

**Department of Veterans Affairs (VA)**  
**Advisory Committee on Women Veterans (ACWV)**  
**Meeting Minutes**  
**VA Central Office, 810 Vermont Avenue, NW, Room 930**  
**Washington, DC 20420**  
**May 17-19, 2016**

**Attendance:**

**VA ACWV Members Present:**

COL Mary Westmoreland, Chair, USAR, Ret.  
Kailyn Bobb, USAF Veteran  
Tia Christopher, USN Veteran  
CMDCM Octavia Harris, USN, Ret.  
LTC Louisa Long Jaffe, USA, Ret.  
Keith Howard-Striecher, USA Veteran  
RADM Joyce Johnson, USPHS, Ret.  
COL Edna Jones, USA, Ret.  
MAJ Shannon McLaughlin, MA ARNG  
Sara McVicker, USA Veteran  
CAPT Leslie Smith, USA, Ret.  
CDR Janet West, USN

**VA ACWV Ex-Officio Members Present:**

Dr. Nancy Glowacki, Women Veterans Program Manager, Veterans Employment and Training Service, Department of Labor (DOL)  
Lillie Nuble, Assistant Director, Buffalo VA Regional Office (VARO) Veterans Benefits Administration (VBA)  
Dr. Patricia Hayes, Chief Consultant, Women's Health Services, Veterans Health Administration (VHA)

**VA ACWV Ex Officio Members Excused:**

Colonel Aimee Kominiac, Military Director, Defense Advisory Committee on Women in the Services (DACOWITS), Department of Defense (DoD)

**VA ACWV Advisors Excused:**

Faith Walden, Program Analyst, Office of Finance and Planning, National Cemetery Administration (NCA)  
CAPT Michelle Braun, Nephrology Nurse Practitioner, National Institutes of Health

**Center for Women Veterans (CWV):**

Kayla M. Williams, Director  
Dr. Betty Moseley Brown, Assoc. Director  
Desiree Long, Sr. Program Analyst  
Shannon L. Middleton, Program Analyst  
Michelle Terry, Program Support

**Other VA Staff:**

Jelessa Burney, Advisory Committee Management Office (ACMO)  
Erin Gittens, Benefits Assistance Service (BAS)

Rhett Herrera, VHA  
Jeffrey Morangue, ACOMO  
Alohalani Pickett, BAS  
Leslie Williams, BAS

**Guests:**

Julie Crockett, American Association of Colleges of Osteopathic Medicine

Lindsey Davis Stover, Edwards, Davis, Stover & Associates (EDS)

Rachel Carrig, Atlas Research

Kayda Keleher, Veterans of Foreign Wars

Shurhonda Love, Disabled American Veterans

Jordanna Mallach, New York Department of Veterans Affairs

Maria McConnell, Women Veterans of America

Cathy Santos, National Association of Women Veterans, Inc.

Josh Taylor, EDS

***The entire meeting package is located in the Center for Women Veterans, Washington, DC.***

**Tuesday, May 17, 2016**

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

- Introduction of Committee members and visitors.
- Review of agenda.
- Approval of minutes from the September 21-24, 2015 Site Visit in Washington, DC.

**Comments from the ACWV Designated Federal Official (DFO), Kayla M. Williams, Director, CWV**

- Discussed the objective of the ACWV's Congressionally-mandated biennial report and the process for timely submittal:
  - The ACWV constructs recommendations and rationales for the report, based on information acquired from meetings, forums, research, surveys, site visits, and summit or other legitimate sources, regarding a demonstrated need that will benefit the women Veterans population.
  - ACWV will submit its report to Secretary of VA through the CWV by July 1, 2016.
  - CWV will coordinate with VA's Administrations (Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration) and Staff Offices to obtain VA's responses to the ACWV's report recommendations.
  - The ACWV's report recommendations and VA's responses will be compiled into a single report to be sent to Congress, as mandated by law.
    - The report is due to Congress by September 1, 2016.

**Federal Advisory Committee Act (FACA) 101 Briefing, Jeffrey Moragne, Director, Advisory Committee Management Office**

- **Discussed the Federal Advisory Committee Act (FACA)**

- FACA is a Federal statute that governs the establishment, termination and management of Federal advisory committees (FACs).
- FACA promotes openness and transparency and regulates the number and duration of FACs.
- FACA applies to all groups with at least one non-Federal employee established or utilized by an agency to obtain advice or recommendations, unless an exception applies.
- Requirements for a FAC are signed/filed charter; designated Federal officer (DFO); public meetings with agenda announced in Federal Register 15 days in advance and an opportunity for public to submit written comments; balanced membership; records maintained and available for public inspection.
- FACA applies to all gatherings where substantive matters upon which the committee provides advice or recommendations are discussed.
  - This includes “virtual” gatherings, such as tele- and video-conferences.
- A DFO is a VA employee who manages day-to-day FAC operations; must approve/call meetings, attend all meetings, and approve meeting agenda; and must ensure meeting minutes are certified by FAC Chair within 90 days.
- FACs may convene to perform two types of work without a public meeting:
  - Preparatory work, solely to gather information, conduct research, analyze relevant issues, facts in preparation for a FAC meeting or to draft papers for deliberation by FAC.
  - Administrative work, solely to discuss administrative matters of the FAC or receive administrative information from agency.
- FAC meetings may also be closed in whole or in part under limited circumstances, such as when discussing trade secrets, personal information, and criminal matters.
  - The Office of General Counsel must concur to the closure.
- If asked to testify, FAC members may speak about FAC matters only in their personal capacity.
  - FAC members do not have authority to testify on behalf of the FAC and do not speak for VA.
  - The testimony should clarify that the FAC member is providing his or her personal opinion and not speaking on behalf of VA or the FAC.
  - Because the FAC member is testifying in a personal capacity, VA cannot not reimburse for expenses or pay honoraria.
  - As a courtesy, FAC members should inform the FAC’s DFO about their intent to testify.

### **Annual Ethics Briefing, Jonathan Gurland, Staff Attorney, Office of General Counsel**

- In accordance with the Federal Advisory Committee Act (FACA), the members of the ACWV received their annual ethics training for special government employees (SGE).
  - Provided information on ethics rules for advisory committee members who are special government employees.

**Update on Accelerated Learning Programs (ALPs) Pilot and VA Learning Hubs, John R. Thompson, Assistant Director, Economic Impact, Office of Economic Opportunity, Veterans Benefits Administration (VBA)**

- A Learning Hub is a blended educational format that consists of online learning and in-person learning sessions.
  - It is targeted towards Veterans, transitioning Servicemembers, and spouses; it offers an opportunity for them to network, engage in subject area discussions, ask experts/guest speakers, and other experts questions relevant to subject areas.
  - It does not require use of the GI Bill benefits.
  - Partnerships consist of organizations such as Coursera, the American Red Cross, and other community partners.
- Five pilots were conducted from September – November 2015.
- Additional Learning Hubs were added across the country (27 for Phase 1 and three for Phase 2).
- To date, over 225 students have completed initial modules.
  - Courses covered topics around business writing, entrepreneurship, information technology (IT), and communication.
- VA launched an Accelerated Learning Program (ALP) pilot in summer 2015, in support of President Obama's Tech Hire initiative, and Department of Labor statistics indicating a significant need for qualified IT professionals by 2020.
  - ALPs typically are completed in under six months, provide opportunities to learn online, in the classroom, or in a blended format, and lead to industry-recognized certifications and industry-ready employees.
  - VA awarded seven contract task orders, totaling \$5 million, focused on building skills and certifications needed to begin or advance in careers in IT.
  - VA is also testing an innovative pay-for-success concept to incentivize and compensate training providers, based on graduation, attainment of industry certification, and career-placement rates.
  - Veteran response for this pilot has been strong.
    - VA received over 1,000 applications within first 24 hours, and over 3,500 applications in the first two weeks.
  - Some of the data the program tracks include: screen-out rates, course completion and certification attainment, connection to employment, and contract lessons learned.
  - Pilot results will be utilized to explore legislative proposals to potentially expand availability of ALPs across multiple sectors.
  - As of early May 2016, there were 3,519 applications received, 1,598 total referrals made, 643 referrals screened out, and 901 total accepted.

**Update on MyVA and 12 Breakthrough Priorities, Scott Blackburn, Director, MyVA Task Force, Office of Policy and Planning**

- **MyVA is:**
  - Creating a new VA that is Veteran-centric, innovative, inclusive, and built on VA's proud legacy and strengths.
    - Re-designing process through the lens of the Veteran.

- Leveraging design and lean thinking to improve processes.
- Using the CX module to care and connect, understand and respond to needs and to guide the journey:
  - Find a way to connect in some way with each person encountered. Demonstrate empathy and try to imagine where the Veteran is coming from.
  - Begin and end the interaction on a positive note, say thank you and show appreciation.
  - Make sure the Veteran feels welcomed, acknowledged, respected, valued, cared for and that VA has their back.
  - Actively listen without interruption and summarize what was heard, to ensure understanding.
  - Ask open ended questions to gain a better understanding of the Veterans' needs. Ask for clarification as needed. If a mistake or misunderstanding occurs, apologize. Never make excuses or place blame.
  - Use best judgment to determine what would best meet (or exceed) the Veterans' needs and expectations. Don't assume the Veteran understands the system and processes. Explain the process and set expectations about what will happen next. Make it easy for the Veteran by outlining the process, providing contact info or the correct forms.
  - The Veteran feels cared and important; understands where he or she is in the process; feels that VA can be trusted to follow through on its commitment.
- Vets.gov is a secure, cloud-based, single-platform website with a goal of meeting customers' needs. Its strives to be a single, one-stop shop for information and self-service features for Veterans and those who care for them.
- Changing the culture of VA, focusing on leadership and improving the employee experience.
  - Moving from a rules to a principles based culture.
  - Implementing the Leaders Developing Leaders program to improve leadership on multiple levels.
  - Utilizing a new generation of management tools.
  - Managing like a business.
  - Eliminating bureaucracy and freeing capacity for innovative improvements.
    - Twenty eight senior executive-level Reports, Approvals, Measurements, Meetings, Policies (RAMMP) items eliminated via the monthly performance review.
    - Eliminating/reducing other RAMMP items locally throughout the VA.
- Focusing on one common Department agenda, to produce clear outcomes and goals, clear ownership, and collaboration through cross-organizational teams.
  - Narrowing-down VA's near-term focus to the 12 "breakthrough priorities" designed to improve the delivery of timely care and benefits to Veterans.
    - Eight Veteran touchpoints: improve the Veterans experience; increase access to health care (same day primary care, seamless care, suicide prevention); improve community care; deliver a unified Veterans experience; modernize

- contact centers (to include Veterans Crisis Line); improve the compensation and pension exam; develop a simplified appeals process; continue to reduce Veteran homelessness.
- Four critical enablers: improve employee experience (to include leadership development); staff critical positions; transform the Office of Information Technology (OIT); and transform supply chain.
- Making progress by implementing changes and producing tangible results in 2016, and building momentum for 2017 and beyond.

### **ACWV Working Session**

- The ACWV began crafting recommendations for its 2016 Congressionally-mandated biennial report.

### **Wrap up/ Adjourn**

**COL Mary Westmoreland (U.S. Army, Retired), Chair, ACWV**

**Wednesday, May 18, 2016**

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

### **Center for Women Veterans Highlights, Dr. Betty Moseley Brown, Associate Director**

- Cumulative fiscal year to date performance update from October 1, 2015 to April 30, 2016:
  - CWV's staff engaged in 196 collaborative meetings, forums, and in-reach events.
  - Activities included keynote speeches, presentations, participation in collaborative meetings, and advisory councils and meetings.
  - CWV had 37 outreach events.
  - CWV's staff answered 353 inquiries, ranging in complexity and issues, from general information requests to personal requests regarding health care concerns, and status of claims.
    - On average, CWV's staff responded in 4.2 days; less than VA's standard of 5 days.
- Web statistics for this period:
  - Number of visits to CWV's [Web site](#) : 77,145.
- Women Veterans Program (WVP):
  - CWV leads the collaboration and coordination of VA's three Administrations (VHA, VBA, NCA), and Staff Offices on the delivery of benefits and services to women, through the WVP.
- CWV strategic partnerships include the eMentor Program (AcademyWomen), Her Mission Continues (Mission Continues), and Center for American Women and Politics (Rutger University/Eagleton Institute of Politics).
- The I'm One Campaign is a new, National outreach campaign focused on developing identity and respect of women Veterans, and encouraging more women Veterans to self-identify.

**Briefing on iGIANT, Dr. Saralyn Mark, Senior Medical Advisors, NASA**

- Gender and sex impact every aspect of our daily lives.
  - "Gender" refers to a person's self-representation as male or female based upon social interactions and "sex is based upon an individual's genes.
  - Understanding and using these definitions correctly has become more complicated by the enhanced knowledge of the influence of the environment on gene expression (epigenetics).
- Roundtables were conducted to explore the impact of gender/sex on innovation and novel technologies (iGIANT).
- During the Roundtables, stakeholders with a gender/sex-specific product, program, policy or protocol share best practices and are encouraged to serve as "ambassadors for innovation".
  - As ambassadors, stakeholders from government, industry, academia, professional societies, and advocacy groups can further enhance awareness of the need for gender/sex-specific design elements for their own sector and others.
  - Sectors include health, information technology (IT), transportation and retail.
- Agencies and organizations, including the National Institutes of Health and NASA, have policies on the inclusion of gender and sex in research studies.
  - Men and women can present with different disease symptoms, courses and responses to therapeutics.
  - Understanding the impact of gender and sex on health can enhance precision medicine (<https://www.whitehouse.gov/precision-medicine>) as well as disease prevention and health promotion strategies.
- The Office on Women's Health within the Department of Health and Human Services hosted the first health iGIANT roundtables on July 15/16, 2015 in Washington, DC.
  - Over 30 organizations and agencies which have a gender/sex-specific design element related to health came together to discuss best practices as well as challenges and opportunities to advance the iGIANT.
  - There was a robust discussion about the need for gender/sex-specific research policies, medical devices, pharmaceuticals, curricula, and even clinical practices.
- Research has also shown that women and men interact with their environments differently.
  - This is reflected in safety profile reports from the automobile industry. The American Journal of Public Health published a study in 2011 which showed that women were 47 percent more likely to suffer more severe injuries compared to men, even after adjusting for weight and height, in motor vehicle accidents.
  - The differences in female neck strength and musculature, seating posture and head restraint position contributed to these findings.
  - In October 2015, a transportation iGIANT roundtable, hosted by J and B Medical Supply in Detroit, examined these issues from a scientific and an engineering perspective.
- It is an exciting time to move from the research bench to the design of car seats, cockpits, computer keyboards, personal protective equipment, and even athletic gear.
  - These are just a few examples where sex/gender can have an impact on ergonomics.

- For example, more apparel, sporting equipment and home repair tools are branded for use by women or men because of gender/sex-specific designs which improve function and not just appearance.
- Stanford University hosted an IT iGIANT roundtable in September 2015 and the Laura W. Bush Institute/Texas Tech University hosted a retail iGIANT roundtable in November 2015. Information from these sessions is available at <https://genderedinnovations.stanford.edu>.
- A symposium with participants from the roundtables will convene at Stanford University in 2016.
  - During this event, best practices from all the sectors will be highlighted to further advance the dissemination of knowledge and partnership formation.
  - There will also be an announcement of iGIANT prizes for outstanding innovation to be awarded at the next symposium in 2017.
- The iGIANT roundtables, symposia and prizes will promote and accelerate the development of gender/sex-based design elements which may improve work efficiency and the safety and quality of life for men and women.

**Homelessness Among Women Veterans, Dr. Ann Eliabeth Montgomery, Investigator, VA National Center on Homelessness Among Veterans, and Birmingham VA Medical Center, Health Services Research and Development; Assistant, University of Alabama at Birmingham, School of Public Health**

- The number of women Veterans has nearly doubled in the past decade; fastest growing segment of Veteran population.
  - Thirteen to 15 percent of women Veterans living in poverty will experience homelessness over the course of a year.
  - During the January 2015 point-in-time count, 9.1 percent (4,338) of Veterans who were homeless were female, 62.4 percent were sheltered, and 37.6 percent were unsheltered.
- Women Veterans are 2.1–3.4 times as likely as their non-Veteran counterparts to experience homelessness.
- Some of the risk factors include younger age, disability, black, unemployed, unmarried, mental health and substance abuse.
- Experience of trauma and post-traumatic stress disorder (PTSD), intimate partner violence (IPV), military sexual trauma (MST), combat and other sources of trauma are other factors.
- Pathways to homelessness include: childhood adversity, trauma, substance abuse during military service, post-military abuse, adversity, relationship termination, post-military mental health, substance abuse, medical problems.
- Homelessness screening clinical reminder (HSCR) asks Veterans:
  - If they have been living in stable housing that you own, rent, or stay in as part of a household, for the past 60 days. (if no, then homeless).
  - If they are worried or concerned that in the next 60 days they may not have stable housing that they own, rent, or stay in as part of a household? (if yes, then at risk).

- Compared with men, women Veterans experiencing homelessness are younger, more frequently OEF/OIF Veterans, and often have dependent children.
- The odds of homelessness are increased among women Veterans who identify as black or unmarried.
- Compared with men, women Veterans experiencing homelessness are less likely to have a history of incarceration, be disabled or retired, or have a substance use disorder.
- Compared with men, women Veterans experiencing homelessness are less likely to be literally or chronically homeless, live in an unsheltered situation, or repeatedly screen positive for homelessness.
- There is no sex-specific “risk” for use of VHA homeless programs.
  - Women more likely to enter HUD VASH and men are more likely to enter GPD.
- Needs of homeless Veterans:
  - Build on strengths of women Veterans experiencing homelessness and tailor interventions accordingly.
  - Address specific needs of younger women by assisting with reentering civilian life, reproductive care, childcare, and education.
  - Address experience of trauma by ensuring access to mental healthcare, especially related to MST and PTSD.
    - Carefully assess for trauma and use trauma-informed models of care.

### **Eating and Weight Related Disorders Among Women Veterans, Dr. Janna L. Fikkan, Staff Psychologist, VA Puget Sound, American Lake Division**

- Eating disorders and disordered eating:
  - Women are much more likely to be diagnosed with an eating disorder (ED) than men.
    - Anorexia nervosa – 4 percent; bulimia nervosa – 1-1.5 percent; binge eating disorder – 1.6 percent; and other specified feeding or eating disorder is the largest group.
- Spectrum of EDs: include anorexia nervosa (eating less), bulimia (binging and purging), and binge eating disorder (eating more).
- Disordered eating is overly restrictive eating, chronic dieting, weight cycling, compulsive (and/or punitive) exercise routines.
  - The individual can become pre-occupied with food, calories, fat content, weight or weight-loss plans and poor body image that negatively impacts person’s life and about which she is preoccupied.
  - Disordered eating can lead to emotional eating, neglect of nutritional needs, dissociation from body, and avoidance of movement/physical activity.
- Diagnosis rates of clinical EDs:
  - Women Veterans self-reporting a lifetime ED diagnosis: 15.6 percent.
  - Diagnosis of active duty women by medical records data yield much lower rates of clinical eating disorders: 2 percent anorexia nervosa; .07—1.2 percent bulimia nervosa, and 1.2 percent binge eating disorder.
  - Percentage per year of Servicemembers with any ED diagnosis (by use of medical database) was .30 percent (females > males).
- Prevalence of self-reported disorder eating:

- Entry level Army women: 33.6 percent reported disordered eating on the Eating Attitudes Test (EAT-26).
  - Active duty women in Army, Navy, Air Force and Marines (self-report of symptoms on the Eating Disorders Inventory (EDI), categorized into ED categories): 1.1 percent for anorexia nervosa; 8.1 percent for bulimia nervosa, and 62.8 percent for eating disorder not otherwise specified.
- Weighted average across studies is that 23.3 percent of AD women are “at risk” for EDs.
- Marines self-report the highest rates (76.7 percent) of eating disorder symptoms falling under the “not otherwise specified” category. Marines also had the majority of diagnosed cases of anorexia nervosa.
- Disordered eating is reported in all ranks of military personnel and may even be higher in enlisted than among officers.
- The few studies that have examined when disordered eating is most likely to be reported have demonstrated increased rates prior to physical fitness assessments.
- Co-morbidity:
  - The odds of an ED among women Veterans was 11.3 fold higher with a single co-morbid mental health diagnosis; 19.7 fold higher with two comorbid mental health diagnoses; and 52.3 fold higher with 3 or more, as compared to those with none.
  - One study found that when age, PTSD status and depression were entered into a prediction model, only age (younger) and depressive symptoms (higher) were associated with increased likelihood of having an ED diagnosis.
  - Relationship between depression and ED symptoms appears to be particularly strong among women Veterans.
  - Women Veterans who screened positive on PTSD symptoms were 5 times more likely to also screen positive on ED symptoms.
  - Women Veterans who screened positive for experience of MST were more than four times more likely to also have ED diagnosis (by review of medical chart data).
  - Women Veterans with PTSD and MST appear to be more at risk for disordered eating than women with PTSD (without MST).
- Risk factors uniquely associated with military service include weight requirements, physical training, exercise used as punishment or remediation, exposure to trauma, and changes in eating behavior while in service.
- Risk factors among Veterans: higher rates of obesity, residual effect of change in eating behaviors during service, and discharge associated with cessation of physical activity.
- Understanding barriers to care:
  - Inadequate data (no standardized screening of EDs in this population to date).
  - Low prevalence rate of clinical eating disorders and historically considered to not affect Veteran population.
  - Treatment of eating disorders is resource intensive.
  - Insufficient training among VA staff to assess and treat.
  - Difficulty with referrals to care outside VA due to cost (and geography).
- Educating VA providers:

- Presentation by teleconference through the Women's Mental Health Teleconference series in October of 2015.
- Three presentations offered at the Women's Mental Health Mini Residency in Salt Lake City in April of 2016.
- The work ahead:
  - Defining the scope of the problem by collecting data on prevalence would inform stakeholders of the magnitude of the problem.
  - Considering the whole spectrum of eating and weight related disorders in considering the various ways these problems can play out, and coordinate interventions accordingly.
- Summary:
  - Women who have served in the military experience unique risk factors for the development of EDs and disordered eating.
  - Screening for EDs is not standardized in VA, treatment options have been nearly non-existent to date, and efforts to change this are in their infancy.

### **ACWV Working Session**

- The ACWV began crafting recommendations for its 2016 Congressionally-mandated biennial report.

### **Wrap up/ Adjourn**

**COL Mary Westmoreland (U.S. Army, Retired), Chair, ACWV**

**Thursday, May 19, 2016**

The meeting was called to order by the Chair.

### **Review Status of Recommendations #6-7 of the 2010 Report and Recommendations #6 of the 2014 Report, ACWV**

- Review of recommendation #7 of the 2010 Report of the Advisory Committee on Women Veterans: The duties and functions of the WVCs be standardized for consistency of services provided to women Veterans and that these duties be evaluated in each VA regional office (VARO) during the scheduled internal Compensation and Pension Services site visit to ensure compliance and efficiency.
  - Response August 2013: VBA implemented standardized duties for Women Veterans Coordinators (WVC) on March 21, 2000, by guidance issued in a formal letter (OFO Letter 210-00-09) to all field personnel.
    - The standardized duties for WVC have enabled VBA to proactively attend outreach initiatives to ensure VA benefits information is provided and women's issues are addressed in these forums.
    - VA Central Office Women Veterans Program Manager (WVPM) provides oversight and ensures new WVCs are aware of their roles and responsibilities.
    - WVCs participate in local women Veterans events and provide outreach to organizations which include women Veterans members.

- WVCs serve as a point of contact for VA and other service providers and Veterans with special needs (Veterans who experienced sexual trauma while on active duty).
- WVCs establish networks among community service providers, share information on claims processing with WVPM at VA medical center (VAMC) Veteran centers and community organizations.
- The WVC serves as the liaison with women Veterans' organizations or groups with predominantly women members. WVCs maintain rosters of primary contacts and provide speakers for meeting and special events, as appropriate.
- Additionally, they maintain a resource directory of community service providers who provide services specifically to women and distribute the directory as appropriate.
- WVCs also promote information about VA benefits and services in places where women Veterans live or frequently visit.
- Updated Response May 2016: WVC duties are standardized in accordance with VBA's M27-1, which governs public contact activities to include all outreach coordinator duties.
  - WVCs are required to complete mandatory training within 120 days of appointment and recertify annually.
  - Additionally, WVCs are required to conduct (1) Special Emphasis Outreach event per quarter specifically targeting women Veterans.
    - VBA site visits ensure WVCs are operating within mandated procedures and conducting effective outreach to women Veterans.
- After discussion, the ACWV decided to close recommendation #7.
- Review of recommendation # 8 of the 2010 Report of the Advisory Committee on Women Veterans: VBA conducts Area conferences every 2 years for WVCs and others who provide women Veteran-specific services. In an effort to build greater communication, collaboration of functions, and awareness of issues, concerns, policies and programs for women Veterans in their respective areas.
  - Response August 2013: VBA currently conducts continuing education for WVCs through Tri Administration quarterly training.
    - This training is a collaborative effort between VBA, Veterans Health Administration, National Cemetery Administration and the Women Veterans Program.
    - The quarterly conferences focus on benefits and services available to women within VA.
    - It also provides information on issues, concerns, policies and programs for women Veterans.
    - By having a national quarterly training conference, VBA can ensure that all WVCs receive the most relevant and up-to-date information.
    - VBA requests this recommendation be closed.
  - Updated Response May 2016: VBA conducts monthly WVC training calls providing essential tools to effectively provide service to women Veterans.
    - Training sessions are recorded and Talent Management System (TMS) training credit is provided.

- VBA also collaborates with the Center for Women Veterans (CWV), VHA, and NCA to conduct quarterly training calls to all WVCs and WVPMs providing information on issues, concerns, policies, and programs for women Veterans.
- Quarterly National Outreach training providing overall Outreach training is also provided to ensure WVCs receive the relevant and current information.
- After discussion, the ACWV voted to close recommendations #8, further noting that VBA exceeded the expected response to this recommendation.
- Review of recommendation #4 of the 2014 Report of the Advisory Committee on Women Veterans: The Department of Veterans Affairs conduct and disseminate an assessment of outcomes of the second review of previously denied MST related post-traumatic stress disorder claims, to ascertain if new policies regarding stress or/marker verification were accurately and consistently applied; to see how many decisions were amended, as a result of the second review; and to conduct gender-specific comparisons of the initial claims decisions and the final claims decisions rendered under the second review.
  - Response July 2014: VBA is engaged in extensive data collection on issues related to MST.
    - As part of this effort, we will be reviewing and collecting data on the responses from Veterans who were sent outreach letters informing them that their previously denied MST/PTSD claim would be re-evaluated if they notified VBA.
    - This data analysis will include any revised service-connected grant rates and a breakdown of those rates by gender.
    - However, there is no deadline for Veterans to respond to the initial outreach letter and we are in the process of sending out a second round of approximately 2,600 outreach letters - this is an ongoing process.
    - As the re-evaluation process continues, VBA will collect and analyze data received and use it to further our MST/PTSD nationwide training goals.
  - Updated Response May 2016: Response will be provided to the Advisory Committee upon receipt from Compensation service.
  - After discussion, the ACWV devotes to close recommendations #6.
- VBA Women Veteran Program updates:
  - Conducted Tri-Administration (VBA, VHA, and NCA)/Women Veteran Coordinator/Women Veteran Program Manager quarterly training.
    - The Center for Women Veterans will assume responsibility for the quarterly training beginning on June 30, 2016.
  - Conducts mandated monthly training and provide TMS credit for participation.
- Women Veteran Data FY 2015, information extracted from BAS Operations plan data metrics:
  - Top five claimed conditions received from women Veterans were knee, back, hearing loss/tinnitus, PTSD and headaches/migraines.
  - There were 393,185 women Veterans receiving compensation benefits, a 9 percent (356,748) increase from FY 2014.
  - There were 12,371 women Veterans receiving pension benefits, a 2 percent (12,624) decrease from FY 2014.

- There were 65,841 women Veterans guaranteed home loans, a 41 percent (46,714) increase from FY 2014.
- Twenty seven thousand women Veterans participated in VR&E, an eight percent (24,929) increase from FY 2014.
- There were 125,938 women Veterans received education benefits, a 12 percent (110,858) increase from FY 2014.
- Unemployed women Veterans: 5.4 percent, a 0.1 percent decrease from FY 2014.
- Women Veterans receiving VGLI benefits: 56,512, a 2 percent increase from FY2014.
- Women Veterans receiving TSGLI benefits: 53, a 44 percent decrease from 2014.
- There were 736 hours committed to women Veteran outreach.

**Briefing on Suicide Risk and Prevention, Dr. Caitlin Thompson, National Director, Suicide Prevention, Veterans Health Administration, VHA**

- Veterans are more likely to die by suicide than the general population.
- While male VHA users have increased, their overall suicide rates remain relatively stable.
- As rates of suicide among male VHA users under age 30 increases, rates have increased in female VHA uses.
- VA's integrated approach to suicide prevention includes: awareness and outreach, access, enhanced care delivery, training and collaboration, and research.
- The Veterans Crisis Line offers free confidential support, 7 days a week, 24 hours a day.
  - Trained responders assist Veterans.
- There are more than 300 suicide prevention coordinators nationwide.
- Operation SAVE teaches communities how to help Veterans at risk of suicide.
  - Operation S.A.V.E. will help responders act with care and compassion if they encounter a Veteran who is in suicidal crisis.
- The warning signs:
  - Hopelessness, feeling like there is no way out, anxiety, agitation, sleeplessness, mood swings, feeling like there is no reason to live, rage, and anger.
  - Other signs include engaging in risky activities without thinking, increasing alcohol or drug abuse, and withdrawing from family and friends.
- The presence of the following signs requires immediate attention:
  - Thoughts of hurting or killing oneself, talking about death, dying, or suicide, and self-destructive behavior such as drug abuse, weapons, etc.
- VeteransCrisisLine.net and www.MakeTheConnection.net:
  - Is relevant to all Veterans and their families, regardless of eligibility for VA care, or the range of mental health issues they may be experiencing.
  - Informs Veterans, their families and friends, and members of their communities about resources designed to help Veterans live well.
  - Reaches Veterans where they are, online and through trusted media and influences when they need support.

- Features true stories from real Veterans, which serve as powerful tools in breaking down barriers and can help Veterans realize they are not alone.

### **Update on Choice Program and Veterans Health Administration Initiatives, Kristin Cunningham, Director, Business Policy, VHA**

- VA's goal for community care is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff.
- VA incorporated feedback from key stakeholders representing diverse groups and backgrounds to create a plan.
- VA is taking immediate steps to improve stakeholders' experiences while also planning and implementing long-term improvements for the new community care program.
  - Immediate steps to improve stakeholder experience include implementing contract modification, reducing unnecessary steps in the process, and improving communications.
  - Long-term steps to improve stakeholder experience include developing detailed implementation plan, executing make/buy decisions, and implementing integrated solutions.
- Improving the Veteran's journey:
  - Provide easy to understand eligibility information to Veterans, community provider, and VA staff.
  - Support accurate and timely payment of community providers.
  - Implement a network that provides access to high-quality care inside and outside VA.
  - Provide quick resolution of questions and issues for Veterans, community providers, and VA staff.
  - Coordinate care through seamless health information exchange.
  - Provide Veterans timely access to a community provider of their choice.
- Core team and portfolio teams have conducted interviews, site visits, and data gathering exercises with VISN and VA medical center staff across the country to inform the future state design.
- VA continues to engage key stakeholders including Veterans, Veteran service organizations, community providers, Congress, and private industry to collaborate and drive improvements.
- There have been rapid changes to community care:
  - In September 2013, patient-centered community care (PC3) was established as the regional contracting vehicle to partner with community providers; VA awarded the PC3 contract to TriWest and Health Net.
  - April 2014, VA completed PC3 rollout.
  - August 2014 Congress enacted the "Veterans Access, Choice and Accountability Act of 2014" (PL 113-146).
    - VA established the Veterans Choice Program (VCP) expanding access to community care in response to excessive wait times and delays.
  - November 2014, a rulemaking to implement PL 113-146.
    - Modified PC3 contracts to support the VCP.

- November 2014- January 30, 2015, contractors mailed out approximately 8.6 million Choice cards to Veterans.
- April 2015, VA changed eligibility requirement to 40 mile driving distance from geodesic.
- May 2015 Congress enacted the “Construction Authorization and Choice Improvement Act of 2015” (PL 114-19).
  - June 2015 implemented three provisions related to unusual and excessive burden.
  - July 2015 implemented Choice First 1B.
- Congress enacted the “Veterans Health Care Choice Improvement Act of 2015” (PL 114-41).
  - October 2015 removed the Choice enrollment date; submitted report to Congress October 30.
  - November 2015 contractors began to make outbound calls to Veterans.
  - Dr. Yehia appointed Assistant Deputy Under Secretary for Health for Community Care.
- December 2015 rulemaking to implement PL 114-19 & PL 114-41.
  - Implemented final provision related to unusual and excessive burden.
- January 2016 changed episode of care from 60 days to 1 year.
- February 2016 released draft Network PWS. Provider expansion to begin phased implementation of provider types to mental health and treatment facilities. Authorization return codes standardized.
- March 2016 removed requirement for medical records for provider payment. Clarified type of medical information to be returned. IT Industry Day.
- April 2016 draft Network RFP released.
- From FY 14 to FY 15, Community Care appointments increased by approximately 20 percent from 17.7 million to 21.3 million.
- VA and contractors have established a joint team to address the following priorities:
  - Improve customer service, simplify referral and authorization process, decrease returned authorizations, match Veterans with right provider and better visibility into the network.
- Accomplishments:
  - Delivering care faster and closer to home.
    - Average number of days to schedule an appointment is about seven days, which represents a reduction of six days from December 2014.
    - The average commute time is about 32 minutes which is four minutes less from December 2014.
  - Expanding the provider network.
    - VA’s Choice Provider Network has ~289,000 providers, an increase of 20 percent from October 2015 to February 2016.
  - Less administrative burdens for providers.
    - Removed requirement for submission of medical records prior to payment.
    - Clarified and simplified medical record submission requirements.
  - Improving provider payment.
    - Set up joint rapid response team.
    - Deployed electronic tools to check claims status.

- Improving customer service.
  - Contractors are answering the phones faster and the average abandonment rate has decreased.
- Responding to VA's needs:
  - Adverse credit reporting happens when there is a poor record for payment of medical claims.
    - If not addressed promptly, these past due items may appear in an individual's credit report and lower his/her credit score, making it difficult to obtain a loan or access credit.
    - Action: Veteran Help Line was established for Veterans to call and learn how to appeal debts sent to collections and work to resolve the adverse credit reporting and/or debt collection issue.
    - Results: resolved more than 500 Issues during the first 10 weeks of the hotline's operation.
- In FY 15, VA processed 16.8 million claims, representing a 21 percent increase from last year.
- In the last six months, we continue to process claims faster.
  - Now about 78 percent of claims are processed within 30 days (> 80 percent for clean claims).
- VA implemented a survey to measure Veterans' experience with Community Care.
  - Developed and validated survey that initially tested with Veteran Insights Panel, piloted with ~1,800 respondents, and sample drawn from claims database.
  - Implemented final survey in the field with 40,000 Veterans sample (initial), online and mail surveys, and ongoing monthly random sampling.
  - First wave of results expected mid-May.
    - The results will inform potential changes.
    - Ability to compare results with internal VA healthcare survey.
    - Will provide continuous monitoring of community care.
- Provider networks include:
  - Health care services: medical care and services for inpatient, outpatient, professional, dental (for eligible Veterans), pharmacy (urgent only), DME (urgent only).
  - Complementary and integrative health services: alternative treatments such as relaxation therapy, tai chi, Native American healing, hypnotherapy, etc.
- Ensuring the right providers in the right places:
  - Contractor shall develop a Network Adequacy Plan, in conjunction with VAMC staff, during the implementation period.
  - Network Adequacy Performance Report to include average drive times, average appointment times, other analysis to include complaint (provider and Veteran) information, pharmacy, and dental have additional requirements.
  - Dedicated contractor liaison, community care provider relations, and VAMC staff will work closely together to customize the network adequacy plan to local market needs.
    - Monthly status calls, monthly reports and corrective action plan requirements.
- Direct communication with Veterans and providers will improve customer service by reducing handoffs; develop and communicate clear eligibility requirements for

community care; ensure Veteran's choice for community care, providers, and scheduling; and move toward electronic communication between VA and community providers.

- Providers paid timely and accurately by auto-adjudicate claims, process and adjudicating 98 percent of all clean claims within 30 days of receipt.
- Managing benefits and other health insurance process and developing an improper payment plan that includes a healthcare fraud detection and prevention plan.

#### **ACWV Working Session**

- Convened as a full group to discuss the 2016 Report Recommendations

#### **Presentation of Certificates of Appreciation and comments from Robert Snyder, Chief of Staff, Accompanied by Gina Farrisee, Deputy Chief of Staff and Moira Flanders, Director, Office of Survivor Assistance**

- Discussed MyVA and explained how this transformative initiative will improve the Veterans' experience when interacting with VA and using VA's programs and services.

#### **ACWV Reconvened Working Session**

- Convened as a full group to discuss the 2016 Report Recommendations

#### **Wrap up/ adjourn**

**COL Mary Westmoreland (U.S. Army, Retired), Chair, ACWV**

**Meeting adjourned.**

**/s/**

Mary Lynch Westmorland  
Colonel, U.S. Army (Retired)  
Chair, Advisory Committee on Women Veterans

Kayla M. Williams  
Designated Federal Officer