it had been before the pandemic. Portland's virtual public contact services include the Veterans Service Center's Public Contact Team and Veteran Readiness & Employment's Veteran Group Orientation video with online assessment and counseling through VA Video Connect or telephone. The VARO continues to see Veterans in person if they wish. There is also a women Veterans' coordinator in the VARO.

Veterans Service Center (VCS) Overview/Topics

Kevin Kalama, VSC Manager, Portland VARO

Veterans Service Center (VSC) Manager Kevin Kalama gave the presentation. The VSC processes VA service-connected disability compensation claims from the national work queue. The VSC has 171 employees of which 61 (35.7%) are women, and of those, 29 are women Veterans. Of its 12 leaders and supervisors, three (25%) are women and one of those is a woman Veteran. Of the VSC's 54 disability rating decision makers, 22 (40.7%) are women, of which 12 are Veterans. Mr. Kalama said that it is the VARO's honor to have been selected to process MST claims for the nation. Of the VSC's 171 employees, 31 have been assigned to the MST special mission site; 17 of those employees are women, of which eight are Veterans. Mr. Kalama highlighted the Portland VBA WVC Stephanie Crawford and Portland VBA Female MST Outreach Coordinator Sue Williams. Portland VSC has completed 14,480 claims in FY20 as of July 31 at an average of 135 claims per day. In that same period it has processed 796 MST claims at an average of 251 days per claim. VSC has held 31 outreach events with 106 total attendees, of which nine have been women.

Mr. Kalama presented data on Oregon Veterans receiving service-connected compensation: of 168,747 total Veterans living in Oregon, 30,134 (17.9%) are women

Veterans; and of the 80,254 Oregon Veterans who receive service-connected compensation, 7,168 (8.9%) are women Veterans receiving an average monthly compensation payment of \$1,613.87.

Mr. Kalama also presented data on Oregon women Veterans who have at least one service-connected disability related to MST: of 1,940 total Oregon Veterans receiving compensation, 1,266 (65.3%) are women Veterans receiving an average monthly compensation payment of \$2,337.21. 15,940 total MST claims are pending across the nations as of August 4, 2021, of which 17,590 claims have been completed by the five special mission offices in New York, Hartford, Columbia, Lincoln, and Portland since the beginning of the fiscal year. 88.4% of those MST-related claims were granted by VA.

**Veteran Readiness and Employment (VR&E) Overview/Topics
Melissa Bay, VR&E Officer, Portland VARO**

VR&E Officer Melissa Bay gave the presentation. VR&E is a Chapter 31 program that provides Veterans with individualized paths to employment. The program recently went through a renaming and rebranding initiative (it was formerly known as Vocational Rehabilitation and Employment) in order to be more Veteran-centric. The mission of VR&E is to help Veterans with service-connected disabilities prepare for, find, and keep suitable jobs. VR&E also offers Veterans with severe service-connected disabilities services to improve their ability to live as independently as possible.

Of VR&E's 19 employees, eight (42.1%) are women, and nine of those are Veterans. The management team consists of three employees, two of whom are female, and one of which is a woman Veteran. Of the 1,847 Veterans served by VR&E, 386 (26.4%) have been women Veterans. Over the past fiscal year VR&E has achieved 294 positive-outcome case closures representing Veteran success in the program, of which women Veterans make up 16.6% (49). VR&E was invited by ODVA to present at the May 2021 Oregon Women Veterans Conference.

The Chair thanked the panel for their briefs and gave the floor to Vice Chair for Benefits McLaughlin. Vice Chair McLaughlin thanked the panel for the extensive inclusion of data on women Veterans and asked whether there were any discrepancies in the rate of approval of disability compensation claims for men versus women. VARO Director Murphy replied that there is not a big discrepancy in the grant rate between men and women's claims, but the VARO plans to continue its targeted town halls in order to reach more women Veterans and underrepresented groups. The VARO is currently requesting information in order to develop a map of where underserved Veterans live and to specifically target those populations. Vice Chair McLaughlin asked to see that data and generally inquired into why the data may show that women Veterans come out of VR&E with higher rates of success. Vice Chair McLaughlin yielded the floor to Ms. Handley, who thanked the panel and asked for clarity regarding the MST data. She then asked for a breakdown on the top disabilities claimed by women Veterans. Mr. Kalama replied that they would provide that data. The Chair gave the floor to the Subcommittee on Health.

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Vice Chair for Health Kirk thanked the panel and Mr. Kalama especially for their presentation of detailed, comparative data. Ms. Wright asked what the MST coordinator and WVC were doing at the VARO since the passing of Isakson and Roe. VARO Director Murphy replied that the collateral duties directive of the legislation was more aligned with the Women Veteran Coordinators at VHA medical centers, not necessarily the ones in VBA offices, who are typically claims processors. However, the VARO WVCs always prioritize meeting with their women Veteran constituents. Women Veterans can request women Vocational Rehab Counselors (VRC) and other service personnel. Ms. Wright suggested that Director Murphy review the legislation in order to continue their mission to serve women Veterans through VBA.

Dr. Mathewson-Chapman asked Ms. Bay how VR&E intersects with the Department of Labor's Career One-Stop Program and American Job Centers, particularly for Guard and Reserve. Ms. Bay replied that VR&E partners with DOL at the national level and with the work source community at the local level in order to coordinate state and DOL employment services for Veterans. VARO Director Murphy added that Isakson and Roe specifically addressed VBA Education programs, which is not represented by their office. Ms. Wright remarked that the law requires VA to study women Veteran coordinator programs to see how well staffed they are and to provide a position description for them. Often the coordinator is buried under so many collateral duties that they are unable to serve women Veterans in their particular area.

Ms. Harris asked Portland VBA WVC Stephanie Crawford if she was the only one in that position, to which Ms. Crawford replied yes and that her collateral duty is processing claims. Ms. Harris asked how much of her time is spent interacting with women Veterans, to which Mr. Crawford replied that she had just begun to perform the duties of the position after having endured extensive training. Mr. Kalama remarked that the Portland WVC before Ms. Crawford had been a supervisor who has since retired, and that for the past year Ms. Crawford has not been able to devote any time solely to address the needs of women Veterans. He remarked that going forward, now that she has completed her training, Ms. Crawford will be able to dedicate the necessary time to women Veteran-specific outreach activities. The previous WVC spent less than 10% of her time on the duties of the position. Ms. Harris replied that giving the WVC the "double duty" of processing claims does a disservice to the growing women Veteran population and it was unfortunate that VBA has not yet been able to establish a stand-alone position for Women Veteran Coordinator. She expressed concern about who had been performing the duties of the Woman Veterans Coordinator in the past year and asked how women Veterans in need would know to contact Ms. Crawford.

VARO Director Murphy replied that WVCs are listed on VARO's and VACO's public-facing sites so that women Veterans in need will know who to contact in VA. Assistant Deputy Under Secretary for Field Operations, Outreach and Stakeholder Engagement Cheryl Rawls is currently looking at the new legislation to align the Women Veteran Program Coordinator position at the national level. VARO supervisors are also empowered to allow any coordinator to drop their collateral duties in order to assist where they're needed. Due to COVID, VARO Coordinators are currently seeing

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Veterans by appointment only, although they are continuing to work with ODVA to hold town halls. The VARO is also waiting for the map overlay data that will locate Veterans who are not in receipt of benefits across Oregon. Ms. Harris thanked Director Murphy for the response. Dr. Mathewson-Chapman asked if VR&E offers house modifications, wheelchairs, automobile upgrades, and prosthetics and how women Veterans get referred if they're needed. Director Murphy replied that some things are handled by VR&E and other services are handled by the VA Guaranteed Home Loan Program, specifically specially adapted housing. Once women Veterans are given a particular disability rating then they are given information for programs for which they may be eligible and the service providers will reach out to them. Dr. Mathewson-Chapman asked for the number of women Veterans in receipt of a benefit, whereupon Director Murphy referenced such data.

The Chair thanked the VARO for their presentation and remarked that Committee members and Veterans have become very passionate about benefits and that the ACVW understands that the VARO is doing everything it can to serve women Veterans. There being no other questions, the Chair recessed the ACWV at 1:01 p.m., and returned at 1:15 p.m.

Committee Discussion

The Chair began discussion and preparation for subcommittee breakouts. She discussed the next day's schedule and emphasized that the Committee should cover the most salient points of the meeting to make advisory recommendations to the Secretary of Veterans Affairs. She reminded everyone to register for the town hall. The Chair then asked the Vice Chairs for comments before the subcommittee break-out. There being no further questions, Ms. Middleton made some administrative remarks. Dr. Patricia Hayes also made some remarks on the Isakson and Roe legislation mandating formal reports to Congress, recommending that the Committee receive information on these matters after such reports have been submitted to Congress. The Chair thanked Dr. Hayes for the remarks. Ms. Miller bid fair winds and following seas to the 12 U.S. Marines killed this day in Kabul, Afghanistan.

Adjourn

At 1:27 p.m., PST the Chair adjourned the third day of the ACWV-VAPORHCS site visit, whereupon the Committee members entered closed subcommittee sessions.

Friday, August 27, 2021

Open Meeting/Introductions

Betty Yarbrough, Chair, ACWV

At 10:00 a.m., PST, the Chair called the fourth day of the ACWV meeting to order. The Committee members, ex-officio members, advisors, staff, and VISN 20 guests introduced themselves.

ACWV Out-briefing with Executive Leadership Teams (VHA/NCA/VBA/VISN)

Betty Yarbrough, Chair, ACWV

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The Chair noted that the Advisory Committee on Women Veterans (ACWV) was chartered in November of 1983 by Public Law 98-160 to assess the needs of women Veterans with respect to compensation, rehabilitation, education, outreach, healthcare, and other relevant programs administered by VA. The ACWV reviews VA's programs, activities, research projects, and other initiatives designed to meet the needs of women Veterans and makes recommendations to the Secretary on ways to improve, modify, and effect change in programs and services for women Veterans. Whereas the ACWV's recommendations are advisory in nature, they are regularly approved by the Secretary of VA and the Congress. ACWV prepares a biennial report for the VA Secretary and Congress, and through the preparation of such report meets with many caring professionals across VA. The Chair remarked upon the monumental effort of the ACWV, CWV staff, and VISN 20 staff to coordinate this meeting, and gave accolades to VISN 20 Medical Director Dr. Curry, VAPORHCS Director Goodspeed, VARO Director Murphy, Willamette NC Director Mr. Howard, ODVA Director Fitzpatrick, and expressed special appreciation to VAPORHCS's Dr. Suniga and VACO's Ms. Middleton. The Chair also recognized VISN 20 Lead WVPM Amy Reno and ODVA WVC Jessica Bradley.

The Chair remarked that VISN 20's geographic size alone presents unique challenges to serving women Veterans and the VISN has demonstrated a great aptitude in administering VA programs to the women Veteran population. It is evident that the VISN has invested in new facilities, programs, equipment and staff to better serve women Veterans. The Chair advised the VISN to remain vigilant and not become complacent when it comes to adding or improving VA support to women Veterans. The Chair highlighted the detailed briefings on Tribal Relations and the LGBTQ+ programs, which gave the ACWV great insight into the unique challenges of minority women Veterans. The Chair also lauded the degree of collaboration taking place vertically and laterally across the local and state program offices. The Chair gave the floor to the Vice Chair for Benefits.

Vice Chair for Benefits McLaughlin delivered the out-briefing for the Benefits Subcommittee, and on behalf of the subcommittee she thanked the entire VISN 20 panel for presentations. Whereas the subcommittee is charged to explore how women Veterans are served by VA benefits system, the Vice Chair focused on VARO, Vocational Rehabilitation and Education, and justice outreach. She commended the VARO for their dedication and pride in processing claims efficiently, which the data clearly demonstrates. The office also has an impressive number of women and women Veterans on staff. The Vice Chair thanked the VARO for being a flagship MST claims processing site.

The Benefits Subcommittee is committed to ensuring that women have both knowledge of and access to the benefits to which they are entitled, and to this end the subcommittee recommends a three-pronged approach, to include the awareness of the benefit, the ability to enroll successfully, and follow-up with on-the-ground assistance. Outreach is critically important to this function. Coordinators must understand their audience in order to overcome the challenges to reaching women Veterans. Building trust takes multiple attempts, interactions, and tools, to include in-person outreach

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events, social media, advertising, and other campaigns. Women Veterans have had access to incredible experiences and accomplishments in the military, however, the military is different for men than it is for women, and these differences in experience can present trust barriers when it comes to engaging with VA. Sexual assault is significantly and disproportionately higher for women in the military than for their civilian counterparts, and women in the military have also historically faced barriers to entry and job placement. Therefore it is important for VA to find ways to overcome these trust barriers and make inroads into the women Veteran population. The Vice Chair encouraged all VA leadership and personnel to do repeated consistent outreach in as many forms as possible, constantly seeking to refine efforts and source best practices from other regions.

Vice Chair McLaughlin emphasized that when women Veterans apply for benefits, their applications should be viewed and considered without any implicit bias. She remarked that the national and regional VA needs to gather and examine empirical data to determine whether VA has a problem with implicit bias. In order to determine that awards are made equally and without bias, the Vice Chair recommended that VISN 20 compare the rate of disability awards for men and women Veterans to determine if there is a statistically significant discrepancy. The Vice Chair asked for a comparison of award percentage rates for men and women Veterans with the same given condition, and also asked whether women Veterans had to appeal for reconsideration more to get the same result as male Veterans. These efforts will require data mining to determine if such a discrepancy exists. The Vice Chair recommended these measures to all of the VISN 20 facilities and offices. Lastly, the Vice Chair put emphasis on supporting the role of the Women Veteran Program Coordinator.

Vice Chair for Health Dr. Kirk gave the out-briefing for the Health Subcommittee and thanked the Chair and Vice Chair for Health for remarking on implicit bias and the level of respect that has been shown to the ACWV during the virtual site visit. She thanked Drs. Curry, Reno, Suniga, and LaFavor for their excellent briefings. Vice Chair Kirk appreciated the VISN addressing the women-specific deficiencies in the July 2021 OIG Report and thanked them for their honesty. Although benchmark VA-wide comprehensive public health measures are not yet available for women Veterans, H.R. 7105 will hopefully institute some of those measurements in order to have a more in-depth picture of women Veterans across VA.

Vice Chair Kirk discussed best practices and opportunities for improvement reported from the Health Subcommittee. She remarked that due to the changing face of the military, in the future VA will be much different than VA is now. The Committee appreciated that the VAPORHCS Chief of Staff mandates all primary care providers to be women's health providers. The Women's Health Navigator, the Women's Health Liaison, and the Maternity Care Coordinator position descriptions appear to be going above and beyond in their day to day work, and although those providers may be doing an excellent job, the Committee is concerned that there may be burnout if they sustain their collateral duties into the future. The Committee recommends that VAPORHCS review the appropriateness of their processes, staffing, and budget for women Veteran

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programs. Women Veterans' processes should be benchmarked with metrics so that productivity, staffing, and budgeting can all be assessed accordingly. Although VAPORHCS's average wait time for care appears to be roughly equal between men and women, women's health services appear to be outsourced disproportionately more often than their male counterparts' and women Veterans at VAPORHCS have a lower empanelment than other VAs.

The silver lining of COVID can be seen in the increase in both nationwide VA usage of telehealth and the number of telehealth services offered by women's health providers. This will help to reduce barriers to women utilizing VA health care, especially for rural women and MST patients. The Committee recommended that VAPORHCS continue to explore and offer alternative apportionment methods to women Veterans, including video telehealth and government-furnished iPads, phone apps, and video tapes.

The Vice Chair recognized the Intimate Partner Violence and Assistance Program (IPVAP) as a VAPORHCS best practice. The IPVAP coordinator is working to implement Directive 1198, has conducted groundbreaking research, provided awareness, and implemented the "Strength at Home" intervention. The Vice Chair stated that the program seems to have the proper staffing, funding, and program management to institutionalize this program, and the Committee recommends that the model be transferred to the Women Veteran Program Manager if possible, further stating that this IPVAP program is an excellent test for the implementation of H.R. 7105 Section 5304 concerning women Veterans. The Vice Chair also recognized the Whole Health Program as a VAPORHCS best practice. Roughly 40% of women Veterans suffer from insomnia and this program can help address that.

The Vice Chair discussed areas in which the Committee felt VAPORHCS could improve or excel. The Health Subcommittee observed ways in which both Federal VA and VAPORHCS could enhance the existing women's health programs. Women are disproportionately affected by problematic medical billing by being forced to receive care in the community for women's health services not offered in VA. VAPORHCS can better provide quality care for women Veterans by following up with those who have accrued unpaid medical bills. The Committee recommended staffing an Outsource Care Billing Coordinator to assist women Veterans with medical billing for outsources care. Furthermore, the Committee believes there have been many rural, tribal, and minority women Veterans who have not been reached due to the VISN's wide geography. As the women Veteran population increase, VAPORHCS can excel in this regard by doing more persistent outreach targeting unserved women Veterans. Although VAPORHCS's facility does have private inpatient rooms, the facility can stand to add more private rooms specifically for women Veterans in mental health and community living as well as woman-specific ingress/egress to the Women's Clinic. Fostering the women Veteran community has become paramount during COVID-19, so the Committee recommends that VAPORHCS enhance telehealth programs for women Veterans' mental health. It is important for Portland to have a Women Veterans Care Coordinator to ensure that women are receiving their screening results and follow on treatment as soon as possible. This FTE should report to the Women Veterans Program Manager (WVPM),

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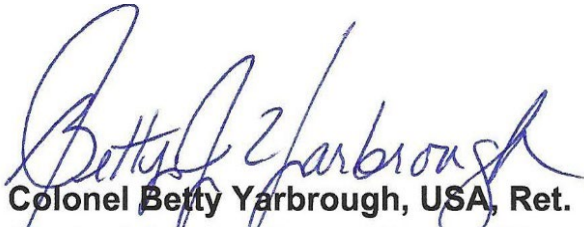
and liaisons currently doing this work should report to the WVPM, who should have oversight of all women Veteran programs. Finally, the Vice Chair emphasized continuing to break down barriers to accessing VA health care for women Veterans, to include childcare, homelessness, MST, IPV, and geography. The Vice Chair thanked VAPORHCS and the VISN for holding an informative ACWV site visit.

The Chair gave the floor to the DFO. DFO Tiglao delivered some remarks and thanked a number of people from VAPORHCS, VISN 20, CWV, VACO, and the site visit planning committee. The DFO recognized and thanked members of the ACWV and remarked that this will be the last meeting of member and former ACWV Chair Octavia Harris. The DFO yielded the floor to the Chair. Lead WVPM Reno, VAPORHCS Director Goodspeed, VARO Director Murphy, and Willamette NC Director Howard delivered some final remarks and thanked the Committee. The Chair gave remarks in preparation of the town hall.

Meeting Adjourned

Betty Yarbrough, Chair, ACWV

At 10:57 a.m., PST the Chair adjourned the last day of the ACWV-VAPORHCS site visit.



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



Lourdes Tiglao

Designated Federal Officer, Advisory Committee on Women Veterans