

Department of Veterans Affairs  
Report of the Advisory Committee on Women  
Veterans

September 2018

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## Chairs Letter



**U.S. Department of Veterans Affairs**

Center for Women Veterans (00W)

810 Vermont Ave NW  
Washington DC 20420  
[www.va.gov/womenvet](http://www.va.gov/womenvet)

In Reply Refer To:

July 1, 2018

The Honorable Robert Wilkie  
Secretary of Veterans Affairs (00)  
Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Dear Secretary Wilkie,

As Chair of the Department of Veterans Affairs' (VA) Advisory Committee on Women Veterans (Committee), it is an honor and privilege to represent the nearly 2 million women who have served in the Armed Forces. This population of Veterans continues to grow exponentially, due to the increased presence of women in the active duty and reserve components. Moreover, the surge of outreach conducted by the Center for Women Veterans (Center) has enhanced women Veterans' awareness of VA's benefits and services, improved their self-identification as Veterans, and made VA a more attractive option for women who seek to access the care and benefits that they have earned through military service.

The Committee appreciates the opportunity to serve our nation's women Veterans and submits to you our 2018 biennial report, which includes seven recommendations--with supporting rationales--on how VA can address emerging issues impacting women Veterans.

The twelve-member Committee, all Veterans from diverse backgrounds and experiences, worked diligently to ensure that the recommendations and rationales were in line with VA's five top priorities. It is imperative that women Veterans' health care and benefits comprehensively align with VA's mission and culture, and is included in foundational services across all Veterans Integrated Service Networks (VISN).

The report covers important issues of significant concern to the Committee, such as direct billing of Veterans for non-VA care, for their potential impact on women Veterans who sometimes have to use non-VA health care due to unavailability of services in VA. For instance, when VA's community partners are not paid timely, it can cause great undue stress on Veterans--and in many cases financial hardship, including severe debt, collections and ruined credit. This impacts their ability to attain stable employment and housing and care for dependents--burdens disproportionately born by women Veterans.

Although the report itself covers issues the Committee deems significant, I would also like to emphasize other areas of concern not covered in the report that relate to those issues--such as of lack of updated information technology (IT). Modernized IT systems would provide pertinent gender specific data collecting capability, analysis, tracking, sharing of health records, and other information that can help eliminate the many challenges VA currently faces. On a related note, IT modernization will also create a more succinct processing benefits claims and payments for non-VA care, some dating back even before the implementation of the Choice Program.

Additionally, there are some lingering issues of great concern to us regarding recommendations from our 2016 report that we believe have not been adequately addressed. We will work through the Center's leadership to reach out to the Department to seek clarification on those specific items. Having these ongoing open recommendation is concerning, as we are now submitting more recommendations without obtaining definitive resolution to recommendations made in our previous report. Again, the work the Committee is Congressionally-mandated to do is taken seriously by every member, as we realize the impact on policies and legislation for Veterans.

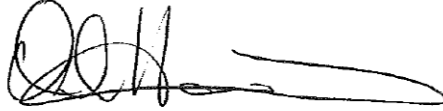
The number of women Veterans continues to increase and the demographic becomes more diverse across all eras, ages and stages in life. Sound recommendations provide support to VA leaders in making the right decisions on when and where to provide critical resources, so there is a proactive approach to meeting evolving needs rather than a reactive approach from not having the information necessary to anticipate projected growth. The Committee appreciates the great efforts and strides that VA has taken to address the needs of women Veterans, but we wanted to ensure significant and attainable goals can be met from our recommendations.

The Committee appreciates your staff's leadership, expertise, and informative briefings, which support the direction we need to take in making our recommendations. Notably, the Center has been instrumental in our success as a Committee. The briefings we receive and the site visits strategically coordinated and executed, give us a better understanding of concerns and issues of women Veterans-- from large urban areas to small rural areas. The Center continues to ensure that we always receive up-to-date information on current matters within the Administrations and Staff Offices.

Thank you for your leadership in supporting women Veterans, and for understanding the value of the Committee's work in our effort to provide meaningful recommendations regarding VA's administration of benefits and services for women Veterans.

Page 3 The Honorable Robert Wilkie, Secretary of Veterans Affairs

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Octavia D. Harris', with a long horizontal flourish extending to the right.

Command Master Chief Octavia D. Harris (U. S. Navy, Retired)  
Chair, Advisory Committee on Women Veterans

## **Part I**

### **Executive Summary**

The Department of Veterans Affairs (VA) Advisory Committee on Women Veterans' 2018 report provides recommendations and supporting rationales that address the following issues:

- Identification of Barriers to Accessing Benefits
- Assessment of the Comprehensive Needs for Women Veterans
- Direct Billing of Veterans for Non-VA Care
- Identification of Women Veterans' Military Occupations and Hazardous Exposures
- Consideration of Non-traditional Treatments for Military Sexual Trauma-related Conditions
- Assessment of the Women Veterans Program Managers Program
- Increased Support for Advisory Committee on Women Veterans' Activities

The report of the Advisory Committee on Women Veterans (Committee) is submitted biennially by the Committee. The Committee members are appointed by the Secretary of Veterans Affairs (Secretary) for a 2-year or 3-year term. The current Committee membership includes Veterans of the Air Force, Navy, Army, Marine Corps, and National Guard. Members represent a variety of military career fields and possess extensive military experience, to include service in the Persian Gulf War, and Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND).

A total of seven recommendations with supporting rationale, as well as responses from VA, are provided in this report. Recommendations stem from data and information gathered in exchange with VA officials, women Veterans, researchers, Veterans Service Organizations, and site visits to Veterans Health Administration (VHA), National Cemetery Administration (NCA), and Veterans Benefits Administration (VBA) facilities. The recommendations and supporting rationales provide insightful advice for VA to strategically and efficiently address the evolving needs of women Veterans.

#### **Highlights**

- Veterans Benefits Administration (VBA) should conduct a study to identify barriers impacting women Veterans' access to the benefits it administers, and develop an action plan to address the barriers identified.
- VA should conduct a comprehensive needs assessment of the women Veterans population.
- VA should identify Veterans who were directly billed for non-VA care, reimburse them for payments made, provide assistance to repair credit, and set mechanisms in place to prevent direct billing.

- VA should examine and document occupational and other hazardous exposures women Veterans encounter during their military service.
- VA should explore the effectiveness of novel psychotherapeutic and psychopharmacological treatment modalities, for clinical practice in the treatment of military sexual trauma-related conditions.
- VA should examine the current utilization of women Veterans program managers (WVPMs) across the enterprise, to ensure that they are functioning in the role as defined in the position description.
- VA should allocate additional resources to the Center for Women Veterans, increase support for the Advisory Committee on Women Veterans' activities.

## **Part II**

### **Recommendations, Rationales, and VA Responses**

#### **A. Identification of Barriers to Accessing Benefits**

##### **Recommendation:**

**1. That the Veterans Benefits Administration (VBA) conduct a comprehensive study to identify barriers impacting women Veterans' access to the benefits it administers, and develop an action plan with specific performance metrics to correct identified disparities.**

**Rationale:** There have been multiple studies completed in the past, with regard to barriers impacting women Veterans accessing Department of Veterans Affairs (VA) health care. Studies like the Veterans Health Administration's *Study of Barriers for Women Veterans to VA Health Care*<sup>1</sup> (Barriers Study)—a Congressionally-mandated, independent study of the barriers women Veterans face in accessing comprehensive health care—have been instrumental in ensuring that women Veterans obtain the quality health care they need and deserve. The Barriers Study, in particular, provides insight directly from women Veterans that can be used to understand how to address these barriers. It is in women Veterans' best interest—and VA's—to proactively conduct a similar study to identify what barriers inhibit women Veterans from accessing the benefits that they deserve.

A study focused specifically on benefits and services administered by VBA (across all VBA business lines), categorized by gender, would be helpful in identifying barriers in accessing VA benefits, and would facilitate more effective allocation of resources to ensure that women Veterans have more equitable access to these benefits. The information obtained from this study would be useful in understanding which of VBA's business lines should receive additional emphasis.

**VA Response: Concur-in-principle.** VA agrees that a comprehensive study to identify barriers impacting women Veterans' access to benefits could potentially identify some areas for improvement. However, Veterans Benefits Administration (VBA) data shows women are accessing the benefits they have earned. In Fiscal Year (FY) 2017, more than 214,000 women accessed Post 9/11 GI Bill education benefits. In FY 2017, nearly 82,000 women Veterans were guaranteed home loans totaling nearly \$21 billion. Targeted training and other efforts that began in FY 2011 have also eliminated an identified 20-point gap between the grant rates of disability claims for Post-Traumatic Stress Disorder (PTSD) related to Military Sexual Trauma (MST) versus other causes. VBA conducts on-going outreach and has reached over 80,000 women Fiscal Year-To-Date. Additionally, VBA works closely with VA's Center for Women Veterans to identify and eliminate any barriers that are discovered.

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<sup>1</sup> Department of Veterans Affairs (2015). *Study of Barriers for Women Veterans to VA Health Care*. Retrieved from: [https://www.womenshealth.va.gov/docs/Womens%20Health%20Services\\_Barriers%20to%20Care%20Final%20Report\\_April2015.pdf](https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf)



At this time, VBA does not have a tool to complete a comprehensive study and furthermore does not believe that a comprehensive study is necessary for accessing benefits.

VA's Annual Benefits Reports (ABR) contains gender-specific data including a summary of recipients receiving compensation and pension benefits. VBA has agreed to explore additional opportunities with its Office of Performance Analysis and Integrity to incorporate any available gender-specific demographic data in the ABR for the Insurance, Loan Guaranty, Education, and Vocational Rehabilitation and Employment programs.

## **B. Comprehensive Needs Assessment**

### **Recommendation:**

**2. That VA conduct a comprehensive needs assessment of the women Veterans population that encompasses anticipated long-term needs as they age, and develop an action plan to ensure identified gaps are filled—including but not limited to staffing, facilities, budgeting, training, and community-based resources.**

**Rationale:** Women Veterans represent one of the fastest growing segments of the Veterans population. According to VA's Women's Health Services, the number of women Veterans using VA health care has tripled from fiscal year (FY) 00 to FY17—representing a 203 percent increase over 17 years.<sup>2</sup> By 2020, women Veterans will comprise 11 percent of the total Veterans population.<sup>3</sup> The vast majority of women who receive care through VA are under the age of 65 and are also more medically complex. Forty seven percent have a service connected disability rating of 50 percent or greater, as compared to only 22 percent of women over the age of 65.

Although VA continues to strive to address the evolving needs of women Veterans, it still faces challenges. The Committee is concerned that VA's health care system is not adequately resourced to meet the future needs of this rapidly growing population as they age—especially with regards to long-term care facilities, resources, and identification of gaps between current capacity and projected needs. It is crucial that VA define the requirements necessary to adequately care for this younger generation of women Veterans as they age, and establish a plan to address any staffing, budgeting, facility, training, and other shortfalls identified in order to adequately meet those demands.

**VA Response: Concur-in-principle.** VA agrees with the recommendation and has been implementing assessments since 2010, assessing the implementation of comprehensive women's health through national site visits.

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<sup>2</sup> Briefing on Women's Health Initiatives, Chief Consultant, Women's Health Services, Meeting of the Advisory Committee on Women Veterans, May 8-10, 2018; Washington, DC.

<sup>3</sup> Department of Veterans Affairs, VetPop07, via the National Center for Veterans Analysis and Statistics (NCVAS).

Women's Health Services (WHS) contracted with Booz Allen Hamilton (BAH) to develop the methodology, metrics, and tools needed to evaluate Women's Health Programs (WHP) across the Veterans Health Administration (VHA). BAH collaborated with subject matter experts from VHA, Department of Defense (DoD), and Department of Health and Human Services in order to complete this task. From FY 2010 to FY 2013, BAH conducted comprehensive evaluations of 70 out of 140 VA Health Care System (VAHCS) WHPs. From FY 2014 through FY 2016, Atlas Research partnered with BAH to conduct 70 additional comprehensive evaluations. By the end of FY 2016, 100 percent (140) of the VAHCS WHPs comprehensive evaluations were completed.

The primary purpose of this program evaluation was to gauge progress towards the full implementation of comprehensive health care for women Veterans as delineated in VHA Directive 1330.01: "Health Care Services for Women Veterans." The information from this evaluation is intended to inform strategic planning and decision making in terms of policy and resources needed to promote the development of WHPs across the Nation.

The assessment teams utilized a capability review tool that addressed five essential WHP domains or components. These include: Program features; Health Care Services; Outreach, Communication, and Collaboration; Patient-Centered Care/Patient Aligned Care Teams; and Education and Training.

Within these 5 components, there are 33 capabilities comprising more than 300 evaluation criteria. Each capability was scored on a 4-point Likert scale: 1= needs development (no ongoing plans to meet critical success factors); 2= being developed (at least one crucial success factor not met); 3= developed (all critical success factors met); 4= high developed (all criteria met). The 2.5-day site visit included: Primary data collection interviews with approximately 20 key individuals or groups; a case discussion (responses to a hypothetical medical case); facility tours; and a review of program-related documents.

Also, WHS conducts an extensive annual national survey, Women's Assessment Tool for Comprehensive Health (WATCH), that is completed by Women Veteran Program Managers (WVPM) at each Health Care System. This survey assesses patient population, population growth projections, women's health program staffing, and women's health models of care, including clinical and patient aligned care team staffing. Also, it includes a self-assessment that uses the same scoring tool from the site visits (described above) that allows sites to identify areas needing improvement. Through WATCH, local VA leadership is able to examine trends in standards and quality indicators reflecting the implementation of Comprehensive Women's Health, and to identify and address gaps in services available for women Veterans.

In conjunction with WATCH, WHS deploys the Designated Women's Health Provider Assessment of Workforce Capacity (DAWC) annually. DAWC is completed by WVPMs at each Health Care System. This tool collects data on the workforce capacity (number of women's health providers) at each site of care, the provider's professional designations, and their women's health specific trainings.

In addition to WATCH and DAWC, WHS evaluates how well locations are meeting the needs of women Veterans through assessment of data and quality indicators using a Veteran Integrated Service Network (VISN) level assessment, the Women's Health Dashboard. Dashboard data, including gaps in care and mitigation plans, is reviewed annually with individual VISN-lead WVPs. When individual sites have significant challenges in performance, WHS sends in teams to support that site and focus improvement effort.

To obtain additional data on Veteran experience and barriers to care, in 2015, VA conducted a study, (the Barriers to Care Study), which built upon the 2009 National Survey of Women Veterans. This study was mandated by Congress and surveyed 8,000 women Veterans across all VISNs who were both users and non-users of VA care. The results of this study have been used to help VA understand the challenges women Veterans encounter when accessing care, as well as those perceptions that potentially deter the use of VA services. The data collected has informed future planning of services and programming so that VA is a provider of first choice among women Veterans.

Also, WHS uses national electronic health record data to develop strategic planning and program implementation. WHS's Women's Health Evaluation Initiative (WHEI) analyzes centralized, national VHA databases to inform WHS strategic policy and program planning objectives. Among WHEI's products is a series of Sourcebooks. Sourcebooks (4 volumes) describe sociodemographic characteristics, health care utilization patterns, and medical conditions of women Veteran patients in VHA. In the most recent volume, Sourcebook Volume 4 provides a view of how the population of women Veterans using VHA has been evolving across a 16-year period coinciding with rapid VHA women's health care delivery system advances, and points to directions for readying the system for future expansion of the number of women Veterans using VHA.

WHS uses data from WHEI to determine highest health care needs in women Veterans, and continues active initiatives to meet those needs, including the Go Red Collaboration with the American Heart Association to raise awareness of heart disease among women Veterans.

WHS has collaborated with Geriatrics and Extended Care to enhance care for women Veterans in Community Living Centers and has developed training programs for primary care providers focused on aging women Veterans, including a collaborative training on dementia.

In summary, currently, WHS is utilizing national survey and electronic data methodology to assess the needs of women Veterans and to plan for the growth and aging of the women Veteran population.

## C. Billing for Non-VA Care

### Recommendation:

**3. That VA identify Veterans who—through utilization of non-VA health care for eligible services—were billed directly for those services, have either paid the charges out-of-pocket and/or received collection notices, and have experienced an adverse impact on their credit.**

**That VA implement policies and processes to retroactively reimburse claims for eligible medical expenses paid for out of pocket.**

**That VA take appropriate action to repair the credit of affected Veterans and lobby for legislation to require credit bureaus to remove derogatory information.**

**Finally, that VA include a clause in the policy governing community care that would preclude non-VA providers from direct billing of Veterans for eligible services in the future.**

**Rationale:** Community care was designed to make timely, high quality health care more accessible for Veterans, when VA does not have the resources or capacity (i.e. staffing limitations, inability to provide specialty care, extensive wait-times, or proximity to VA facility) to provide care internally.<sup>4</sup> It was created to provide a seamless network of care for Veterans, for authorized treatment that is preapproved by a provider and eligible emergency medical treatment that meets the criteria established in 38 C.F.R. § 17.1002(b).<sup>5</sup> VA is expected to provide timely payment to its community partners. Veterans who are billed directly for care due to VA's untimely payment are unexpectedly forced to be fiscally responsible for this care. The financial hardship resulting from high medical expenses or negative credit ratings can adversely impact Veterans' physical and mental health, as well as their ability to attain stable employment and housing and care for dependents—burdens disproportionately born by women Veterans. More than 30 percent of women Veterans use non-VA health care in the community, due to a shortage of women's health providers and services.<sup>6</sup>

In the VA Office of Inspector General's (VAOIG) January 2017 report, *Review of the Implementation of the Veterans Choice Program*<sup>7</sup>, fear of fiscal liability was identified as a barrier to Veterans accessing care through Choice. When VA is not timely in their payments to providers, Veterans can receive bills directly for the care provided. Untimely payments also discourage providers from participating in the Choice program, which further impacting women Veterans' access to care.

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<sup>4</sup> Briefing on Office of Community Care, Executive Director, Delivery Operations, VHA, Meeting of the Advisory Committee on Women Veterans, May 8-10, 2018; Washington, DC.

<sup>5</sup> 38 CFR 17.1002 - Substantive conditions for payment or reimbursement. Retrieved from: [www.gpo.gov/fdsys/pkg/CFR-2012-title38-vol1/pdf/CFR-2012-title38-vol1-sec17-1002.pdf](http://www.gpo.gov/fdsys/pkg/CFR-2012-title38-vol1/pdf/CFR-2012-title38-vol1-sec17-1002.pdf).

<sup>6</sup> Briefing on Women's Health Initiatives, Chief Consultant, Women's Health Services, Meeting of the Advisory Committee on Women Veterans, May 8-10, 2018; Washington, DC.

<sup>7</sup> Review of the Veterans Choice Program, VA Office of Inspector General, January 30, 2017. Retrieved from: [www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf](http://www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf).

Because of a lack of knowledge about the claims process or administrative errors on the part of VA, many Veterans have either paid those expenses out of pocket, or have been reported to credit bureaus as being delinquent or in default. VA staff admitted, during the VAOIG interviews for this report, that some Veterans have been billed for services, as a result of delayed payments to providers.

The VAOIG found that the time to payment by the third party administrator averaged greater than 30 days, and approximately 50 percent of the 2 million payments made by the VA Office of Community Care to the third party administrator were in excess of 30 days. Additionally, VA's has no ability to enforce third party administrators' timely payment to providers under the Choice contracts.<sup>8</sup> The VAOIG report also noted a backlog of 400,000 claims, as of June 2016, due to inadequate staffing and the Financial Services Center's inefficient processing system.

To mitigate the adverse financial impact on Veterans, VA established a Community Care Call Center and has written letters on behalf of Veterans.<sup>9</sup> The Committee lauds VA's efforts to work with providers to find an alternative to reporting Veterans to collection agencies,<sup>10</sup> when possible. However, this assistance depends on Veterans' effort to reach out for assistance first. This unfortunate situation creates a significant and lasting impact on Veterans' livelihood, and that their families, for years to come. It is imperative that VA actively seeks out Veterans who were impacted by this issue, take corrective action to compensate them for any expenses paid, and facilitate resolving any negative credit reporting that resulted from them receiving bills for medical services to which they were eligible to have covered by VA.

**Response: Concur in principle.**

***3a. That VA identify Veterans who—through utilization of non-VA health care for eligible services—were billed directly for those services, have either paid the charges out-of-pocket and/or received collection notices, and have experienced an adverse impact on their credit.***

**VA Response:** Since publication of the referenced VA Office of the Inspector General (VAOIG) report in 2017 and even prior to it, VA has undertaken targeted efforts and outreach to assist Veterans inappropriately billed for authorized community care services. At the same time, VA has implemented a continuous stream of improvements to VA and Third-Party Administrators (TPA) operations focused on enabling timelier and more accurate payments to community care providers, the root cause behind these Veteran issues.

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<sup>8</sup> Review of the Veterans Choice Program, VA Office of Inspector General, January 30, 2017. Retrieved from: [www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf](http://www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf).

<sup>9</sup> Testimony of Assistant Deputy Under Secretary for Health for Community Care, Veterans Health Administration. February 11, 2016. Hearing Before the Subcommittee on Health of the Committee on Veterans Affairs, U.S. House of Representatives. Retrieved from: <https://www.gpo.gov/fdsys/pkg/CHRG-114hhrg25101/pdf/CHRG-114hhrg25101.pdf>

<sup>10</sup> Review of the Veterans Choice Program, VA Office of Inspector General, January 30, 2017. Retrieved from: [www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf](http://www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf).

At present, of the six recommendations made to the VA in the VAOIG report, VA has addressed or resolved four and is working to resolve the remaining two. VA believes that the number of Veterans now experiencing these issues should decrease because of these improvements, as well as the additional actions taken for the other ACWV recommendations below.

As the ACWV report notes, VA's Adverse Credit Reporting Hotline, opened in January 2016, provides direct and Nation-wide assistance to Veterans who have been inappropriately billed for authorized community care charges, received collection notices and/or who have experienced an adverse credit impact because of VA/TPA delayed provider payments. The toll-free number reaches VA employees trained to resolve collection-specific issues. VA staff assist the Veteran in understanding eligibility and in determining whether the bill received was appropriate. They research the claim, contact the community care provider and when needed, request that the Veterans' account be removed from collections, assist with ensuring Veteran reimbursement and expungement of related adverse credit reporting.

VA has employed various communication, education, and mass outreach tactics to identify and offer help to Veterans experiencing these and other health care-related financial issues. VA has used blogs (e.g. Vantage Point, VA Pulse) and its Web sites (e.g. Veterans Choice) to communicate information on how and where to receive assistance with resolving billing and provider payment issues, and obtaining reimbursement for eligible and out of pocket medical expenses. Also, information has been shared through major media outlets, in social media postings (e.g. Facebook), as well as via multiple outlets managed by Veterans Service Organizations, Congress, and other VA partners and Veterans advocate groups. VA Town Hall meetings with employees have also been conducted to share developments and important information needed to better assist and support Veterans and community providers. These efforts have all been an important part of identifying ways to improve Veterans' overall experience with the Veterans Choice Program (VCP), as well as the actions VA can take to assist Veterans with mitigating the detrimental impact and stress that avoidable financial hardships can have.

VA continues to educate and remind Veterans, providers, and the general public about the assistance provided by the Hotline. VA's outreach has been fruitful. As of July 28, 2018, the Hotline has handled a total of 48,529 Veteran-related financial issues since its opening. Of calls received, 42,335 (87 percent) have been resolved and 6,194 (13 percent) remain active. On average, 15 percent of issues presented to VA are resolved within 14 days. More than 15,000 calls (32 percent) have dealt specifically with Veteran issues associated with VCP.

Status: In Progress

Target Completion Date: May 2019

**3b. That VA implement policies and processes to retroactively reimburse claims for eligible medical expenses paid for out of pocket.**

**VA Response: Concur.** Currently, VA has processes in place to reimburse Veterans for eligible out of pocket expenses when requested and appropriate. Operational policies and procedures for processing reimbursements are in place based on the type of claim. These are documented in formalized standard operating procedures available for employee reference and use. Also, VA Web sites provide out of pocket expense reimbursement guidance and information to Veterans and the general public and covers health care service claims from emergency care to pharmacy. For example, see [https://www.va.gov/COMMUNITYCARE/programs/veterans/Emergency\\_Care.asp#payment](https://www.va.gov/COMMUNITYCARE/programs/veterans/Emergency_Care.asp#payment).

Veterans who have paid out of pocket for authorized and eligible community care expenses, are typically reimbursed by the provider they paid. Particularly if a Veteran pays out of pocket to a community provider because of a delayed VA community care payment, VA's first course of action is to request a claim from the provider and to pay the applicable amount to them. At that point, the provider will reimburse the Veteran for what the Veteran has paid. VA's payment for authorized community care is considered payment in full, leaving no balance due by the Veteran.

For other types of Veteran out of pocket expense claims, such as for pharmacy orders, the process requires the Veteran to submit to VA a payment receipt along with the provider bill. Typically for these claims, VA will issue reimbursement directly to the Veteran as appropriate.

Status: Complete

Target Completion Date: Not Applicable

***3c. That VA take appropriate action to repair the credit of affected Veterans and lobby for legislation to require credit bureaus to remove derogatory information.***

**VA Response: Concur.** Veterans are encouraged to call VA's Adverse Credit Reporting Hotline 1 (877) 881-7618 when they experience adverse credit reporting activity as a result of delayed payments for VA authorized community care. The toll-free number reaches VA employees trained to resolve credit and collection-specific issues. VA staff work with medical providers to expunge adverse credit reporting for Veterans inappropriately impacted.

VA believes that legislation addressing this recommendation was recently enacted by Public Law (P.L.) 115-174 The Economic Growth, Regulatory Relief and Consumer Protection Act. President Trump signed this law on May 24, 2018. Section 302 of P.L. 115-174 protects Veterans' credit by working to rectify problematic reporting of medical debt included in the Veteran's credit report due to inappropriate or delayed payment of hospital care, medical services, or extended care services provided in a non-VA facility. The law allows consumer reporting agencies to remove Veterans' medical debt from their credit report when proof of liability of debt by the VA is made or documentation provided showing that VA is in the process of making payment for such debt. The legislation allows 1 year for implementation of Section 302. VA will work with the necessary agencies to ensure successful and timely implementation.

Status: In Progress

Target Completion Date: May 2019

***3d. Finally, that VA include a clause in the policy governing community care that would preclude non-VA providers from direct billing of Veterans for eligible services in the future.***

**VA Response: Concur.** VA's activities to ensure proper billing and payment of community care services are supported by the passage of The Choice Act. The Choice Act, P.L. 113-146 as amended, designated that community providers bill VA as the primary payer for care approved under the Choice Act. Similarly, other VA authorities for preauthorization for care now designate VA as the primary payer of care authorized in advance.

It should be noted that as long as a Veteran participates in VCP in accordance with the law – getting pre-authorization to see VCP providers and opting into the program -- they are not responsible for the full cost of these services. However, by law, for non-service connected conditions, Veterans may be liable for a portion of the costs not covered by their Other Health Insurance. If the Veteran uses the Choice card outside the parameters of the law, then the Veteran may be financially liable for the full cost of unauthorized care. VA continues to educate Veterans, providers, and the public about participation in VCP and proper utilization of Choice.

Primarily, VA considers timely payment to community providers the critical factor in precluding community providers from inappropriately billing Veterans for service-connected and authorized health care services. While VA cannot enforce timely payment expectations under current contract conditions, VA does now monitor TPA timeliness statistics and addresses reported deficits with them monthly. Numerous processing improvements implemented over the past 2 years have had a significant impact on TPA payment performance. For the month of June 2018, TriWest processed 97.89 percent of clean claims within 30 days and 99.31 percent total within 45 days and had an average date to payment of 27 days. Health Net, on the other hand, processed 58.3 percent of clean claims within 30 days and 79.9 percent total within 45 days. VA has chosen not to exercise the next contract option year for Health Net, so Health Net services will end September 30, 2018.

Internal VA improvements have also been implemented to accelerate the timeliness of payments VA makes to TPAs. As of January 2018, VA had eliminated the backlog of reimbursement claims to TPAs. VA's Financial Services Center, which processes these VA payments, had implemented additional controls and robust checks, and has maintained a timely payment rate of 99 percent or better.

Looking to the future, VA has included specific requirements and more stringent standards in the Community Care Network Request for Proposal that will further impact the underlying concerns associated with this recommendation. Provider payment timeliness standards are more clearly defined, as are contract incentive/disincentive factors (IDF) for provider education and claims payment and accuracy. The IDF will encourage TPAs to place extra effort towards ensuring that the claim process is easy



for providers to understand and use. As well, it provides an incentive for educating providers to support their submission of accurate and clean claims. As with today's process, VA requirements further stipulate that TPAs may not invoice VA for services for which the community provider has not yet been paid. VA believes that these types of incentives and processing standards will promote payment to providers within 30 days of a clean claim submission, thus improving overall provider satisfaction, payment timeliness, and decreasing the potential for Veterans to be billed for the services. The 30-day payment standard is also one incorporated into the recently signed Mission Act and affects VA payment processes. The Mission Act establishes a prompt payment process that requires VA to pay for, or deny payment for, services within 30 calendar days of receipt of a clean electronic claim or within 45 calendar days of receipt of a clean paper claim.

Status: Complete

Target Completion Date: Not Applicable

## **D. Identifying Military Occupational/Hazardous Exposures**

### **Recommendation:**

**4. That VA capture and document occupational and other hazardous exposures women Veterans encounter during their military service, and develop a comprehensive education program on identification and treatment of adverse health outcomes resulting from such exposures, for VA providers and non-VA providers.**

**Rationale:** As the fastest growing segment of the Veterans population, the number of women Veterans using health care services has tripled since 2000, representing a 203 percent increase over 17 years.<sup>11</sup> By 2020, women Veterans will comprise 11 percent of the total Veteran population, and the vast majority of these women are under the age of 65. Exposure to toxic environmental chemicals and other stressors is ubiquitous in military service, and preconception and prenatal exposure to toxic environmental agents can have a profound and lasting effect on reproductive health across the life course. The evidence that links exposure to toxic environmental agents and adverse reproductive and developmental health outcomes is sufficiently robust, and includes interference with menstruation and ovulation, fertility and fecundity, and menopause, as well as increase risk for malignancy.

Many environmental factors are harmful to reproductive health also disproportionately affect vulnerable and underserved populations, which leaves some populations, including underserved women, more vulnerable to adverse reproductive health effects than other populations. VA currently employs registries to track health outcomes related to six specific exposures, but these do not encompass all the potential hazards to which women Veterans may have been exposed during military service. VA also does not offer routine screening for toxic exposures in the form of blood and urine

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<sup>11</sup> Briefing on Department of Veterans Affairs Women's Health Services, Chief Consultant, Women's Health Services. Meeting of the National Association of State Women Veteran Coordinators. June 27, 2018.

testing, or have a mechanism in place to capture individuals' exposure history as they transition from active service. This information must be available to providers treating women Veterans during the episode of care in order to have the greatest impact. The National Health and Nutrition Examination Survey<sup>12</sup> conducted by the Centers for Disease Control has established average levels of common environmental and occupational hazards in the general population, and could be used as a gender and age adjusted reference for comparison to women Veterans.

It is crucial for VA to institute a universal method to document service related occupational and other hazardous exposures that is easily recognized by treating providers at the point of care, and to educate providers on how to identify and treat the adverse health outcomes resulting from these exposures.

**VA Response: Concur.** Post Deployment Health Services agrees and is working on the individual longitudinal exposure record (ILER) in conjunction with DoD. The pilot is set to be implemented at DoD in September 2018, with VA development to follow in 2019. This tool will allow direct DoD manpower data feed of deployment locations, as well as garrison assignments and include reports and monitoring of environmental exposures. VA is funded for this initial development and is exploring the addition of this concept into the new electronic health record.

The ILER will provide the capability to meet multiple, complex requirements and/or recommendations from the White House, Congress, DoD, and the Institute of Medicine to:

- Create a longitudinal exposure record of Service-related exposures;
- Apply epidemiological research to determine whether deployment-related exposures are associated with post-deployment health outcomes;
- Support clinical care and public health activities;
- Conduct appropriate medical surveillance to detect emerging (latent) health conditions;
- Assist individual Servicemembers and Veterans with Veteran's Affairs disability claims; and
- Create exposure registries based on location, date, time, and agents.

## **E. Non-traditional Treatment for Military Sexual Trauma-related Conditions**

### **Recommendation:**

**5. That VHA provide resources and training to expand available treatment options, as well as research the effectiveness of novel psychotherapeutic and psychopharmacological treatment modalities, for clinical practice in the treatment of military sexual trauma-related conditions.**

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<sup>12</sup> National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/nchs/nhanes/index.htm>.

**Rationale:** Studies have shown that women Veterans experience higher levels of post-traumatic stress disorder than their civilian counterparts, as a result of sexual trauma. Not only do female survivors of military sexual trauma often feel a loss of control, they also have high levels of distrust in interpersonal relationships and the larger military institution. Due to operational demands, as well as military culture in general, they may not be able to avoid the perpetrator, obtain physical safety and distance, or access to their social support system. As a result, the psychological and physical symptomatology is often complex and layered. Additionally, the effectiveness of therapeutic treatment is also dependent on the stage of healing, willingness to engage, and therapeutic rapport.

While there have been studies that show the effectiveness of cognitive processing therapy (CPT) and prolonged exposure (PE)—VA’s gold standards for treating PTSD—the presenting challenges are that these current treatment modalities are focused on cognitive interventions, in which the survivors are not in control of the pace of their recovery. The targeted, one-size-fit-all approach that is provided by manualized treatments, such as CPT and PE, can miss co-occurring problems often seen with PTSD, such as substance use disorder, eating disorders, and depression.

Many theorists found that a multi-modal approach is most beneficial in addressing the complexity of the layers of trauma and impaired functioning. It has been recommended in the literature on sexual assault that mind-body integration utilizing a “top-down bottom-up” approach is most beneficial in treating symptoms associated with trauma. While VA readily provides the “top-down” treatment via CPT and PE, symptoms of PTSD and complex trauma may not be easily resolved through cognitive insight and behavioral interventions. The “bottom-up” approach—such as neural integration, eye movement desensitization and reprocessing (EMDR), somatic experience therapy<sup>13</sup>, sensorimotor psychotherapy, trauma resiliency model, and trauma-focused yoga—engages the nonverbal pathways, such as addressing the neurobiological and somatic needs that are often found in trauma.

While it can be argued that there is a lack of available research that support for or against the recommended treatments, VA should be at the forefront of providing clinically useful treatment modalities and in conducting research to determine the effectiveness of novel treatment interventions in order to provide the best care for our nation’s warriors.

**VA Response: Concur.** VA is committed to radically transforming health care to promote Veterans’ Whole Health<sup>14</sup> and ensure Veteran-centric care. This is a core component of its Strategic Goal focused on empowering Veterans to improve their well-being. Specifically, VA facilities have been actively working to shift from a system designed around *points of medical care* primarily focused on disease management, to a

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<sup>13</sup> Somatic Experiencing for Posttraumatic Stress Disorder: A Randomized Controlled Outcome Study. Danny Brom, Yaffa Stokar, Cathy Lawi, Vered Nuriel- Porat, Yuval Ziv, Karen Lerner, Gina Ross. J Trauma Stress. 2017 Jun; 30(3): 304–312. Published online 2017 Jun 6. doi: 10.1002/jts.22189. Retrieved from: [www.ncbi.nlm.nih.gov/pmc/articles/PMC5518443/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5518443/)

<sup>14</sup> N Engl J Med 2016; 374:1003-1005.

system that is based on a *partnership across time* focused on a Veteran's comprehensive health and well-being. VA uses the term Whole Health to refer to this approach, which empowers and equips Veterans to take charge of their health and well-being and live their life to the fullest. The Whole Health approach strongly embraces multimodal services, including the use of complementary and integrative health (CIH) services, and consists of three components:

- **The Pathway (Empower)** – In partnership with peers and family and loved ones, Veterans explore their personal life mission, aspiration, and purpose. They then develop an overarching personal health plan (PHP) that supports this mission, aspiration, and purpose.
- **Wellbeing Programs (Equip)** – VA facilities have Whole Health programming available to support Veterans' movement forward with their PHP. Services focus on proactive health promotion, self-care, skill building, and support and include CIH approaches such as stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture, and health coaching.
- **Whole Health Clinical Care (Treat)** – In VA, the community, or both, clinicians partner with Veterans to pair conventional treatment and Whole Health services to support the Veteran's PHP and ensure the full range of a Veteran's health and well-being needs are addressed.

Whole Health and CIH approaches may be particularly beneficial for survivors of military sexual trauma (MST) and other traumatic experiences for the reasons discussed in the Recommendation. They offer an important means to address potential barriers to care, ensure that the full range of a Veteran's recovery needs are addressed, and restore a sense of control and choice. The treatment and recovery needs of survivors often evolve over time, and the range of foci, approaches, and modalities offered by CIH, particularly when combined with conventional treatment approaches, provides crucial flexibility to meet Veterans where they are at in their recovery. In adopting a strengths-based, recovery-oriented focus that is not diagnosis or disease-based, Whole Health and CIH undercut some of the messages related to being "damaged" or "weak" that many survivors struggle with after experiencing MST. As such, the general transformation of VA to promote and incorporate CIH services will be of tremendous benefit for MST survivors.

VHA has national policy, implementation, and educational efforts to support expansion of CIH and Whole Health services nationwide. For example:

- In 2017, **VHA Directive 1137 (Provision of Complementary and Integrative Health (CIH))** was approved by the Acting Under Secretary for Health. The CIH Directive establishes policy regarding the provision of CIH approaches including those considered part of the medical benefits package (acupuncture, biofeedback, clinical hypnosis, guided imagery, massage, meditation, tai chi, and yoga).

- In FY 2018, VA will implement a **Whole Health System Demonstration site in each of the 18 Veteran Integrated Service Networks (VISN)**. These demonstration sites will serve as a delivery system for bringing effective, evidence-based CIH therapies and self-care strategies into the care plan of every Veteran.
- **Whole Health Education** courses are offered to VA staff in the areas of: Whole Health in Your Practice, Whole Health in Your Life, Whole Health for Pain and Suffering, Eating for Whole Health, Whole Health Coaching, Whole Health Facilitated Groups, and Whole Health Partner training. A Whole Health for Mental Health course will be developed next year. An internal mindfulness facilitator training is also being offered starting with facilitators from the Whole Health Flagship sites.

In addition to this extensive transformative effort more generally, VHA has also hosted national training opportunities designed to familiarize staff with the benefits and relevance of CIH approaches specifically for their work with Veterans who experienced MST. For example, recent webinars hosted by VHA's national MST Support Team focused on "Yoga, Meditation & Mindfulness for Healing from MST & Maintaining Health," the neurobiology of the experience and recovery from sexual assault, and mind-body practices for recovery from trauma and PTSD. A presentation on "Recovery from MST: Strategies Beyond the Therapy Room" was included in the MST Support Team's 2016 national conference. Staff have responded very positively to these offerings and the MST Support Team continually looks for ways to expand its training and other opportunities in the area of CIH. The expansion and transformation occurring within VHA related to Whole Health will provide a natural vehicle for continuing these efforts.

## **F. Women Veterans Program Managers**

### **Recommendation:**

**6. That VHA review the current activities and utilization of women Veterans program managers (WVPMs) across the enterprise, to identify discrepancies between their intended role as defined in the position description (VHA Handbook 1330.02) and their actual utilization.**

**That VA incorporate dedicated training for Veterans Integrated Service Network (VISN) and facility leadership on the roles and responsibilities of the WVPMs, and their responsibility to ensure that the WVPMs have adequate resources to effectively execute these roles and responsibilities.**

**That VA develop an incentive program, to recognize high performing programs and staff that serve women Veterans.**

**Rationale:** As the WVPMs play a vital role in promoting access to care, conducting outreach to women Veterans in the community, and ensuring that the unique needs of women Veterans are included in planning decisions and operations, it is essential all VISN and facility leadership have a clear understanding of the mandated roles, responsibilities, and expectations of the WVPMs. During recent site visits conducted by the Committee, committee members observed differences in how the WVPMs were integrated into the leadership of both at the facility and the VISN levels. In some facilities, the WVPMs were organizationally positioned to report directly to the facility leadership, as mandated by VHA Handbook 1330.02;<sup>15</sup> in other facilities, the WVPM's organizational position was not aligned properly. VHA Handbook 1330.02 mandates that facility directors are responsible for ensuring that WVPM contact information is publicized in each facility (e.g., on the facility website and accessible through the facility locator web tool). In some facilities, the WVPMs' images were displayed among facility leadership, so women Veterans would be aware of this resource; in other facilities, they were not. Facility directors are responsible for ensuring that the WVPM is full-time, have no collateral duties and have adequate resources to perform their roles. Due to available resources, some WVPMs indicated that limited resources challenged the facilities' ability in guaranteeing these items, and that they were forced to employ creative ways to serve women Veterans; others received adequate support and resources. It is imperative that VHA assess the effectiveness of the program's implementation—to identify discrepancies between the WVPM's intended role, as defined in the position description, and how they are actually used, and to address a reconciliation of the discrepancies.

Additionally, providing an incentive and recognition for high performing programs and staff can provide encouragement to improve performance as well as reinforce best practices.

**VA Response: Concur-in-principle.** VA agrees, VHA Directive 1300.02 which describes the requirements for health care professionals appointed as Women Veterans Program Managers (WVPM) is in concurrence for revision. The Directive clarifies the duties, responsibilities, performance standards, and functional statements for VISN Lead WVPMs and facility WVPMs who are responsible for planning, executing, monitoring, and evaluating the Women Veterans Health Program services at the local level. As part of this Directive release, Women's Health Services (WHS) will present the policy and implementation on nationwide teleconferences with the Office of the Deputy Under Secretary for Health for Operations and Management; WVPMs and Women's Health Medical Directors and Lead WVPMs.

The WVPM position is to be a full-time position without collateral assignments. It is an administrative management position in charge of program development and has direct supervisory reporting to the Facility Director or Chief of Staff.

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<sup>15</sup> Women Veterans Program Manager: VHA Handbook 1330.02. (May 23, 2012). Retrieved from: <https://www.va.gov/vhapublications/publications.cfm?pub=2>

Each VISN Lead WVPM is responsible for leading and coordinating access to the highest quality health care services for women Veterans with multiple disciplines within the VISN.

The VISN Lead WVPM reports directly to the Network Director or Chief Medical Officer, has direct access to top management in the VISN and serves on appropriate administrative and clinical boards or committee. They serve as a vital resource and advisor for programmatic, clinical, or other crucial women Veterans health issues and inquiries within the VISN.

Regarding the role and WVPM organization position, VHA WHS assesses it several ways. From 2010-2016, with contractor support, WHS visited every health care system (140). The primary purpose of this program evaluation was to gauge progress towards the full implementation of comprehensive health care for women Veterans as delineated in VHA Directive 1330.01: "Health Care Services for Women Veterans."

The assessment teams utilized a Capability Review Tool that addressed five essential Women's Health Program domains or components. The Program component assessed the role of the WVPM at each facility, their administrative support, reporting structure, and collateral duties. These assessments and education about the role of the WVPM were shared with facility leadership.

Additionally, WHS conducts an annual survey (the Women's Assessment Tool for Comprehensive Health (WATCH)) that is completed by WVPMs and shared with facility leadership. Also, this tool assesses whether the role of the WVPM is filled, the professional designation of the WVPM, reporting structure, administrative support, and collateral duties.

WVPMs at the facility level are supported and mentored by Lead WVPMs at the VISN, who report to Deputy Field Directors in the Women's Health Services Program Office.

WHS conducts training needs assessments and develops field leader training for WVPMs and VISN Lead WVPMs. The trainings provide them with the most current knowledge and practical skills needed to coordinate and provide high quality care for women Veterans at their facilities. They learn directly from subject matter experts, utilize a community of practice to identify evidence-based practices, and to network with experienced WVPMs and VISN Lead WVPMs to resolve common issues.

One example of this is in August 2018, WHS will host a 3-day summit for VISN Lead WVPMs and Clinical Taskforce Women's Health Medical Directors to develop a consensus of shared priorities for women Veterans; identify strategies to address these priorities and establish key governance and strong practices across all sites of care to advance modernization efforts that align with the needs of women Veterans. At this summit there will be two leadership panels, representing both VA Central Office and field leadership in which the role of the WVPM, leadership engagement, and reporting structure will be highlighted.

## **G. Increased Support for Advisory Committee on Women Veterans' Activities**

### **Recommendation:**

**7. That VA allocate additional resources (funding and staffing) to the Center for Women Veterans, so it will be able to effectively support projected enhancement of Advisory Committee on Women Veterans activities—such as increasing the frequency of regular meetings and conducting focus groups—and enable the Committee to better accomplish its mission.**

**Rationale:** Given the projected increase in the number of women Veterans, as more women are separating from the military, it is imperative that the Committee be able to address any issues or trends that may arise. To do so, it needs to meet on a more frequent basis. The Center for Women Veterans will require additional support, in order to assist the Committee in meeting the future needs of women Veterans. This will likely improve VA's ability to meet women Veterans' needs, and positively impact women Veterans' usage of VA benefits and services.

The Advisory Committee on Women Veterans is Congressionally-mandated to provide advice to the Secretary of Veterans Affairs, on its administration of benefits and services to women Veterans. The Committee receives briefings from VA leadership and subject matter experts during its regular meetings. The information gleaned from these meetings—and policy implantation observed during site visits—are instrumental in crafting recommendations for the Committee's Congressionally-mandated, biennial report. According to the Committee's current charter<sup>16</sup>, the Committee is expected to conduct at least two meetings annually. However, in order for the Committee to have adequate time to develop the members' knowledgebase and craft more in-depth recommendations for its reports, it would need to meet more frequently and possibly conduct focus groups to gather more information about the needs of women Veterans. More frequent meetings would mitigate schedule conflicts and enable members, ex-officio members and advisors more opportunity to participate. This would impact the intensity of the Center's support to the Committee, as there are many processes—mandated by Federal Advisory Committee Act (FACA) and by VA—that comprise the planning/execution/wrap-up components of a FACA meeting. The Center needs an additional full-time staff member to accommodate the increased workload, as well as resources to ensure that its administrative support is more closely aligned with that of other VA advisory committees.

Additionally, Public Law 103-446, section 509<sup>17</sup>, requires the Center's director to advise the Secretary on the effectiveness of VA's inclusion of women and minorities in clinical research, as well as promote the inclusion of health conditions affecting women's health as a part of the Department's medical research program. This information would be extremely beneficial to the Committee, as it creates recommendations and as it assesses the evolving needs of women Veterans.

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<sup>16</sup> 2017 Charter of the Advisory Committee on Women Veterans. Retrieved from: <https://www.va.gov/ADVISORY/Women.asp>

<sup>17</sup> Public Law 103-446, section 509. Retrieved from: <https://www.gpo.gov/fdsys/pkg/STATUTE-108/pdf/STATUTE-108-Pg4645.pdf>



To effectively support this function, the Center needs additional resources to acquire a contractor to provide research support.

**VA Response: Concur in principle.** The Advisory Committee on Women Veterans (Committee) and the Center for Women Veterans (Center) are instrumental in providing recommendations and guidance on the Department of Veterans Affairs' (VA) administration of benefits and services to women Veterans. Each provide insight on the evolving needs of women Veterans and facilitate Enterprise-level discussion on what VA can do to address those needs.

VA is committed to ensuring that those who serve our Nation receive the benefits that they earned through their honorable military service. VA values the Committee's work and is dedicated to ensuring that it has the resources needed to fulfill its Congressionally-mandated function of advising VA on the needs of women Veterans.

Under P.L. 103-446, the Center is required to provide support and administrative services to the Committee. The Center is responsible for all of its internally and externally required activities, including but not limited to planning and facilitating regular meetings and site visits; coordinating with VA's Administrations to acquire responses to the Committee's Congressionally-mandated biennial report recommendations and requests for information; and ensuring that members have adequate opportunities to work and accomplish the Committee's mission.

The Center is an integral part of the Committee's ability to successfully accomplishing its mission. It remains dedicated to providing quality support to the Committee, and continues to work internally and with VA leadership to address the ongoing challenges with resources (staff and funding) that impact its ability to execute the Center's functions in a timely manner--to include those that affect the Committee's activities. VA leadership is engaged in discussion with the Center to ascertain ways to enhance its resources, in an effort to better equip staff to support the Committee's activities and to better equip the Center to carry out its mission. Additionally, the Center is working with a contractor to better align its activities with its Congressional mandate—to include examining staff utilization; developing a solid operations plan; and identifying other resources needed to enable the Center to fulfill its mandated functions.

## **PART III**

### **Appendices**

## **Appendix A**

### **Historical Perspective**

The 1980 Census was the first time that American women were specifically asked if they had ever served in the Armed Forces. In response, 1.2 million women indicated that they had military service. However, very few of these newly identified Veterans used VA services. Congress and VA then began a concerted effort to recognize women Veterans and inform them of their benefits and entitlements. Activities were initiated to increase public awareness about services for women in the military and women Veterans.

Soon after the 1980 Census, Congress granted Veteran status to women who had served in the Women's Army Auxiliary Corps during World War II. In 1982, at the request of Senator Daniel Inouye, the General Accounting Office conducted a study and issued a report entitled: "Actions Needed to Insure that Female Veterans Have Equal Access to VA Benefits." This study found that:

- Women did not have equal access to VA benefits.
- Women treated in VA facilities did not receive complete physical examinations.
- VA was not providing gynecological care.
- Women Veterans were not adequately informed of their benefits under the law.

At the same time, VA commissioned Louis Harris and Associates to conduct a "Survey of Female Veterans: A Study of the Needs, Attitudes, and Experiences of Women Veterans," to determine the needs and experiences of this population. Published in August 1985, the survey found that 57 percent of the women did not know they were eligible for VA services, benefits, and programs. Another particularly troublesome finding was that women Veterans reported twice the rates of cancer as compared to the women in the general adult population, with gynecological cancers being the most common.

In November 1983, Congress passed Public Law 98-160, "Veterans' Health Care Amendments of 1983," mandating that VA establish an Advisory Committee on Women Veterans. Not only were they tasked with assessing the needs of women Veterans with respect to adequate access to VA programs and services, but they were also empowered to make recommendations for change. The Committee was entrusted with the responsibility to follow up on these activities and to report their progress to Congress in a biennial report.

To further ensure that women Veterans had access to VA's benefits and services on par with male Veterans, Congress passed Public Law 103-446 in November 1994, which established the Center for Women Veterans.

The Center for Women Veterans continues to monitor and coordinate VA's administration of benefits and services for women Veterans, and promote cultural transformation, through the Women Veterans Programs (established in 2012) and other collaborative initiatives with Federal/state/local governmental and non-governmental stakeholders.

The following events and data highlight recent Administration, Congressional, VA, and Advisory Committee on Women Veterans efforts to address the needs of Women Veterans.

- 2016** The Women Veterans Call Center implemented a chat feature, to increase access for women Veterans.

The Center for Women Veterans and the VA Women's Health Group launched a new campaign "I'm One: I'm a Veteran," focusing on developing identity and respect for women Veterans.

The Center for Women Veterans partnered with the Veterans Benefits Administration's (VBA) Benefits Assistance Service and Women Veterans Interactive (WVI) on the #StateOfWomenVeterans social media and blogging campaign.

The Center for Women Veterans hosted its inaugural Partners Collaborative Meeting with representatives from Veterans Service Organizations, Military Service Organizations, and non-profit organizations, to engage with the groups to learn how they are working on behalf of women Veterans.

- 2017** Public Law 114-223 authorized VA to offer in vitro fertilization (IVF) to Veterans with a service connected disability resulting in their inability to procreate without the use of fertility treatment. VA published its interim final rule on January 2017; corrected in February 2017.

VA developed a mobile women's health training for rural VA sites, to increase the number of women's health primary care providers and nurses serving rural women Veterans.

VBA's women Veterans coordinators continued their efforts to improve women Veterans' access to VA benefits, by conducting outreach via events, workshops, counseling, and partnerships with community providers and women Veteran organizations.

VBA and the Veterans Health Administration (VHA) participated in a VA sponsored Women Veterans Facebook Live event, held on the Disabled American Veterans Facebook page, focusing on health care, benefits and services.

VA held its first-ever national VA gynecology conference: VA Gynecology Health System - Optimizing Access and Facilitating Best Practices Training, to optimize access to gynecologic services for women Veterans, and to engage gynecologists in creating a high-performance network of providers who are committed to incorporating best practices in their care of women Veterans.

The National Breast Cancer Clinical Task Force developed a Breast Cancer Clinical Pathway that highlights best practices for Breast Cancer Care that can be used as a resource for all providers caring for breast cancer patients, and a breast cancer risk assessment tool for primary care providers.

The Center for Women Veterans partnered with the Veteran Artist Project, to showcase art of 10 women Veterans at 10 VA medical centers around the United States. This powerful narrative showed women Veterans as a key part of the military and active participants in communities across America.

Marked the centennial anniversary of women being allowed to officially join the military during the last 2 years of World War I; approximately 33,000 women served as nurses and support staff and more than 400 nurses died in the line of duty.

The Center for Women Veterans, in collaboration with the Veterans Experience Office, held a National Summit on Women Veterans, in Houston, Texas. The purpose of the Summit was to engage in transparent dialogue about issues impacting women Veterans; share women-focused research and innovations; and connect with community partners.

- 2018** The Center for Women Veterans partnered with Team Red, White, and Blue to create the Women's Athlete Initiative, a traveling photo exhibit highlighting a diverse selection of women Veterans engaged in healthy lifestyle.

The Center for Women Veterans initiated the I Am Not Invisible campaign to enhance cultural awareness in VA Central Office of women Veterans' continued service to Veterans.

VA hosted its first ever Nationwide Baby Shower, a 2 week-long initiative at 60 VA Medical Centers created to honor and support Veterans welcoming new babies into their families in 2018.

## **Appendix B**

### **VA Advisory Committee on Women Veterans**

#### **Current Membership Profiles**

**Command Master Chief Petty Officer Octavia Harris, U.S. Navy (Retired)**, is the current Chair of the Committee. She began her military career in 1982, as a yeoman. She was one of the first women to serve onboard a combatant warship, the USS NIMITZ, where she earned the surface warfare specialist qualification and achieved the rank of chief petty officer. As command senior chief and department head for Amphibious Squadron ONE, she led a staff supporting amphibious warships in direct support of Operation Enduring Freedom and Operation Iraqi Freedom. As command master chief on the USS Pinckney, she became the destroyer's first female enlisted leader--leading a crew in support of direct counter piracy efforts and the Global War on Terror's anti-terrorism efforts. As Command Master Chief of Space and Naval Warfare Systems Command, she was instrumental in the development of the Information Dominance Warfare Program. Her many military decorations include: the Legion of Merit; several meritorious service medals; several Navy and Marine Corps Commendation medals; Global War on Terrorism Expeditionary medal; humanitarian service medals for Hurricane Katrina and counter piracy efforts; and Armed Forces Expeditionary medal. Command Master Chief Harris retired in 2012. She received a bachelor of arts degree in healthcare management from the National University, and a master of science degree in operations management from the University of Arkansas. As a civilian, she was program manager of the Comprehensive Advanced Restorative Effort (CARE) and Naval Medical Center San Diego, where she served on the VA/ DoD joint Interagency Care Coordination Committee (IC3); the board of directors for the San Diego chapter of Women in Defense; and the board of directors for San Diego's Support the Enlisted Project—which supports active duty and Veterans in financial crisis. She is now retired from Federal service and currently serves as a Veterans' advocate and independent consultant.

**Kailyn Bobb** served in the U.S. Air Force from 2002 through 2009, where she was responsible for maintaining information systems network and providing hardware and software support to ensure operation for mission critical tasks in Camp Humphreys, South Korea, and in support of Operations Enduring and Iraqi Freedom. In 2017, she earned a doctorate degree in clinical psychology from Alliant International University-California School of Professional Psychology, focusing on military psychology, trauma, neuropsychology, and research. In her dissertation, titled "Women Veteran Identity and Its Impacts on Preference and Use of VA Health Care Services and Reintegration," she studied the factors that impact women Veteran identity; whether women Veteran identity impacts the use and preference for VA services; and how well women Veterans reintegrate into civilian society after their time in service. Additionally, Dr. Bobb earned a bachelor's degree in chemistry from Loyola University Chicago, a master's degree in psychology from the University of Phoenix; and a master's degree in clinical psychology from the Alliant International University-CSPP.

She is engaged in a research study on Servicemembers with traumatic brain injury and post-traumatic stress disorder at Mather VA Medical Center (VAMC), and is completing a clinical practicum rotation at the Behavioral Health Inpatient Care Unit at Mather VAMC. Dr. Bobb is a Veterans' advocate, especially regarding increased provisions and reducing stigma of mental health in the military community. She is also passionate in bridging the military-civilian divide, by actively educating currently practicing and future mental health professionals on military culture and current issues that Servicemembers, Veterans, and their families face.

**Lieutenant Colonel Kate Germano, USMC (Retired)**, served from 1996 to 2016. Her leadership roles included serving as Marine aide to the Secretary of the Navy; assistant chief of staff, Manpower, Marine Corps Installations Command; commanding officer, 4th Recruit Training Battalion; and presiding officer, Naval Clemency and Parole Board. Lieutenant Colonel Germano received a master's degree in military science from the Command and Staff College, and a bachelor's degree in history/pre-law from Goucher College. She previously served as chief operating officer for Service Women's Action Network (SWAN), a non-profit organization solely focused on supporting the needs of service women and women Veterans. She has authored article for various publications on the impact of the military on women in the services. Lieutenant Colonel Germano continues to serve as a dedicated Veterans advocate.

**Lieutenant Colonel Lisa Kirk, Maryland Air National Guard (Retired)**, graduated from the United States Air Force (USAF) Academy in 1990, where she received a bachelor's of science degree in civil engineering. She also received a doctorate in public health from the Uniformed Services University of the Health Sciences. Lieutenant Colonel Brown served as a biomedical science officer in the USAF, and as a bio-threats issues manager in the Maryland Air National Guard, where she retired in 2012. She was the chief executive officer for Pink to Camouflage, which provided consulting services to federal, state, local governments, and academia that promoted Veterans' health. Lieutenant Colonel Brown is a motivational speaker for Achieve Well Being, where she has developed a model to motivate disabled Veterans, and provide educational seminars to support groups and community partners on achieving well being. She served as a member of the Washington State Department of Veterans Affairs' Women Veterans Advisory Committee, a member of the Whatcom County Veterans Advisory Board, and a Disabled American Veterans Service Officer.

**Chief Warrant Officer Moses McIntosh, U.S. Army (Retired)**, served in both the United States Air Force and the United States Army from 1981-1997. In the United States Air Force, he was stationed in the 51st Bombardment Heavy Squadron Strategic Air Command (SAC), where he served as instructor defense aerial gunner B-52G; promoted optimum use of aircraft defensive fires control systems; and was responsible for operation of the Air Force satellite communication link. In the United States Army, he was stationed with the 498th Medical Evacuation Company, where his leadership experience included serving as rear detachment commander and UH-60 helicopter pilot; providing medical evacuation coverage; serving as executive officer, and project manager; and managing day-to-day operation of the company.

Chief Warrant Officer McIntosh has a master of science degree in human resource management, from Troy State University, and bachelor of science degrees in management from the University of Maryland, and in management studies from Louisiana Tech University. He served more than 21 years in Disabled American Veterans (DAV), in various positions of organizational leadership. He is the immediate past National Commander of DAV, where served as the official spokesman of the 1.3 million member (Veterans and families) organization; testified before legislative bodies on disabled and ill Veterans issues; conducted outreach activities to raise Veterans' awareness of the organization's services and programs; advised the board of directors; and provided leadership to the National Executive Committee (NEC). He also previously served as DAV's Georgia State Commander, where he was responsible for the department's operation and the execution of local DAV programs and services.

**Lieutenant Colonel Shannon McLaughlin, Massachusetts Army National Guard** is a Veteran of Operation Enduring Freedom and currently serves full-time as the Legal Advisor to The Adjutant General, for the Massachusetts National Guard, a two-star general. She is responsible for advising on ethical, administrative, fiscal, operational, and contract law issues as the agency's lead attorney; and is a member of the Sexual Assault Response Board and Executive Diversity Committee. Lieutenant Colonel McLaughlin is trained in the Army's new Special Victim Advocate Program, which provides attorney-level representation and assistance for sexual assault survivors. Lieutenant Colonel McLaughlin has more than 17 years of military service—as a former sailor in the U.S. Navy Reserves and as an officer in the Army National Guard. She earned numerous medals, to include the Meritorious Service Medal, five Army Commendation Medals and several Navy and Marine Corps Achievement Medals. Lieutenant Colonel McLaughlin served on the American Bar Association's Standing Committee for Armed Forces Law, has received numerous awards for her public service, and has a Lesbian Gay Bisexual Transgender courage award for public service from Boston College Law School named in her honor. She also serves part-time as the chief of military justice, where she administers justice and discipline to an 8,200 member force. Lieutenant Colonel McLaughlin is an elected member of the Planning Board for the Town of Sharon, Massachusetts.

**Yareli Mendoza** served in the U. S. Air Force from 2005 through 2010, as a member of security forces. She served as patrolman/desk sergeant at Travis Air Force Base, where she responded to medical and emergency calls; led on-scene rapid response efforts to domestic violence and other community crisis; and compiled investigative and informative reports. She completed three deployments, in both Iraq and Afghanistan, fulfilling various security based missions to include: law and order, detainee operations, perimeter security and visitation. As a student at California State University Fullerton (CSUF), she participated in the CSUF Women Veterans Group and served on CSUF's "Women Veterans in Higher Education" annual conference committee, which provides a network opportunity for women Veterans and connects them with community organizations that provide services. She participated in the *Cal State DC Scholars Program in 2014, where she was assigned to VA's Office of Congressional and Legislative Affairs.*

In that capacity, she conducted legislative research, drafted reports, researched and prepared responses to inquiries, assembled briefing materials for senior level staff for Congressional briefings, and reviewed responses to Congressional inquiries for quality, accuracy, and responsiveness. Ms. Mendoza has a master's degree in public administration from California State University, Fullerton and is currently pursuing a doctor of philosophy degree in higher education and student affairs, with a specialization in higher education administration and policy at the University of Iowa.

**Colonel Karen O'Brien, USA (Retired)**, has 27 years of military service as a family physician--in the USAF and the USA—and has served at many levels in the military health care system, from administering family care and delivering babies, to writing Army-wide policy. Colonel O'Brien received a doctor of medicine degree from Uniformed Services University of the Health Sciences, in 1991. She served as Vice Chief of the Army's Suicide Prevention Task Force Council and the American Academy of Family Physicians' Commission on Health. Among her many leadership roles, Colonel O'Brien served as command surgeon for US Army Training and Doctrine Command; deputy surgeon for US Forces in Afghanistan; deputy commander for Madigan Army Medical Center in Tacoma, WA; and chief of Strategic Development of Warrior Care. She currently serves as a part-time compensation and pension physician for the Veterans Benefits Administration in American Lake, WA.

**Keronica Richardson** served in the U.S. Army from 2004 through 2013, where she served in various positions of leadership. She enlisted in the U.S. Army and then commissioned through Reserve Officer Training Corps. While enlisted, she was stationed at Fort Lee, VA and deployed to Iraq, Afghanistan, and Kuwait. She served as an operations team leader of a combat organization in Iraq and Kuwait, supervising the processing of U.S. and coalition force deceased personnel, and serving as convoy commander responsible for the efficient and safe movement of personnel and equipment across Iraq, Afghanistan, and Kuwait. As deputy manager, she was accountable for the synchronization of operations and logistical functions. As operational planning coordinator, she oversaw all aspects of training management, was appointed investigating officer, and managed deployment plans. While serving in the U.S. Army Judge Advocate Corps, she was a legal assistant, where she assisted in solving complex criminal law and family law prosecutions—from the discovery phase through the trial phase. Following her military service, she served in various positions to further her legal and Veterans policy experience, to include: a judicial extern for the Mecklenburg County Courthouse in Charlotte, NC; a legal intern for Piemonte Law Firm in Charlotte, NC; and Congressional fellow for Senator Joe Donnelly, serving as assistant military legislative assistant. Ms. Richardson earned a juris doctorate from Charlotte School of Law in 2015, completed a study abroad program in criminology at University of Oxford, Magdalen College in 2013, and received a bachelor of arts in public relations from Claflin University in 2008. Currently, Ms. Richardson serves as the Assistant Director for Women and Minority Veterans Outreach at The American Legion.



Among her duties are: monitoring and analyzing legislation impacting women Veterans; keeping women Veterans abreast of emerging policies for women and minority Veterans; advocating for women and minority Veterans; building trusted relationships with Congressional members, VA, and women support groups in the community.

**Commander Janet M. West** has served over 10 years in the U.S. Navy, to include serving three combat deployments as a flight surgeon to Iraq, Afghanistan, and the Horn of Africa. During her career, she has provided comprehensive primary care, including women's health and behavioral health, for Servicemembers and Veterans. She participated in the transition of two U.S. Navy primary care clinics to patient centered medical homes; both facilities successfully attained National Committee on Quality Assurance Level III recognition and significantly improved patient satisfaction, access to care, and multiple population health quality metrics. Commander West received a bachelor of arts degree in biochemistry from Hamline University in 2000, and a doctor of medicine degree from the University of Minnesota in 2005. She completed residency training in family medicine at Naval Hospital Pensacola in 2006, then practiced as a staff family physician at Naval Hospital Pensacola (2011-2014), Naval Hospital Jacksonville, and associated branch clinics (2014 to present). Her professional affiliations include the American Medical Association, American Academy of Family Physicians, and the Uniformed Services Academy of Family Physicians. Currently, Commander West serves as senior medical officer at Jacksonville Naval Air Station.

**Colonel Wanda Wright, USAF (Retired)**, graduated from the U.S. Air Force Academy in 1985. Throughout her military career, she has served in various positions of leadership—to include the Arizona Air National Guard and the Arizona National Guard. She was also selected to command Air Force personnel on a southwest border mission, in support of Operation Jump Start. As executive director of the Arizona Air National Guard, she developed and coordinated policies, instructions, and procedures, and provided project management for the wing commander. As director of staff for the Arizona National Guard, Colonel Wright served as the principal full-time spokesman of Air National Guard senior leadership; developed long range strategic plans and programs and executed short term objectives; wrote definitive policies based on staff analysis; directed compliance on all regulatory mandates; managed all Arizona Air National Guard military personnel issues (2500 personnel); and initiated contact and maintained liaison with public officials and civic groups. She has the distinction of being the first African American female Colonel in the history of the Arizona National Guard. She retired in 2011, after 26 years of service. In 2015, she was selected by the governor of Arizona Governor to be the Director of Veterans Services for Arizona. Colonel Wright has a bachelor's degree in general engineering and financial management from the U.S. Air Force Academy, a master's degree in business administration from Webster University, a master's degree in public administration, and is currently pursuing a master's degree in educational leadership.

**Colonel Betty Yarbrough, USA (Retired)**, was commissioned a Second Lieutenant in the Quartermaster Corps. She received a bachelor's degree in business administration from Arkansas Tech University, a master's degree in logistics management from Florida Institute of Technology, and a master's degree in national resource strategy from National Defense University. Her extensive military career included: deployment in support of Operations Desert Shield/Desert Storm; deployment and participation in Operation Iraqi Freedom; service as the assistant executive officer to the Director of the Army Staff; and service as the Army National Account Manager in the Defense Logistics Agency, where she served in Operation Enduring Freedom. She is the immediate past military director of the Defense Advisory Committee on Women in the service, where she served as the primary advisor to the Secretary of Defense for Personnel and Readiness on all matters pertaining to women in the armed forces. During this time she also served as ex-officio member of the Department of Veterans Affairs Advisory Committee on Women Veterans. Colonel Yarbrough retired in 2015.

## **Appendix C**

### **Summary of Site Visits for (2016-2017)**

The Advisory Committee on Women Veterans (Committee) generally conducts an annual site visit to a VA health care facility that has an active program for women Veterans. The site visit provides an opportunity for Committee members to compare the information that they receive from briefings by VA officials with actual practices in the field. In an effort to observe how VA provides services for women Veterans in diverse geographical settings, the Committee visited an urban and a rural location. The Committee had two site visits during this timeframe.

#### **San Diego, CA:**

The Committee conducted a site visit on September 19-23, 2016, in San Diego, CA. During this site visit, the Committee received overview briefings from the San Diego VA Medical Center leadership, the women Veterans program manager, and other medical center staff on programs and services for Veterans in the area; participated informational tours of the San Diego VA Medical Center, and the Mission Valley Clinic; attended the VA's National Veterans Summer Sports Clinic, hosted by the San Diego VA Medical Center; toured the San Diego VA Regional Benefit Office, the Fort Rosecrans National Cemetery, and the Miramar National Cemetery; and conducted a town hall meeting with local women Veterans and other stakeholders.

#### **Muskogee, OK:**

The Committee conducted a site visit on September 18-22, 2017, in Muskogee, OK. During this site visit, the Committee received overview briefings from the Jack C. Montgomery VA Medical Center leadership, the women Veterans program manager, and other medical center staff on programs and services available for Veterans in Muskogee. The Committee participated in informational tours of the Jack C. Montgomery VA Medical Center, the Fort Gibson National Cemetery, and the Muskogee Regional Benefit Office, the Ernest Childers VA Outpatient Clinic, and the Tulsa Vet Center. Additionally, the Committee conducted a town hall meeting with local women Veterans and other stakeholders.

## **Appendix D**

### **Briefings to the Advisory Committee on Women Veterans (2016-2018)**

The Advisory Committee received the following briefings during the period covered by this report:

#### **Office of the Secretary and Center for Women Veterans (CWV)**

- Center for Women Veterans Initiatives, Kayla Williams, Director, Center for Women Veterans/ Designated Federal Officer (DFO), Advisory Committee on Women Veterans; May 2017, May 2018.
- Presentation of Certificates of Appreciation and Comments, Scott R. Blackburn, Interim Deputy Secretary of Veterans Affairs; May 2017.
- Presentation of Certificates of Appreciation and Comments, The Honorable Robert Wilkie, Acting Secretary of Veterans Affairs; May 2017.

#### **Veterans Benefits Administration (VBA)**

- Update on Benefit Assistance Service's Women Veterans Initiatives and Outreach, Margarita Devlin, Director, Benefit Assistance Service; May 2017, May 2018.

#### **Veterans Health Administration (VHA)**

- Entrance Briefing/Welcome of Leadership and Introduction, Dr. Robert M. Smith, Director, VA San Diego Healthcare System (VASDHS); September 2016.
- Overview of San Diego VA Facilities/Programs/Demographics, Dr. Robert M. Smith, Director, Dr. Kathleen Kim, Acting Chief of Staff, Carmen Concepcion, Associate Director for Patient Care Services and Nurse Executive, Cindy Abair, Associate Director, Ada YC Clark, Assistant Director, VASDHS; September 2016.
- Overview of VASDHS Women Veterans Program/ Women's Health/ Gynecology Services/Maternity Care, Jennifer Roberts, Women Veterans Program Manager, Dr. Meredith Barnes, Medical Director, Women's Health, Dr. Deborah Arsenault, Gynecologist, Melanie Krupa-Kelly, Maternity Care Coordinator, VASDHS; September 2016.
- Briefing on Transition and Care Management (TMC), Kym Grey, Program Manager, TCM, VASDHS; September 2016.
- Briefing on Suicide Prevention, Dawn Miller, Social Worker, Suicide Prevention Coordinator, VASDHS; September 2016.
- Briefing on Mental Health, Dr. Niloo Afari, Acting Associate Chief of Staff, Mental Health Services, VASDHS; September 2016.
- Homeless Veteran Program, Cara Franke, Homeless Veteran Program Manager, VASDHS; September 2016.
- Caregiver Support Program, Deena Brooks, Coordinator, VASDHS; September 2016.
- Telehealth Program, Dr. Nilesh Shah, Director, Telehealth, VASDHS; September 2016.

- One VA Community Advocacy Board (CAB), John Meyer, Representative, One VA CAB; September 2016.
- Veterans Choice, Ray Deal. Jr., Assistant Chief, Health Administration Service, VASDHS; September 2016.
- VA 101, Gary S. Walters, Program Manager, Performance Improvement
- Office of Enterprise Integration; Marvin Cornish, Protocol Officer, DC VA Medical Center; May 2017.
- Identification and Treatment of Eating Disorders in Women Veterans: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #1), Dr. Susan McCutcheon, National Mental Health (MH) Director, Family Services/Women's MH/Military Sexual Trauma; May 2017.
- Overview of VA Canteen Service and Collaborative Women Veterans Initiatives Lori Lee, Assistant Chief Merchandising Officer, Veterans Canteen Service; May 2017.
- Veteran Peer Support Specialist Pilot Program: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #5), Dan O'Brien-Mazza, National Director, Peer Support Services, Mental Health Services; May 2017.
- Overview of the Office of Academic Affiliations, Dr. Kathleen Klink, Director, Health Professions Education, VA Office of Academic Affiliations; May 2017.
- VA's National Academic Affiliations Council, Stephen K. Trynosky, DFO, National Academic Affiliations Council; May 2017.
- Update on Choice Program and Veterans Health Administration Initiatives, Kristin Cunningham, Executive Officer to the Deputy Under Secretary for Health for Community Care; May 2017.
- Access to Gender-specific Prosthetic Care: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #2), Penny Nechanicky, National Director, Prosthetics and Sensory Aids Service; May 2017.
- In Vitro Fertilization: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #3); Women's Health Initiatives, Dr. Patricia Hayes, Chief Consultant, Women's Health Services; May 2017.
- Overview of the VA Voluntary Service (VAVS) National Advisory Committee, Sabrina Clark, Director, VAVS; May 2017.
- Project Community Homelessness Assessment, Local Education and Networking Groups (CHALENG), Mary O'Malley, Senior Project Manager, Office of Homeless Programs; May 2017.
- Entrance Briefing/Welcome of Leadership and Introduction, Jonathan Plasencia, Acting Medical Center Director, EOVAHCS; September 2017.
- Overview of Eastern Oklahoma VA Health Care System/Programs/Demographics, Jonathan Plasencia, Acting Medical Center Director, Dr. Nasreen Bukhari, Acting Chief of Staff, Dr. Bonnie Pierce, Associate Director of Patient Care Services, EOVAHCS; September 2017.
- Overview of VISN 19 Women Veterans Services, Jonna Brenton, Lead Women Veterans Program Manager, VISN 19; September 2017.

- EOVAHCS Women's Health Program, Susan Hartsell, Women Veterans Program Manager, Dr. Tuana Diep, ACOS/ Co-Chief Primary Care, Women's Health Clinical Champion, Dr. Doug Raymer, Women's Health Medical Champion, Ms. Lottie Goff, Women's Health Liaison, Nurse Manager Muskogee PACT, Chaplain Nancy McCoy, Women's Health Chaplain, EOVAHCS; September 2017.
- Care in the Community (CITC), Gene Richison, Acting Chief, CITC, EOVAHCS; September 2017.
- OEF/OIF/OND Program, Padgett Beatty, OEF/OIF/OND Program Manager, EOVAHCS; September 2017.
- Tele-Health Services, Lynette Gunn, Nurse Manager, Tele-Health, EOVAHCS; September 2017.
- Primary Care/Mental Health Integration, Tom Potter, Social Worker, EOVAHCS; September 2017.
- Suicide Prevention Program, Patty Parmeter, Suicide Prevention Coordinator, EOVAHCS; September 2017.
- Mental Health Intensive Case Management (MHICM) Program, Jackie Chambliss, MHICM Program Manager, EOVAHCS; September 2017.
- Homeless Program, Melanie Goldman, Homeless Program Manager, EOVAHCS; September 2017.
- Military Sexual Trauma (MST) Program, Dr. Patty Byrd, MST Coordinator/Staff Psychologist, EOVAHCS; September 2017.
- Update on Women's Health Services, Dr. Patricia Hayes, Chief Consultant, Women's Health Services, VHA; May 2018.
- Gender-specific Prosthetic Care: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #2), Penny Nechanicky, National Director, Prosthetics and Sensory Aids Service, VHA; May 2018.
- Eating Disorders in Women Veterans: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #1)/ VA-DoD Women's Mental Health Mini-Residency/Parenting STAIR Program, Dr. Susan McCutcheon, National Mental Health (MH) Director, Family Services/Women's MH/Military Sexual Trauma, VHA; May 2018.
- Update on Choice Program, Dr. Gene Migliaccio, Executive Director, Delivery Operations, VHA; May 2018.
- Update on Veterans Health Administration Initiatives, Dr. Carolyn Clancy, Executive in Charge, VHA; May 2018.
- Overview of Strategic Capital Investment Planning (SCIP) Process, Vinay Gupta, Management Analyst, Capital Asset Policy, Planning and Strategy Service, OAEM, Ed Litvin, Director, Office of Capital Asset Management Engineering and Support, VHA; May 2018.
- Briefing on Women Veterans Research, Dr. Elizabeth Yano, Director, VA Health Services Research and Development (HSR&D), Center of Innovation, VA Greater Los Angeles Healthcare System, Dr. David Atkins, Director, VA HSR&D Service, VHA; May 2018.

### **National Cemetery Administration (NCA)**

- Pre-need Determination of Eligibility Program, Eric Powell, Director, Memorial Products Service, Office of Cemetery Operations and Field Programs, National Cemetery Administration (NCA); May 2017.
- Veterans Legacy Program, Bryce Carpenter, Educational Outreach Programs Officer, Office of Management; May 2017.
- Women Veterans Monuments, Jessica Tozer, Transformation, Technology and Data Management; May 2017.
- Update on National Cemetery Administration Initiatives, Kimberly Wright, Executive Director, Field Programs, NCA; May 2018.

### **Homeless Veterans**

- Definition of Homelessness: Update on 2016 Report of the Advisory Committee on Women Veterans (Recommendation #7), Mary O'Malley, Senior Project Manager, Office of Homeless Programs; May 2017.
- Homelessness Among Women Veterans, Dr. Ann Elizabeth Montgomery, Researcher, VA National Center on Homelessness Among Veterans/Health Science Specialist, Birmingham VA Medical Center, HSR&D, VHA; May 2018.

### **Office of General Counsel**

- VA's Medical Legal Partnerships and Assistance for Women Veterans, Lara K. Eilhardt, Special Advisor, Veterans' Access to Legal Services, Office of the General Counsel; May 2017.

### **Board of Veterans Appeals**

- Briefing on New Web Tool Tracking Appeals/Brief Overview of Board of Veterans Appeals, The Honorable Cheryl Mason, Chairman, Board of Veterans Appeals, May 2018.

### **Office of Congressional and Legislative Affairs**

- Update on Legislative Initiatives Impacting Women Veterans, Christopher O'Connor, Acting Assistant Secretary, Congressional and Legislative Affairs; May 2017.

### **Rural Health**

- Telehealth Program for Rural Veterans with Post Traumatic Stress Disorder, Dr. John Fortney, Principal Investigator, Virtual Specialty Care QUERI/Core Investigator, HSR&D Center of Innovation for Veteran-Centered and Value-Driven Care, VA Puget Sound Health Care System, VHA; May 2018.

## **Appendix E**

### **2017 Charter of the Advisory Committee on Women Veterans**

#### DEPARTMENT OF VETERANS AFFAIRS CHARTER OF THE ADVISORY COMMITTEE ON WOMEN VETERANS

1. OFFICIAL DESIGNATION: Advisory Committee on Women Veterans (Committee)
2. AUTHORITY: The Committee is authorized by statute, 38 United States Code (U.S.C.) § 542, and operates under the provisions of the Federal Advisory Committee Act, as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITY: The Committee provides advice to the Secretary with respect to the administration of benefits by the Department of Veterans Affairs (VA) for women Veterans; reports and studies pertaining to women Veterans; and the needs of women Veterans with respect to health care, rehabilitation benefits, compensation, outreach, and other relevant programs administered by VA.
4. DUTIES OF THE COMMITTEE: In carrying out its primary responsibility of providing advice to the Secretary of Veterans Affairs, the Committee will provide a report to the Secretary not later than July 1 of each even-numbered year, which includes (1) an assessment of the needs of women Veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by VA; (2) a review of the programs and activities of VA designed to meet such needs; and (3) such recommendations (including recommendations for administrative and legislative action) as the Committee considers appropriate.
5. OFFICIAL TO WHOM THE COMMITTEE REPORTS: The Committee reports to the Secretary through the Director, Center for Women Veterans.
6. OFFICE RESPONSIBLE FOR PROVIDING SUPPORT TO THE COMMITTEE: The Center for Women Veterans is responsible for providing support to the Advisory Committee on Women Veterans.
7. ESTIMATED ANNUAL OPERATING COSTS IN DOLLARS AND STAFF-YEARS: The estimated annual operating costs for the Committee are \$243,102 and .75 staff-years. All members will receive travel expenses and a per diem allowance, in accordance with the Federal Travel Regulation, for any travel made in connection with their duties as members of the Committee.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO), a full-time VA employee, will approve the schedule of Committee meetings. The DFO, or a designee will be present at all meetings, and each meeting will be conducted in accordance with an agenda approved by the DFO. The DFO is authorized to adjourn any meeting, when he or she determines it is in the public interest to do so.



9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Committee is expected to meet at least two times annually.

10. DURATION: There is a continuing need for the Committee to assist the Secretary in carrying out the responsibilities under 38 U.S.C. § 542.

11. TERMINATION DATE: Authorized by law for an indefinite period, the Committee has no termination date.

12. MEMBERSHIP AND DURATION: By statute, the Committee shall consist of members appointed by the Secretary from the general public, including representatives of women Veterans; individuals who are recognized authorities in fields pertinent to the needs of women Veterans, including the gender specific health care needs of women; representatives of both female and male Veterans with service-connected disabilities, including at least one female Veteran with a service-connected disability and at least one male Veteran with a service-connected disability; and women Veterans who are recently separated from service in the Armed Forces. The Committee shall include ex officio members, as specified in 38 U.S.C. § 542, representing the Secretary of Labor (or designee), the Secretary of Defense (or a designee), the Under Secretary for Health (or a designee) and the Under Secretary for Benefits (or designee). The Secretary shall determine the number and terms of service of members of the Committee—except that a term of service of any such member may not exceed 3 years—and may reappoint any such member for additional terms of service.

The Committee will be comprised of not more than 12 members. Several members may be Regular Government Employees, but the majority of the Committee's membership will be Special Government Employees.

13. SUBCOMMITTEES: With the DFO's approval, the Committee is authorized to establish subcommittees to perform specific projects or assignments as necessary and consistent with its mission. The Committee Chairperson shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership and estimated duration. The objectives of the subcommittees are to make recommendations to the chartered Committee with respect to particular matters related to the responsibilities of the chartered Committee. Such subcommittees may not work independently of the chartered Committee and must report their recommendations and advice to the full committee for full deliberation and discussion. Subcommittees have no authority to make decisions on behalf of the parent Committee, nor can they report directly to VA.

14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 6.2 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C. § 552.

15. DATE CHARTER IS FILED:

Approved: David J. Shulkin, M.D. Date: SEP 29 2017  
David J. Shulkin, M.D.  
Secretary of Veterans Affairs

## Appendix F

### Center for Women Veterans Mission and Goals



#### Contact Us:

U. S. Department of Veterans  
Affairs  
Center for Women Veterans  
(00W)

810 Vermont Avenue, NW  
Washington, DC 20420

Phone: 202-461-6193  
Fax: 202-273-7092

<http://www.va.gov/womenvet>  
[00W@va.gov](mailto:00W@va.gov)



# Center for Women Veterans

The Center for Women Veterans was established by Congress in November 1994 by P. L. 103-446

#### Our Mission

- Monitor and coordinate VA's administration of health care and benefits services, and programs for women Veterans.
- Serve as an advocate for a cultural transformation (both within VA and in the general public) in recognizing the service and contributions of women Veterans and women in the military.
- Raise awareness of the responsibility to treat women Veterans with dignity and respect.

#### Our Activities

- The Director serves as primary advisor to the Secretary on Department policies, programs, and legislation that affect women Veterans.
- Monitor and coordinate with internal VA offices on their delivery of benefits and services to women Veterans.
- Liaison with other Federal agencies, state and local agencies and organizations, and non-government partners.
- Serve as a resource and referral center for women Veterans, their family and their advocates.
- Educate VA staff on women Veterans' military contributions.
- Ensure that outreach materials portray and target women Veterans with images, messages, and branding in the media.
- Promote recognition of women Veterans' military service and contributions by sponsoring activities and special events.
- Coordinate meetings of the Advisory Committee on Women Veterans.

#### Where To Get Help

- **Women Veterans Call Center:** Is your guide to VA. Contact 1-855-VA-WOMEN (1-855-829-6636) for assistance. Hours of operation are Mon-Fri, 8:00am—10:00pm (ET), and Sat, 8:00am—6:30pm (ET).
- **Benefits:** Designated women Veterans coordinators (WVC) can be contacted at your nearest VA regional office to assist with claims. Contact 1-800-827-1000; visit their website at <http://www.benefits.va.gov/benefits/> for more information.
- **Homeless:** National Homeless Call Center for Homeless Veterans can be reached at 1-877-424-3838. Homeless Veterans coordinators can be located at <http://www.va.gov/homeless/index.cfm>
- **Crisis Hotline:** To help a Veteran in crisis, call the Crisis Hotline at 1-800-273-8255, press option 1 and you will be connected to a skilled, trained counselor at a center in your area, anytime 24/7. You can also confidentially chat, by texting 838255 to get help now, or visit the website at <https://www.veteranscrisisline.net/>

- **Health Care:** Full-time women Veterans program managers (WVPM) are located in VA health care facilities across the country. WVPM can assist women Veterans with accessing VA's health care services. Visit <http://www.womenshealth.va.gov>
- **Locating the nearest VA Medical Center:** VA medical facilities can be found across the country. Visit <http://www.va.gov> or call the regional office at 1-800-827-1000 for assistance locating a facility.
- **Minority:** Minority Veterans program coordinators are at every VA healthcare facility, regional office, and national cemetery. For more information, please visit their website at <http://www.va.gov/centerforminorityVeterans/>
- **Access to Patient Medical Information:** My HealtheVet is VA's online health record system designed to help VA Patients manage their healthcare records from medical providers. Contact 1-877-327-0022 or visit their website at <https://www.myhealth.va.gov/index.html>
- **VA for Vets:** VA for Vets is designed to help you successfully transition from military service to civilian careers and can be contacted at 1-855-824-8387 or via the web at <http://vaforvets.va.gov/>
- **Home Loan Assistance:** VA helps Servicemembers, Veterans, and eligible surviving spouses become homeowners. As part of our mission to serve you. Contact 1-877-827-3702 or via the web at <http://www.benefit.va.gov/homeloans/index.asp>
- **Education and Training:** For information on the Post 9/11 GI Bill contact 1-888-442-4551 or visit the website at <http://www.GIBILL.va.gov>

## Legislation Related to Women Veterans

- P.L. 111-163, "Caregivers and Veterans Omnibus Health Services Act of 2010," provides contract for a comprehensive study on barriers to health care for women Veterans, pilot program to provide group readjustment counseling in retreat settings for newly separated women combat Veterans, mandates inclusion of recently separated women on Advisory Committees for Women Veterans, and requires VHA to carry out a 2 year pilot program to assess feasibility and advisability of offering child care to Veterans.
- P.L. 110-186, "Military Reservist and Veterans Small Business Reauthorization and Opportunity Act," established a Women Veterans business Training Resource Program.
- P.L. 108-422, "Veterans Health Improvement Act of 2004," extended VA's authority permanently to extend Military Sexual Trauma counseling and treatment to active duty service members or active duty for training.
- P.L. 107-330, "Veterans Benefits Act of 2002," authorized special monthly compensation for women Veterans who lost 25 percent or more of tissues from a single breast or both breast in combination (including loss by mastectomy or partial mastectomy) or has received radiation of breast tissues.
- P.L. 106-419, "Veterans Benefits and Healthcare Improvement Act of 2000," authorized special monthly compensation for women Veterans with a service connected mastectomy. It also authorized benefits to children born of mothers who served in Vietnam and who have certain types of birth defects.
- P.L. 113-146, The Veterans Choice Act of 2014 closed an eligibility gap for military sexual trauma (MST), permitting Veterans of the National Guard/Reserves to receive VA care related to experiences of MST during inactive duty training.