



**Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans (ACWV)
Virtual Meeting
December 14-16, 2021**

The Advisory Committee on Women Veterans (ACWV) met via video-teleconference; Betty Yarbrough, Chair, presiding.

ACWV Members Present:

COL Betty Yarbrough, USA, Ret., Chair
FLTCM April Beldo-Lilley, USN, Ret.
CMDCM Octavia Harris, USN, Ret.
MG Marianne Mathewson-Chapman, USA, Ret.
CW2 Moses McIntosh, Jr., USA, Ret.
LTC Shannon McLaughlin, Massachusetts Army National Guard, Benefits Vice Chair
Sandra Miller, USN Veteran
MSG Lachrisha Parker, USAR, Ret.
COL Wanda Wright, USAF, Ret.

ACWV Ex-Officio Members Present:

CAPT Michelle Braun, Medical Affairs Branch, U.S. Public Health Service
Dr. Patricia Hayes, Office of Women's Health (OWH), Veterans Health Administration (VHA)
Meg O'Grady, Veterans Employment and Training Service (VETS), U.S. Department of Labor (DOL)
Dr. Lawrencia Pierce, Office of Transition and Economic Development, Veterans Benefits Administration (VBA)

Center for Women Veterans (CWV) Staff Present:

Lourdes Tiglaio, CWV Executive Director/Designated Federal Officer (DFO)
Elizabeth Estabrooks, CWV Deputy Director/ Alternate DFO
Shannon Middleton, Alternate DFO/Committee Manager
Ana Claudio
Julia Kelly
Missina Schallus
Michelle Terry

Other VA Staff:

Dr. LeAnn Bruce, Intimate Partner Violence Assistance Program, VHA
Edith Davis, VA Spokane Health Care
Elaine Westermeyer, St. Petersburg Regional Office
James Albino, Center for Minority Veterans
Kimberly Kinerd, VA Central Texas Healthcare System
Amanda Haverkamp, VHA
Leanna Lynch, VA Bedford Healthcare System
Maggie Callahan, Albany VA Medical Center Research Service

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Minnie Bowie-Garcia, VA Central Texas Healthcare System
Nancy Dailey, VA Salt Lake City Health Care System
Yvonne Grissett, VA Washington DC Healthcare System

Public Guests:

Alfreda Goods
Casey Nash, Disabled Veterans National Foundation
Cassie Ricci, GE Healthcare
Elizabeth Cooper, Pennsylvania Department of Labor and Industry
Eunice Garcia, U.S. Digital Service
Janette Krolczyk, Pennsylvania Department of Military and Veterans Affairs
Janice Jann Campbell
Jessica Bradley, U.S. Department of the Navy
Karen Harrop, Dynamic Integrated Services
Kourtney Hopkins, Illinois Department of Veterans Affairs
Amy Thurston, Organon
LaTalya Jenkins, Veterans Business Committee
Lauryn Formey
Lindsey Stanford, Government Affairs Specialist, Wounded Warrior Project
Marie Black, The American Legion
Marsha Lilly, U.S. Army Reserve
Misty O'Kane, State of Tennessee
Nestor Aliga, Disabled American Veterans
Rene Campos, Military Officers Association of America
Roslyn Jones, Maryland Department of Veterans Affairs
Sheena Linville, Indiana Department of Veterans Affairs
The Honorable Su Ryden, Colorado General Assembly
Telisha Reinhardt, Southern Illinois University Edwardsville
Theresa Wrzesinski, U.S. Senate Veterans' Affairs Committee
Kim Moore
Lauren Mosteller, U.S. Government Accountability Office
Matejka Baumgardner, U.S. Department of Labor
Cathy Santos, National Alliance of Women Veterans, Inc./ Women Veterans Business Solutions, LLC
Sharron Stewart, Texas Veterans Commission
Patricia Jackson-Kelley, National Association of Black Military Women

Tuesday, December 14, 2021

Open Meeting/Introductions/Approve Minutes/Committee Discussion

Betty Yarbrough (Colonel, U.S. Army, Retired), Chair, ACWV

The Chair called the meeting of the Advisory Committee on Women Veterans (ACWV) to order at 10:01 am EST. The ACWV works diligently to improve women Veterans' access to benefits and services at the U.S. Department of Veterans Affairs (VA). During today's meeting, the ACWV will discuss the status of recommendations from its 2020

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report. ACWV members, ex-officio members, advisors, and staff introduced themselves. A motion to approve the minutes was made by Wanda Wright and seconded by Ms. Harris. The Committee voted unanimously to approve the minutes.

Update on 2020 ACWV Report Recommendation #2

Ricardo Da Silva, Program Integration Officer, Education Service, VBA

Mr. Da Silva presented an update on VBA's work to address recommendation 2 of the 2020 ACWV report. The recommendation reads as follows: that the Veterans Benefits Administration's (VBA) Education Service collaborate with the Veterans Experience Office to examine barriers that exist for women Veterans, in relation to accessing education benefits across all formats (traditional/online/hybrid academic environments), enrollment in academic programs, and continuation of higher education.

Since July 2020, VBA has been working with the Veterans Experience Office (VEO) to establish and distribute VSignals surveys. These surveys collect data on Veterans' experiences with VA and GI Bill and are completed at three key milestones during an individual's GI Bill journey: application for benefits, enrollment in school, and receipt of benefits. In the past year, VBA delivered over 700,000 surveys and received 38,000 responses. The male Veterans' response rate was 2.5 times that of women Veterans; VBA is exploring ways to increase the women Veteran response rate.

VBA generates a monthly beneficiary listening report using data collected from social media, calls made to the Education Call Center and meetings with stakeholders to be able to proactively identify and address any trends or issues. VBA is partnering with Accenture Federal Services, VA's Office of Information and Technology and others to modernize the GI Bill systems under the Digital GI Bill program. Improvements aim to modernize the user experience for both Veterans and schools and are informed by feedback collected from VSignals surveys and beneficiary listening reports. VBA is also working to better target communications and outreach to key moments in the GI Bill process.

Mr. Da Silva provided an overview of trends identified in the collected VSignals data. The data indicates a positive relationship between women Veterans and VA. Overall, women Veterans rated their experience and satisfaction levels higher than male Veterans. Women Veterans also rated VA's transparency and equity higher than male Veterans, which indicates that, in general, women Veterans feel that VA is delivering benefits transparently and with equity. Women Veterans generally rated VA highly in terms of providing resources needed to help beneficiaries feel secure in their benefits; this indicates that VA's information campaigns have been effective. Male Veterans reported a higher satisfaction rate than their women Veteran counterparts regarding school assistance in submitting a certificate of eligibility; VBA plans to explore the cause of and ways to address this disparity.

Protections allowing VA to pay student beneficiaries the resident versus the online rate have been put in place due to the COVID-19 pandemic. These protections expire on December 21, 2021; however, legislation to extend the protections to June 1, 2022 has

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passed the House of Representatives and is currently in the Senate. VBA anticipates that this legislation will pass the Senate and has prepared messaging regarding this extension. The Isakson and Roe Act of 2020 expanded the Veterans Technology Education Courses (VET TEC) program. VET TEC is an immensely popular program with Veterans. Women represent 14.3% of VET TEC participants; VA plans on targeting communications to increase women Veteran VET TEC recruitment. The Veteran Rapid Retraining Assistance Program (VRRAP) was introduced in March 2021. Although there has been strong interest in the program, VA hopes to increase program participation. VA plans to release targeted messaging that links training opportunities to high-demand occupations.

Benefits Vice Chair Shannon McLaughlin complimented VBA's response to the ACWV's 2020 report recommendations and asked what may have caused the disparate rates of response between male and women Veterans. Mr. Da Silva responded that this disparity could in part be because 70% of GI Bill beneficiaries are men. VBA and VEO are exploring ways to oversample the women Veterans population to mitigate this population difference. Vice Chair McLaughlin suggested surveying women Veterans when they are available as a captured population, for example when receiving women Veterans health care services. Ms. Wright asked if and how qualitative data will be collected. Mr. Da Silva responded that as part of the Digital GI Bill project, VBA plans to conduct more focus groups and small sessions to solicit feedback and suggestions about the GI Bill user experience.

The Chair noted that the ACWV is working to address the parity of women Veterans representation in VA media and asked Mr. Da Silva to provide examples of the targeted messaging VBA plans to provide to women Veterans. Mr. Da Silva responded that VBA is conducting outreach to increase women Veterans' awareness of programs and opportunities such as VET TEC, VRRAP, and VA's STEM Scholarship. He added that Education Service strives to remain mindful of the inclusivity of its messaging and to create messaging that represents the full breadth of Veterans. The Chair commented that many women Veterans do not identify as Veterans; more inclusive messaging could help change this.

Vice Chair McLaughlin commented that the expiration of protections regarding resident versus online rates may disproportionately affect women Veterans because women Veterans often serve as the caregivers in their home. She asked if VA has given any thought to extending this portion of the program. The Chair expressed agreement with this comment. Mr. Da Silva responded that VA has received a lot of Veteran feedback regarding the difference between online and resident rates. Statute requires that online rates be set at half the national average. VA has brought this issue to congressional stakeholders many times; however, Congress has not yet addressed this issue, likely due to funding concerns. VBA will examine data around resident versus online rates to better understand any trends or impacts. Mr. Da Silva added that VA will also need to explore how the education landscape has changed, because of the COVID-19 pandemic.

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Ms. Beldo-Lilley asked if VA has a target percentage for returned responses it aims to receive from VSignals surveys. Mr. Da Silva responded that Education Service aims to receive responses that adequately represent all programs administered. He is unaware of any specific response targets; VBA will explore this question further. Lachrisha Parker asked if VBA's VSignals data regarding women Veterans have been broken down by age and state. Mr. Da Silva responded that VBA could do so if the ACWV is interested. Ms. Parker commented that this data would be helpful to understand who is being targeted by the VRRAP program and what organizations could be helpful partners to the program.

Update on 2020 ACWV Report Recommendation #3

E. Maquel Marshall, Lead Program Analyst, Outreach, Transition, and Economic Development (OTED), VBA

Mr. Marshall presented an update on VBA's work to address recommendation 3 of the 2020 ACWV report. The recommendation reads as follows: that VBA modernize the Women Veterans Coordinator (WVC) position by establishing it as a duty with measurable position standards.

In January 2021, VBA began a process to rewrite the M27-1 manual to standardize the WVC position. The manual's status is currently in concurrence; VBA has updated its target to continue for FY22. M27-1 chapter enhancements include aligning duties with organizational goals, defining the amount of time WVCs should conduct outreach per quarter and defining the WVC position's basic duties. A VBA office review allowed for an opportunity to update the entire manual at one time rather than in a piecemeal fashion. VBA allowed employees working directly with Veterans to review the proposed updates and recommend changes. Although these practices have delayed the manual's review process, they will result in a better manual.

Mr. Marshall presented women Veteran outreach data from FY20 and FY21. Data is collected through the Outreach Reporting Tool Plus (ORT+), which was last updated in October 2021, to capture more pertinent data points regarding WVC's outreach efforts. VBA completed a total of 290 women Veteran outreach events in FY21 and 220 events in FY20; 85% of FY21 events were virtual. In FY21, VBA completed 531 outreach hours; this was almost a third of the hours completed in FY20. The number of women Veteran attendees almost doubled and the number of Veteran attendees at women Veterans-specific events almost tripled in FY21. Although VBA put forth less outreach hours in FY21, it garnered significant increases in direct engagements with women Veterans. Virtual events have allowed VBA to target women Veterans and improve the efficiency of its outreach efforts. In September and December of 2021, OTED partnered with VETS to host Spouse Support Summits. The summit is hosted for spouses of transitioning Servicemembers and features employment workshops and resources regarding VA benefits, social and emotional health and survivor and casualty assistance.

VBA's next steps include publishing the updated M27-1, continuing to monitor and enhance the ORT+ to capture data on WVC outreach efforts and engagements to

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women Veterans at all outreach events, and continuing collaborations with the Center for Women Veterans, VHA and NCA to advance the aims and purposes of VA in providing excellent service to women Veterans. VBA challenged its regional offices to collaborate with a women Veteran-specific organization or organization targeted towards supporting and helping women Veterans during the month of March with a goal to reach 100% participation.

The Chair asked if the ACWV would be able to review VBA's M27-1 revisions. Mr. Marshall responded that he would take this question back to VBA and provide the response to Shannon Middleton. Vice Chair McLaughlin agreed that it would be beneficial for the ACWV to review the revisions, even if it is only able to offer informal feedback. She commended on VBA's increased outreach efforts and asked how VBA measures engagement. Mr. Marshall responded that VBA tracks the total number of Veterans, family members, caregivers and survivors who attend an event and measures the number of people who VBA staff directly talk or otherwise engage with. He added that it is more difficult to collect this data in a virtual environment. Vice Chair McLaughlin suggested that VBA capture separate engagement data for male and women Veterans to understand if there are any trends or differences between the two populations. Mr. Marshall commented that ORT+ enhancements have allowed other special emphasis program coordinators and managers to specify direct engagement data for women Veterans.

Ms. Wright asked when the M27-1 updates will be complete. Mr. Marshall responded that VBA aims to complete the updates by the end of March 2022. She asked if VBA reviewed and changed the number of collateral duties being done by the WVC position. Mr. Marshall responded that aligning WVC duties with organizational goals is a very important piece of the update; VBA wants to ensure that WVCs are given ample time to support women Veterans and develop innovative ways to reach women Veterans. Ms. Harris asked how women Veterans are being reached virtually and how the average woman Veteran knows about VBA briefs. Mr. Marshall responded that the VBA Central Office creates flyers advertising VBA briefs and events and encourages regional offices to do the same. Flyers and event information are circulated through social media platforms and GovDelivery. VBA targets women Veterans by marketing the event as a women Veterans-specific event or as an event geared towards assisting women Veterans. VBA asks WVCs and organizations that support women Veterans to advertise the event to their networks and targets and socializes the event across all platforms and to all Veterans to ensure that all populations are informed about the event.

Update on VA's National Strategic Plan for Breast Imaging (Recommendation #6 2020 ACWV Report)

Lisa Wall, Assistant Director for the National Radiology Program; Christina Davidson, National Director for Mammography; Dr. Jeffrey Chenoweth, Acting Deputy Executive Director for Diagnostic Services, VHA

Ms. Wall presented an update on VA's National Strategic Plan for Breast Imaging. This strategic plan was developed in response to recommendation 6 in the 2020 ACWV

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report. The recommendation reads as follows: that VHA establish a national strategic plan for breast imaging services that covers the evolving needs of women Veterans.

The National Radiology Program's (NRP) Mammography Program Office is responsible for the oversight and certification of all VHA in-house mammography programs. All VHA mammography programs are accredited by the American College of Radiology and certified by VHA. VHA facilities undergo the accreditation process at the time of mammography program implementation and then triennially. Programs undergo annual U.S. Food and Drug Administration (FDA) inspections to ensure compliance with the Mammography Quality Standards Act. Inspections were temporarily postponed in March 2020 due to the COVID-19 pandemic and were resumed on a limited basis in March 2021. In response, the NRP led an initiative to conduct virtual mammography inspections. In FY21, all VHA mammography program sites were inspected by the FDA and/or VHA.

VHA's Mammography Advisory Committee examines VA's breast imaging services and discusses ways to improve them. NRP reviews clinical restructuring proposals for facilities desiring to establish a new mammography program. Requests are reviewed to determine the number of women who will be served, the facility's staffing and equipment and the imaging room's design and space. NRP works with the Office of Women's Health (OWH) to encourage breast cancer screening for the appropriate populations and is working to reduce no-shows.

VHA had four essential goals when developing the National Strategic Plan for Breast Imaging: 1) ensure the maintenance or improvement of the Healthcare Effectiveness Data and Information Set (HEDIS) measure for screening for breast cancer, 2) determine the utility of mobile mammography, 3) ensure flexible and reliable processes for closed-loop communication of suspicious and highly suggestive malignancy mammogram exam results with the referring provider and patient and 4) ensure quality and professional oversight in the provision of diagnostic mammography. These goals support evidence-based medical practice and represent fundamental pillars of access, quality, outreach, and the Veteran experience.

The HEDIS measure allows VA to compare itself to the private sector. HEDIS data as of 2018 confirm that women Veterans are significantly more likely to receive timely breast cancer screening than women covered by a commercial insurance plans, or by Medicaid/Medicare. A central element of the strategic plan is for all women Veterans to have access to timely, convenient breast imaging services regardless of geographic location and in a manner that best addresses their needs. A critical first step to doing this is to optimize the distribution of mammography services. NRP must review existing service availability and establish criteria to determine when it is appropriate to expand services and to determine whether best service can be provided by VA or by community care partners. Mobile mammography could be used to expand VHA's service range and increase Veteran access to screening mammography. However, these potential benefits must be weighed against the challenges of implementing mobile mammography. VHA is exploring telemammography to improve access; however, telemammography can only

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be used for screening. VHA is also considering implementing remote interpretations. VHA currently has 68 active mammography programs and recognizes that community care will continue to be a significant element in providing breast imaging services. NRP promotes the use of digital breast tomosynthesis (DBT) or 3D imaging when replacing mammography units. DBT has been shown to detect smaller breast cancers than traditional imaging and has been proven to decrease patient recall rates when evaluating areas of concern, which in turn reduces patient anxiety. Currently, 91% of VHA mammography programs offer DBT.

VHA recognizes the importance of enhancing communication with patients, providers, and community partners and is now soliciting feedback from patients who do not keep their appointment. Although this data is preliminary, it reveals areas for improvement. Since May 2021, NRP has written four articles regarding breast imaging for the MyHealthVet newsletter. Engagement rates have increased from 11% in May to 15% in October. In September 2020, VHA released imaging design guides that promoted a Veteran-centric environment of care that identified wheelchair-accessible doorways and dressing rooms. In FY21, VHA partnered with OWH to secure funding for sites needing to purchase adjustable mammography positioning chairs; multiple sites participated in this initiative. VHA is exploring expanding services such as self-referral, same day mammography and direct mammogram scheduling without a provider order. When feasible, these services would help improve compliance and timely screening for breast cancer rates.

VHA aims to complete a second draft of the National Strategic Plan for Breast Imaging for leadership review by Quarter 3 of FY22. NRP looks forward to presenting a finalized version of the National Strategic Plan for Breast Imaging to the ACWV once it is approved. VHA has already submitted a first draft of the plan for leadership review; however, leadership requested that VHA research some aspects of the plan further. This has delayed release of the final strategic plan.

Ms. Wright asked if women Veterans who receive mammography services in the community experience any billing issues. Ms. Wall responded that NRP does not conduct any work in billing and deferred the question to OWH. Vice Chair McLaughlin asked if there have been any hurdles preventing VHA sites from implementing DBT. Ms. Wall responded that all sites have either purchased units or are conducting market research; however, some sites are facing construction and/or construction funding hurdles. She added that all new sites will have DBT. Ms. Estabrooks thanked NRP for researching why women Veterans are canceling or not attending their appointments; CWV is eager to understand this issue. She asked that NRP contact CWV if they need any support in pushing out messages to improve attendance and participation.

Update on VA's Breast and Gynecological Cancers System of Excellence
Dr. Michael Kelley, Executive Program Director, Oncology, Specialty Care Services, VHA; Chief, Hematology/Oncology Durham VAMC; Professor of Medicine, Duke University National Oncology Program
Dr. Haley Moss, Director, Breast and Gynecologic Cancers System of

Excellence, VHA; Assistant Professor of Obstetrics and Gynecology, Duke University Medical Center, VHA

Dr. Kelley presented an update on VA's Breast and Gynecological Cancers System of Excellence. The System of Excellence's mission is to build necessary infrastructure to provide cutting-edge care to women Veterans. It builds on work already done by VA to provide every Veteran with access to the best of cancer care. The System of Excellence has four objectives: 1) to provide women Veterans with access to fully-coordinated, state-of-the-art screening and diagnosis to ensure the greatest possible detection and treatment, 2) to enhance VA's ability in breast oncology to provide services and personalized care that is coordinated with women Veterans' specific needs, 3) to ensure best-in-class cancer care using precision oncology and 4) to expand women Veterans' access to care through building partnerships. VHA's action plan for implementation is to stand up the System of Excellence's core staffing, begin building a clinical pathway, establish a national tumor board, enhance its breast cancer health informatics capability and innovate care through telehealth and decentralized clinical trials for women Veterans across VHA.

A clinical pathway is a preferred practice pattern, when all other factors are equal, that helps ensure precision medicine is done systematically. VHA plans to launch the breast cancer clinical pathway in January 2022. Once developed, the clinical pathway will be circulated to educate staff. An accompanying decision support tool will be built into the electronic health record (EHR) system to allow a provider to identify where their patient is on the pathway and the recommended next steps.

VHA is building the Breast and Gynecological Cancers System of Excellence in conjunction with its National Precision Oncology Program (NPOP). The NPOP, which conducts tumor testing, has tested over 20,000 Veterans since its inception. The NPOP is available throughout VHA. The NPOP's Molecular Oncology Tumor Board works to educate VA's oncology community about the interpretation of complex genetic alterations and has an on-demand, asynchronous, patient-specific consult request linked into the EHR. Although this consult request service was originally used by providers to request help in interpreting molecular testing, it is increasingly being made available to request second opinions not related to molecular testing. There have been some requests made concerning breast and gynecologic cancers. VHA expects these requests to increase as NPOP's ability to respond to them expands.

Telehealth service allows VHA to realign the supply and demand for oncology services. It is currently in use in over 10 VHA sites and is expected to reach 20 sites soon. The initial target service area is smaller VA medical centers (VAMCs). The service uses disease-specific oncologists with affiliation to National Cancer Institute-designated Comprehensive Cancer Centers and often involves community partners. Patients can be located anywhere but often access the service from the cancer clinic at a local VA hospital. Data are the core of quality clinical care; VHA is discussing ways to offer patients access to clinical trials in this setting.

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The Chair thanked Drs. Kelley and Moss for their work in building the Breast and Gynecological Cancers System of Excellence. In the interest of time, ACWV members' questions will be gathered and sent to Dr. Kelley through Shannon Middleton.

Update on 2020 ACWV Report Recommendation #8

Dr. Sally Haskell, Deputy Chief Officer, Office of Women's Health; Dr. Mary Driscoll, Consultant, Women's Health, VA Connecticut Healthcare System; Dr. Katherine Hoggatt, Research Health Science Specialist, San Francisco VA Health Care System and Associate Adjunct Professor, University of California, San Francisco; Dr. Friedhelm Sandbrink, Executive Director, Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP), Specialty Care Services, VHA

Drs. Haskell, Driscoll, and Sandbrink presented an update on VHA's work to address recommendation 8 in the 2020 ACWV report. The recommendation reads as follows: a) that VHA increase women Veteran-centric pain management training for providers and increase women Veterans' access to diverse modalities of treatment for co-occurring chronic pain and substance abuse for women Veterans, and b) that VHA continue to research how pain management impacts women Veterans differently than male Veterans, as well as the links between pain management and substance abuse in women Veterans.

VHA's first step in addressing recommendation 8 was to collaborate with experts across specialty care, mental health care and the OWH to identify and disseminate information to providers and service lines responsible for caring for women with chronic pain and substance use. VHA continues to make existing trainings regarding musculoskeletal and pelvic pain available and plans to develop and incorporate women's pain and substance use content into national trainings. Ongoing programs such as VA-DoD Women's Mental Health Mini-Residency and the Women's Health Gynecological Grand Rounds have included topics such as pain management and pelvic pain treatment. OWH's internal SharePoint contains several provider resources; OWH's external website contains several patient resources. OWH's Musculoskeletal Mini-Residency Program held small group sessions to teach primary care providers how to do musculoskeletal exams for women Veterans. OWH has also held a series of trainings teaching providers how to conduct musculoskeletal exams in a virtual setting.

OWH was able to incorporate several women's health sessions into the National Pain Program's Veterans in Pain – Pain management, Opioid Safety, and Suicide Prevention Teams training. In November, OWH presented on the behavioral pain management community of practice and participated in a virtual gynecology conference in August that included sessions on pelvic pain. OWH has released a series of podcasts for women Veterans and in September released one on musculoskeletal health. OWH's Reproductive Health Team worked with Dr. Georgine Lamvu to develop pelvicpaineducation.com, which has a series of videos and presentations on pelvic pain that providers can share with patients. OWH is participating in an exploratory program that convenes stakeholders across program offices to discuss program development projects targeting women with comorbid pain and substance use disorder. The program

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is sponsored by the Pain Management Program Office and its goal is to develop a pilot telemedicine program for women Veterans with co-occurring pain and substance use disorder. The program is currently in the needs assessment phase.

OWH has several research-related action plan initiatives underway. The initiatives consist of collaborations with experts across research offices and programs to examine gender differences in pain and its management, the feasibility, engagement, and effectiveness of non-pharmacologic pain treatments, as well as efforts to safely discontinue long-term opioid therapy. The goal is to understand and disseminate knowledge that can better inform and optimize the care of women Veterans who have pain and/or substance use disorder.

VHA has several existing and ongoing research programs. The technology-based, non-pharmacologic pain interventions and peer-support pain self-management clinical trials have a target end of 2024. Research on reduction of long-term opioid use has a target end of 2022. Research on the needs of rural women Veterans with pain has a target end of 2023. Findings from the rural women Veterans research show that women Veterans are less likely to be on opioids as well as gabapentinoids and nonsteroidal anti-inflammatory drugs; however, rural women Veterans are more likely to receive muscle relaxers and duloxetine and more likely to be on psychiatric medications. Research also found that rural women Veterans were more likely to see primary care but less likely to see specialty care than their urban counterparts; effects did not differ substantially between rural male and rural women Veterans. Findings from the long-term opioid use research show differences in comorbidities, challenges and presenting issues between men and women. Women are more likely to have psychiatric and ill-defined pain conditions and receive risky co-prescriptions, whereas men are more likely to have severe medical comorbidities.

PMOP provides staffing support to enhance and expand access to clinical care with the intent to support interdisciplinary pain management teams or pain clinics at VA facilities with expertise on both pain medication and non-pharmacological treatment modalities. Access to addiction medicine and treatment for opioid use disorder is integrated within pain management teams, although not specifically funded by the program office. The office also supports a fully accredited interdisciplinary pain rehabilitation program with at least one dedicated Commission on Accreditation of Rehabilitation Facilities International-accredited program in each Veterans Integrated Service Network (VISN). Other important access issues for pain management include supporting TelePain, opioid safety initiatives, and education initiatives

The office not only supports access to clinical care, but also provides dedicated administrative support for coordination and collaboration across facilities through Pain point of contacts and patient aligned care teams (PACT) Pain Champions. In April 2021, the office created the PMOP coordinator position to support this collaboration and coordination. Almost all VISNs have implemented this position; PMOP expects the position to be fully implemented across VA in the next year. In FY22, PMOP began to provide funding to support TelePain teams under VA's Clinical Resource Hub (CRH)

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structure. The office recommends that teams are interdisciplinary and contain expertise on pharmacological and non-pharmacological treatment modalities. Funding opportunities are available to all VISNs and will be provided through a 3-year funding cycle. Eleven VISNs are in the process of implementing these teams. PMOP has a dedicated TelePain implementation team to guide this process.

Ms. Wright asked if women Veterans are increasing their access to new modalities of pain treatment through PMOP's initiatives. Dr. Sandbrink responded that this is a question PMOP will need to follow up on. He said that PMOP wants to increase facilities' capacity not only to provide broader access, but also to allow for the increased creation of women Veteran-specific groups and groups specific to conditions important to women. At this point, PMOP is still building capacity; more work needs to be done to create gender-specific groups. Ms. Harris thanked the presenters for the brief and expressed appreciation for PMOP's integration of whole health in its programming.

Committee Discussion

The Chair encouraged members to send any unasked questions to their Vice Chair. Ms. Tiglao thanked the Chair and Committee Members for their insightful questions and thanked all attendees for their presence.

Adjourn

Betty Yarbrough (Colonel, U.S. Army, Retired), Chair, ACWV

The Chair adjourned the meeting at 1:02 pm EST.

Wednesday, December 15, 2021

Open Meeting/Introductions

Betty Yarbrough (Colonel, U.S. Army, Retired), Chair, ACWV

The Chair called the meeting of the ACWV to order at 10:00 am EST. The Chair and DFO welcomed Committee Members and attendees. Members introduced themselves.

Update on VHA's Implementation of PL116-315 (Deborah Sampson/Women's Health)

Dr. Patricia Hayes, Chief Officer, OWH, VHA

Dr. Hayes presented an update on VHA's implementation of the Deborah Sampson Act. The Deborah Sampson Act is a section of the Johnny Isakson and David P. Roe Veterans Health Care and Benefits Improvement Act of 2020 (PL116-315), which was passed on January 5, 2021. Some of the goals of the Deborah Sampson Act include ending sexual harassment and assault for Veterans, enhancing women Veterans' reintegration and readjustment, expanding reintegration counseling retreats, increasing availability of prosthetics, and bolstering women Veterans' counseling and legal services. About 17 sections of the Deborah Sampson Act have been assigned to OWH. VA's Office of Healthcare Transformation (OHT) is supporting OWH and other VHA offices to ensure that all sections of the Deborah Sampson Act are being implemented in a structured manner. OHT has also helped organize a system for requesting funding.

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PL116-315 is an authorizing law and has very little money attached to it. Each section of the law may require significant budget considerations; some sections are taking longer to implement due to funding concerns.

Section 3006 gives Secretary of Veterans Affairs (SECVA) the authority to furnish medically necessary transportation for newborn children of certain women Veterans and requires VA to report to Congress; the National Defense Authorization Act (NDAA) authorizes VA to provide extension of medical care for newborn children of certain women Veterans. OWH developed cost estimates for transportation and coverage expansion for newborn children in May 2021. The transportation of newborn regulation is being bundled together with the regulation covering the expanded care of newborns. The regulations will be circulated at the VHA level and will begin vetting process in early 2022. Both transportation and extension of medical care will be set to 31 days. Dr. Hayes expects that the regulatory process for these regulations will be completed in 18 months.

Section 5101: elevates central office prioritization of health for women Veterans by creating an Office of Women's Health within VHA, headed by a chief officer, to oversee women's health programs within VHA, ensure standards of care are created and outreach to women Veterans is performed; elevates OWH to report directly to the Undersecretary for Health. VA satisfied this requirement before the law took effect. Annual reports on models of care, staffing, wait times and accessibility are due to Congress in January 2022. The reports are currently undergoing final signature by VA SECVA. The ACWV can ask for a briefing on the reports after they are released by VA. VA must provide quarterly focus groups and biannual town meetings for women Veterans. As of now, 92.8% of facilities implemented these. Every focus group is expected to discuss harassment along with other topics.

Section 5102: requires VA to submit to Congress by January 5, 2022, a 5-year strategic plan to address deficiencies in environment of care (EOC) and retrofit medical facilities. Under this initiative, VHA must retrofit existing medical facilities to improve privacy, dignity, and access for women Veterans. The initiative has an identified \$20 million set aside for construction projects and a congressional mandated report (CMR) describing the details of the initiative has been submitted.

Section 5103 requires VA to establish a policy for EOC standards and inspections at VA medical centers that aligns with VHA's women's health handbook, requires frequent inspections, delineates roles and responsibilities, requires every VAMC report publicly on its compliance with the standards, and includes a remediation plan. VHA Directive 1608 was finalized on June 21, 2021; expecting two (2) EOC GS-14 Program Managers to facilitate the program for program sustainment; and the CMR was submitted to Congress.

Section 5104 requires VA to create a retreat program for eligible Veterans and family members to augment the readjustment counseling they are receiving. VA will expand and make permanent reintegration and readjustment services offered to women

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Veterans by providing counseling services individually or in a group retreat setting. Veterans also have the option of receiving counseling with family members or in group retreat settings where all the participants are women. Readjustment Counseling Services (RCS) finalized the scope for the updated retreat program in September 2021. RCS is working to establish contracts in each of the five districts by February 2022. Additionally, RCS plans to focus on program implementation by the end of 2022 and establish a process of outcomes and compliance monitoring on a quarterly basis.

Section 5105 requires VA to enter into one or more agreements with external entities to provide certain types of legal services to women Veterans. These legal services must address legal needs identified in VA's Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) survey of homeless Veterans. VA will comply with section 5105 through the legal services grant program required by section 4202 to address the unmet needs for legal services among homeless women Veterans as identified in the CHALENG survey. The Homeless Program Office (HPO) will publish a rule defining criteria under which the agency will award grants for the provision of legal services for Veterans, including women Veterans (as part of section 4202). HPO will publish a Notice of Funding Opportunity inviting applications for these grant funds as soon as possible after publication of the regulation.

Section 5108 requires VA to ensure that women Veterans can access clinically appropriate prosthetic appliances through each VAMC and to report by January 2022 on the (1) availability from VA of prosthetics made for women Veterans, including variability across facilities. VA continues to collaborate with VHA Prosthetic & Sensory Aids Service, Amputation System of Care, Clinical Orthotic & Prosthetic Service, and the 3D Printing Advisory Committee to assess the availability of prosthetics made for women Veterans. VA provided available elements in the CMR focusing on prosthetic limbs and items that are specific to women Veterans. VA deployed the patient satisfaction survey, disseminating it by email, text, and mail to 46,613 Veterans with amputations. There were 4,981 respondents, including 1,356 women Veterans. The analysis of the survey results and data are being finalized. The CMR going through the concurrence process and is on target for timely submission by the statutory deadline. Section 5109 requires SECVA to enhance the Women Veterans Call Center's capabilities; there is no deadline. VA will improve call center response and assistance for accessing health care and benefits. OWH has added new training components on VA health care services and benefits for call center staff to include enhanced and updated information on benefits, employment assistance and food assistance. Also, VA is in the process of delivering ongoing training. Dr. Hayes believes that OWH has met the spirit of the law.

Section 5110 directs SECVA to conduct a study on infertility services available at VA. VA conducted a study assessing infertility services and is submitting a report to Congress with results of study, which is due in January 2022. For the next steps, VA is undertaking actions to address study findings and recommendations, including enhanced communications with Veterans.

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Section 5111 has no statutory requirement, but it does articulate the sense of Congress that members of reserve components of the Armed Forces should be able to access all VA health care facilities, not just Vet Centers, to receive treatment related to military sexual trauma (MST). VA and the Department of Defense (DoD) are firmly committed to ensuring all Veterans and Service members have access to the care they need to recover from MST. Accomplishing this involves complex planning with DoD. VHA's current policy in this area is the result of several years of complex planning with DoD to implement changes to 38 U.S.C. 1720D made by Public Law (PL) 113-146, section 402, and PL 115-91, section 707; VHA believes the current implementation is the best way to balance patient trust, safety, and confidentiality concerns. All current Service members can receive MST-related counseling from VA's more than 300 Vet Centers without a referral from DoD, regardless of current duty status. In addition, Service Members can receive care at all VA health care facilities with a TRICARE referral or authorization, in emergency situations, or through any VA-DoD sharing agreements at the facility.

It is important to ensure that the law lines up with VA's and DoD's definitions of active duty, Reservists and Veterans and how these different groups obtain care. The law currently does not do so; VA has gone to Congress to follow up on this issue. Dr. Hayes recommended that ACWV ask VA's MST team to provide a specific briefing on this section.

Section 5201 requires VA to ensure that each VA medical facility at least one full-time or part-time women's health primary care provider. Data for this section was included in the Section 5101 Annual Report to Congress and will be cross-referenced with the OIG primary care providers report requiring every facility to submit an attestation about actions to ensure a minimum amount of primary care providers, which is due to OWH by January 15, 2022. OWH will have a list of action plans for facilities that do not have the minimum amount of primary care providers.

Section 5202 requires VA to provided funding to bolster the Women Veterans Health Care Mini-Residency Program. VA has allocated \$1 million annually as mandated, which will be used to train additional primary care and emergency care clinicians on Women Veteran health care needs. VA conducted a virtual training for primary care clinicians in the mini-residency program in September 2021, will host an additional virtual mini-residency program to train primary care clinicians in April 2022 and plans to offer additional face-to-face mini-residency trainings in FY23-25. The program may have trouble spending this money due to the lack of in-person trainings. The program has trained over 7,000 providers; however, there may still be a gap due to turnovers and recruitment issues.

Section 5203 of the Act required VA to develop competency cultural training module for community care providers focused on the health care needs of women Veterans. VA completed the training module for community care providers. It went live in April 2021 and is available on Training Finder Real-time Affiliate Integrated Network (TRAIN). VA will monitor the utilization and effectiveness of the training and draft an evaluation plan by April 2022. There has been a large uptake of the module by non-VA providers across

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the spectrum. VA continues to update the module and will be adding elements of maternal care shortly.

Section 5204 requires VA to conduct a study on the women Veterans program manager (WVPM) program to address whether the program is appropriately staffed; each medical center has a WVPM; and if a women Veterans ombudsman program is feasible. Section 5204 (c) also requires that the Secretary ensure that all WVPMs receive the proper training by 10/2/2021. VA has completed a report on this requirement and has determined that it does not need an ombudsperson in addition to the manager position. VA wants to ensure that the women Veterans program manager is completely available to meet the advocacy needs for women Veterans. However, VA also believes that it is important that everyone be responsible for caring for women Veterans.

Section 5206 requires VA to consult with the Inspector General of VA to assess the capacity of peer specialists who are women at VA. The assessment will consider geographical distribution of the women peer specialists and women Veterans as well as the proportion of women peer specialists who specialize in mental health/suicide prevention versus non-mental health matters. VA is analyzing the data and developing the staffing assessment report, based on information gathered by the Office of Mental Health and Suicide Prevention (OMHSP). OMHSP will provide areas of success and improvement in the assessment, which will be used to develop a staffing plan for peer specialists.

Section 5301 requires VA to expand its coverage of counseling and treatment for sexual trauma, regardless of duty status or line of duty determination, to include care for physical health conditions, as appropriate, to former members of the Armed Forces who VA determines require such counseling and care and services to treat a condition, which in the judgment of a health care professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while the former member of the Armed Forces was serving on duty.

VHA has disseminated information to ensure facilities' ability to currently implement this expanded authority and is making changes to processes and IT systems to further facilitate access to care. Additionally, OMHSP and Member Services have published amended policies and updated staff education and Veteran outreach materials. Updates to the enrollment system and MST screening process are in progress and scheduled to take effect in FY22. Marketing campaign specific to former Service members with another than honorable discharge has been implemented.

Section 5304 requires a pilot program to assess the feasibility and advisability of assisting former members of the Armed Forces who have experienced or are experiencing intimate partner violence or sexual assault in accessing VA benefits. On October 1, 2021, VA launched a 2-year pilot program. Ten VA medical centers were selected based upon unique characteristics, resources, and capacity to establish programming that meets the requirements of the law. A data and analysis hub was

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established in collaboration with the Portland VA Healthcare System to collect and assess metrics from each of the pilot sites to inform the project. VA will continue the pilot program through September 30, 2023 and submit a summary report to Congress with recommendations from the results.

Section 5402 of the Act directs the OWH to conduct a study on barriers for women Veterans to receive healthcare from VA. OWH will account for all barriers listed in the law but is also exploring ways to maximize this opportunity to ask Veterans about barriers to receipt of care. It will take several years to complete this study. VA contracted (awarded on 9/8/21) with a qualified independent entity to conduct the study to include assessing the effects of various factors on women Veterans in the survey, such as: barriers to seeking and providing mental health care, driving distance and transportation to the nearest facility, availability of child care, satisfaction with VA primary care delivery and other factors. In June 2021, VA requested timeline extension to complete study within 42 months of enactment, to allow adequate time to conduct the study based on the timelines of similar studies conducted in the past. The contractor will conduct the study 2022-2023 pending OMB approval; results will be shared with the Advisory Committee on Women Veterans and the Center for Women Veterans.

Section 5403 of the Act directs the VHA to examine the feasibility of offering parenting skills training. There is a lot of uptake on current VA parenting skills training programs; VA will be implementing new programs. A CMR is due to Congress in January 2024.

Section 5403 requires VA to conduct a study on the feasibility and advisability of offering the Parenting Skills Training in Affective and Interpersonal Regulation (Parenting STAIR) program at all VAMCs. As part of this work, VA will assess the feasibility of including the program in care provided to former members of the Armed Forces who have experienced MST. VA will assess the utilization of the Parenting STAIR program in the field to determine the feasibility of offering the program at all VAMCs and identify barriers for implementation. The Office of Mental Health and Suicide Prevention (OMHSP) has evaluated FY21 use of the Parenting STAIR program. The evaluation results are in the process of being submitted to Congress. The evaluation will inform the final report to be submitted to Congress by January 2024. In FY22, OMHSP will continue to track use of Parenting STAIR and examine key factors to inform the final report (e.g., review relevant evidence base, evaluate need for trauma-informed parenting skills training in VA).

The Chair asked when the report for Section 5204 will be submitted to Congress and asked if the ACWV can receive a copy. Dr. Hayes responded that all the reports are due to Congress by January 5, 2022. The ACWV can request to review any of these reports after they are submitted to Congress. Ms. Wright asked if VA keeps metrics on the number of providers that have received the Veteran competency cultural training module according to the number of providers that are on contract. Dr. Hayes responded no. VA has the number of providers who have taken the training but cannot require providers to take the training. She asked Dr. Hayes to explain the Veteran experience champion position. Dr. Hayes responded that a Veteran experience champion is partly

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an ombudsperson/advocate but also works on the whole health experience for Veterans. VHA can brief the ACWV on this position if interested.

Vice Chair McLaughlin asked for examples of the environmental retrofits described in Section 5102 of the Act. Dr. Hayes responded that most of the retrofits are smaller projects and include adding women's clinics, lactation rooms and women's restrooms. She asked if there is an opportunity for feedback or forums, once a CMR has been published. Dr. Hayes responded that once a CMR is returned to Congress, it is their report.

Ms. Parker asked who the point of contact is for the MST program regarding Section 5111. Dr. Hayes responded that the point of contact is Dr. Margret Bell in the Office of Mental Health and Suicide Prevention. Ms. Parker asked why VA was having trouble spending the money allocated for the Veteran competency cultural training module. Dr. Hayes responded that the most critical component of the training is pelvic exam training using gynecological teaching associates. This training must be done in person and requires providers to travel. Most of the program's cost is due to this travel. This aspect of the training could not be conducted during the pandemic and so it was difficult to spend the allocated money because providers were not traveling.

Overview of Office of Small and Disadvantaged Business Utilization (OSDBU) and Initiatives for Women Veteran Entrepreneurs

Michelle Gardner-Ince, Director, Women Veteran-Owned Small Business Initiatives, OSDBU

Ms. Gardner-Ince presented an overview of VA's Women Veteran-Owned Small Business (WVOSB) initiative. WVOSB's mission is to help VA meet its goal of awarding 5% of its Federal contracting dollars to women-owned small businesses and to increase women Veteran entrepreneurs' access to economic procurement and learning opportunities. The initiative's success has been through collaborations.

VA is the only Federal agency mandated to give a portion of its contracts to Veterans. Less than 1% of these contracts are held by women. VA must select Veteran contract set-asides from a database; less than 10% of the 15,000 contractors in the database are women. Industries where VA spends most of its contracting money are industries where women are underrepresented, such as construction, information technology (IT), medical, and logistics. Barriers to entry other than capital include a lack of intensives helping women become subcontractors and no accountability to the big companies. Women Veterans face challenges such as transitioning skills from the military to business setting; combating issues of racism, sexism, ageism, and ableism; networking; breaking into predominantly male markets; and finding mentors and other resources.

WVOSB was implemented three years ago. The first cohort consisted of 30 women with 29 companies that ranged from \$25,000 to \$38 million. All military services were represented except for the Coast Guard and the cohort also had some military spouses. VA has launched a website for the initiative. WVOSB has hosted My Business Journey webinars. VA held its first ever Women Veteran-Owned Small Business Summit, which

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had 24 different Federal agencies, 11 prime vendors and more than 200 women. VA has given \$30,000 in grants to three women Veteran-owned businesses through a memorandum of agreement with the PenFed Foundation. VA is completing the Vet Biz Lady Grow program, which was conducted in partnership with SBA's Women Business Centers in Washington, D.C., Maryland, and Virginia. It is a 12-week program designed to assist women Veteran-owned businesses in working with the government.

WVOSB plans to conduct more collaborations in FY22, to include collaboration with the PenFed Foundation to conduct one or two more cohorts. The initiative will continue to examine data and solicit feedback from women Veterans about ways the initiative could improve. The initiative plans to build more official collaborations. Women Veterans have said that WVOSB has given them vision, direction and a sense of community and belonging. Increasing women Veterans' system of wealth decreases homelessness and unemployment and increases women Veterans' sense of independence and belonging.

The Chair commented that women Veterans often have difficulty identifying as women Veterans and asked how WVOSB measures whether efforts to reach out to women Veteran entrepreneurs are successful. Ms. Gardner-Ince responded that when women Veterans enter the program, their company's D-U-N-S number is entered into VA's database. This allows the program to track whenever a business receives a contract. She added that success from handshake to contract award takes several years to culminate; the initiative is beginning to see success in its cohort. In 2020, the initiative's cohort's revenue had increased by \$20 million. However, only 12 of the 29 businesses were ready to receive contracts.

Vice Chair McLaughlin asked what elements Ms. Gardner-Ince finds to be the most challenging when working with cohort businesses to get them to a level of success or self-sufficiency. Ms. Gardner-Ince responded that focus is a crucial and challenging element. Instead of having a broad vision of who they want to contract for, business owners should have a very focused and targeted idea of what the business will be and who will be their client. Vice Chair McLaughlin commented that choosing a focus increases risk and so it is important to have a foundation of confidence to rest this risk in. Ms. Gardner-Ince responded that she believes having a community of successful women Veterans helps increase this confidence.

Ms. Wright asked if there is anything the ACWV can do to support WVOSB. Ms. Gardner-Ince responded that the initiative needs a commitment of resources to women Veteran entrepreneurship and corporate partners who are committed to supporting women Veteran entrepreneurs.

Overview of VA's Assault and Harassment Prevention Office/Update on 2020 ACWV Report Recommendation #10

Lelia Jackson, Director, Assault and Harassment Prevention Office, VHA

Ms. Jackson presented an update on VHA's work to address recommendation 10 in the 2020 ACWV report. The recommendation reads as follows: that VHA conduct an assessment of its End Harassment campaign to ascertain its effectiveness and to

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devise a plan for modernization of the effort to resolve the ongoing problem of sexual assault and harassment physical violations against women Veterans in VA facilities moving forward.

VA has an ongoing problem with sexual harassment and assault. The Assault and Harassment Prevention Office's (AHPO) mission is to end sexual harassment and assault throughout VA. AHPO conducts periodic reviews across VA to understand areas of strength and areas for improvement. AHPO was created in October 2019 and currently consists of two staff members. AHPO has begun its work by tackling issues identified by staff and Veterans in the Stand Up to Stop Harassment Now! campaign.

AHPO is increasing its social media messaging and is putting messages about ending sexual harassment and assault on VHA waiting room TVs. AHPO has integrated the White Ribbon VA pledge into its programming. The pledge is an individual commitment to never commit, excuse, or remain silent about sexual harassment, sexual assault, or domestic violence against others. Although the White Ribbon pledge is focused at ending sexual harassment and assault against women, VA has expanded the pledge to be genderless. Eighty seven percent of facilities have White Ribbon VA champions and about 23,000 Veterans, VA staff and VA leadership have taken the White Ribbon VA pledge, which began in April 2020.

In 2020, AHPO began rolling out bystander intervention training to VA employees. VHA has integrated bystander intervention training into its mandatory harassment prevention training. AHPO recently launched bystander intervention training for Veterans and has already received positive feedback. The training is housed on several websites, including CWV's websites. AHPO has been working with VA Police to build out a Veteran-centered policing training that includes scenarios involving sexual harassment and assault. This training will be available for VA Police nationwide in the next month or so. AHPO will release training for staff on how to respond if receiving inappropriate, harassing, or discriminatory comments from Veterans. AHPO has rolled out new anti-harassment and anti-assault signage across VHA. AHPO is working to enhance collaboration with VSOs and partners.

Section 5303 of the Deborah Sampson Act discusses VHA's anti-harassment and anti-sexual assault policy and identifies multiple areas for improvement. VHA now has a new sexual harassment and assault policy that is in congruence with the policy outlined in the Act. On December 1, AHPO sent out an electronic letter from SECVA notifying Veterans of VA's anti-harassment and anti-assault policy. The letter included a brochure defining sexual harassment and assault and explaining VA resources for reporting sexual harassment and assault when it occurs. AHPO will mail this letter and brochure to Veterans who do not have an email address on file.

SECVA's Sexual Harassment and Sexual Assault Workgroup has been in place since September 2021. VA has been mandated to put a banner detailing the sexual harassment and assault policy on its websites. VHA has completed this requirement; VBA has almost completed it.

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Facilities with five or more substantiated sexual harassment and assault cases in a fiscal year must now complete a remediation plan discussing how the facility will address these events. VHA's VSignals surveys include questions on Veterans' feelings of safety during their visits; these questions do not specifically ask about sexual harassment or assault. Only a few survey responses have raised concerns about sexual harassment or assault; VHA will continue to closely examine survey responses for these concerns. VA has been mandated to establish designated points of contact at facilities for reporting sexual harassment or assault. VHA is training patient advocates on how to respond to reports of sexual harassment or assault. Ms. Jackson commented that she would love for the ACWV members to take the AHPO's bystander intervention training and share it with their networks; AHPO would appreciate assistance in advertising the training.

The Chair asked how bystander intervention training is being conducted for and received by Veterans. Ms. Jackson responded that this training has received positive feedback from Veterans. AHPO is conducting outreach to increase awareness of this training. Ms. Wright asked if there has been a decrease in sexual harassment and assault complaints or increase in actions taken in sexual harassment and assault cases since the AHPO's inception. Ms. Jackson responded that AHPO has emphasized educating staff and Veterans on how to report harassment and assault. Reporting has increased; she believes this is because people feel more empowered to report. Ms. Wright said that the Committee is interested in knowing the amount of reports made and may submit a request for information (RFI) for this data. Shae also asked if the VSignals survey has questions specifically on sexual harassment and assault; Ms. Jackson responded no. She added that AHPO has been working with VEO to screen for sexually based words throughout VHA outpatient surveys. AHPO investigates any concerning survey comments or responses identified through this screening.

Vice Chair McLaughlin asked what will determine whether a sexual harassment or assault complaint is substantiated and how consistency is maintained across facilities for reporting. Ms. Jackson responded that VA Police investigate reports made at VHA facilities. VHA defines sexual assault as any inappropriate, unwelcome touch; AHPO defines a substantiated claim as one with enough evidence to support the allegation. Vice Chair McLaughlin asked what elements will be included in a remediation plan for agencies with five or more sexual harassment and assault cases and who will approve the plan. Ms. Jackson responded that facilities must choose at least two remedial actions from a list of 24. Remedial actions include bystander intervention training, prevention of disruptive behavior training, and fact findings; Ms. Jackson can send the full list of actions to the ACWV. AHPO notifies a facility's leadership team and VISN once a facility reaches three substantiated sexual harassment and assault complaints in a fiscal year. The facility must submit their remediation plan to their VISN director for approval.

Committee Discussion on Status of 2020 Report Recommendations

The full committee discussed the status of the remaining open ACWV's 2020 report recommendations. The Health and Benefits Subcommittees were assigned to lead the discussion when the recommendation addressed their respective areas of responsibility. Final status of the recommendation was decided by the full committee.

The Benefits Subcommittee lead the discussion on recommendation 1, regarding academic "break pay" for women Veterans utilizing their GI Bill education benefits. The subcommittee determined that recommendation 1 rolled into recommendation 2 and so recommends keeping recommendation 1 open. The full committee had no objections to keeping recommendation 1 open; its status will remain open.

The Benefits Subcommittee lead the discussion on recommendation 2, regarding barriers that exist for women Veterans, in relation to accessing education benefits across all formats (traditional/online/hybrid academic environments), enrollment in academic programs, and continuation of higher education. They had the following RFIs for recommendation 2:

- How do education benefits survey response rates differ between male and women Veterans? If they do differ, what are potential causes?
- Does VA have a target percentage or amount of responses it is tracking to measure success?
- How is VA looking into the low response rates and potential causes of low response rates when it surveys women Veteran populations?

The subcommittee expressed concern that, due to the COVID-19 pandemic, VA's ability to conduct robust surveys and interactions with the community is very limited. It would be beneficial to keep recommendation 2 open, to see the development of outreach to women Veterans be done in a more traditional setting. Considering this and its outstanding questions, the Benefits Subcommittee recommends keeping recommendation 2 open. The full committee had no objections to keeping recommendation 2 open; its status will remain open.

The Benefits Subcommittee lead the discussion on recommendations 3, regarding modernization of the WVC position. Recommendation 3 concerns VBA's M27-1 manual update. The subcommittee recognized that the ACWV would like to be part of the M27-1 review process. The subcommittee will ask if VBA would allow the ACWV to have an opportunity to review the draft M27-1 chapter on the WVC position. Understanding that this request may not be granted, the subcommittee is developing a series of targeted RFIs regarding different parameters in the current draft to ensure that specific issues are being addressed. The subcommittee recommends keeping recommendation 3 open. Ms. Wright agreed with the subcommittee's recommendation and added that she would like to review the old and draft M27-1 WVC position chapters for comparison purposes. Dr. Pierce commented that the ACWV cannot legally review the M27-1 draft. She said that she can provide this legal citation, or the subcommittee can specifically request it from VBA if they want it in the record. The full committee had no objections to keeping recommendation 3 open; its status will remain open.

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The Benefits Subcommittee lead the discussion on recommendation 4, regarding naming of VA facilities to honor women Veterans. They recommend keeping recommendation 4 open, in order to allow for further discussions on creative and innovative ways to prioritize women Veterans in naming of facilities, such as naming spaces rather than facilities, and how to prioritize naming women Veterans for new facilities that are introduced to VA system. The Chair agreed that these discussions need to be had but suggested that the ACWV close this recommendation and resurrect it for a future report to include these discussions. Given that recommendation 4 has multiple parts, leaving it open may cause it to become convoluted. Vice Chair McLaughlin agreed with this suggestion. Ms. Miller commented that the Vietnam Veterans of America is making women Veteran naming of facilities one of its national priorities in its report to Congress; the Chair asked that this report be provided to the ACWV when it is submitted. Ms. Tiglao said that CWV has been working to ensure that there is support from VA executive leadership when naming facilities after women Veterans. The full committee had no objections to closing recommendation 4; its status will be closed.

The Health Subcommittee lead the discussion on recommendations 5, regarding incentivizing VA health care providers to become designated women's health providers to improve access to care for women Veterans. The subcommittee found that VHA cannot fulfill this recommendation due to statutes and so would recommend closing this recommendation and opening another recommendation. The full committee had no objections to closing recommendation 5; its status will be closed.

The Health Subcommittee lead the discussion on recommendations 6, the establishment of a national strategic plan for breast imaging services that covers the evolving needs of women Veterans. The subcommittee identified ongoing questions regarding recommendation 6 and noted plans to submit the following RFIs:

- How are women Veterans notified of their mammograms?
- What are the no show rates in VA facilities versus community care providers?
- How is VA ensuring that reports from outside mammogram providers are coming back to VA in a timely manner?
- Who is responsible for ensuring that the bill is paid in a timely manner for women Veterans who are sent to community care providers?
- Do women have the opportunity to make their own appointments in VA facilities and with community providers? If VA is making appointments for Veterans, this might contribute to the no show rate.
- When will the strategic plan be completed for breast imaging services?

Based on these outstanding questions and the fact that the strategic plan has not been completed, the Health Subcommittee recommends keeping recommendation 6 open. The full committee had no objections to keeping recommendation 6 open; its status will remain open. The Chair asked the Health Subcommittee to gather the RFIs so that they can be officially submitted. The ACWV hopes to close recommendation 6 once it

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receives answers to these RFIs. The ACWV may also choose to submit further recommendations on its next report, depending on the RFI answers.

The Health Subcommittee lead the discussion on recommendation 7, regarding VHA providing a plan for projecting future demand and capacity requirements that would enable VA to meet the anticipated needs of women Veterans onsite and annual reporting to the Committee regarding metrics on comprehensive care. The subcommittee recommends keeping recommendation 7 open, given its relationship to Isakson and Roe Act-mandated actions and reporting. The full committee had no objections to keeping recommendation 7 open; its status will remain open.

The Health Subcommittee lead the discussion on recommendation 8, regarding pain management for women Veterans. The subcommittee found that VHA sufficiently addressed recommendation. The subcommittee will likely have another recommendation in response to the new programs discussed in yesterday's update briefing. The subcommittee will need to further examine the briefing to develop new recommendations. The full committee had no objections to closing recommendation 8; its status will be changed to closed. The ACWV expects to have additional recommendations and/or RFIs in response to the update briefing on recommendation 8.

The Benefits Subcommittee lead the discussion on recommendation 9, regarding establishment of a memorandum of understanding between VA and State Departments of Veterans Affairs to create collaborative partnerships between VHA's women Veterans program managers, VBA's women Veterans coordinators, and states' women Veterans coordinators to enhance women Veterans' access to local, state, and Federal Veterans benefits and services. The subcommittee recognizes that there may be a newly implemented MOU; however, the subcommittee is unsure of its contents or whether it adequately addresses the recommendation's stakeholders. The subcommittee will be submitting RFIs to this effect. As a result, the subcommittee recommends keeping the recommendation open. The Chair will send the MOUs to the Subcommittee for review; a decision on this recommendation will be deferred until tomorrow's meeting.

The Health Subcommittee still has a number of questions regarding recommendation 10, which asks VHA to conduct an assessment of its End Harassment campaign, to ascertain its effectiveness and to devise a plan for modernization of the effort to resolve the ongoing problem of sexual assault and harassment physical violations against women Veterans in VA facilities. Although it needs to meet to develop specific RFIs, the subcommittee knows that the recommendation cannot be closed. The Chair deferred the decision on this recommendation until tomorrow's meeting, to give the subcommittees additional time to discuss the recommendation.

Committee Discussion

The Chair summarized the Committee's decisions on the status of open 2020 report recommendation.

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Adjourn

Betty Yarbrough (Colonel, U.S. Army, Retired), Chair, ACWV

There being no further discussion, the Chair adjourned the public portion of the meeting at 12:57 pm EST.

Thursday, December 16, 2021

Open Meeting/Introductions

Betty Yarbrough (Colonel, U.S. Army, Retired), Chair, ACWV

The Chair called the meeting of the ACWV to order at 10:00 am EST. The Committee revisited its discussion on recommendations 4 and 9 and continued its deliberation on the status of recommendation 10.

The Benefits Subcommittee recommends that the ACWV close recommendation 4 with the intent to make a new recommendation in its next report that focuses on prioritizing naming spaces (versus facilities) after women Veterans as appropriate. The ACWV would like to emphasize this process and potentially have input as a committee. The full committee had no objections to closing recommendation 4; its status will be changed to closed.

After reviewing the MOUs associated with recommendation 9, the Benefits Subcommittee found that not all stakeholders listed in the recommendation were included in the MOUs and that not all states or territories have partaken in the MOU process. The subcommittee recommends that the ACWV keep recommendation 9 open to ensure all stakeholders are included. The full committee had no objections to keeping recommendation 9 open; its status will remain open.

The Health Subcommittee has several RFIs regarding recommendation 10 and recommends that the ACWV keep recommendation 10 open. Vice Chair McLaughlin commented that the Benefits Subcommittee also has several RFIs regarding recommendation 10. The full committee had no objections to keeping recommendation 10 open; its status will remain open.

Overview of Veteran Homelessness and VA's Homeless Programs

Dr. Dina Hooshyar, Director, National Center on Homelessness Among Veterans, VHA

Dr. Hooshyar presented an overview on Veteran homelessness and VHA's homeless programs. The Federal government defines homelessness as lacking a fixed, regular, adequate nighttime residence. Homelessness can either be sheltered, such as transitional housing or designated emergency shelters, or unsheltered, such as on the streets or in vehicles. The Federal definition does not include couch surfing, which is a type of housing insecurity women or people with minor dependents often have. Chronical homelessness and chronically homeless people in families exist when either a person or people in families in which the head of household has a disability

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experience continuously homeless for a full year or have at least four experiences of homelessness in three years totaling at least 12 months.

Veterans can determine their eligibility for VA benefits by calling 877-222-8387 or visiting <https://www.va.gov/health-care/eligibility/>. VA employees and external homeless service organizations can access the Status Query and Response Exchange System (SQUARES), a VA web application, for detailed information about Veteran eligibility.

VHA's has several programs designed to connect with homeless Veterans. For outreach, engagement, assessment, and referral VHA offers services through Health Care for Homeless Veterans' (HCHV); Community Resource and Referral Centers and the National Call Center for Homeless Veterans (NCCHV). Through these programs, VHA conducts direct outreach to homeless Veterans and connects them with community partners.

VHA offers residential services: transitional housing assistance through the HCHV Contract Residential Service (CRS); the Grant and Per Diem (GPD) Program, for transitional housing; the Safe Haven program; and the Domiciliary Care for Homeless Veterans (DCHV) program.

VHA collaborates with the Department of Housing and Urban Development (HUD) to provide Veterans with permanent supportive housing through the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program. In this collaboration, VA provides services ranging from medical care to case management. The Supportive Services for Veteran Families (SSVF) program partners with grantees to prevent homelessness and rapidly address homelessness by providing Veterans and their families with care management and financial resources. VHA also provides services for justice involved Veterans, such as the Veterans Justice Outreach (VJO) program and the Health Care for Re-entry Veterans (HCRV) program, which work to prevent Veteran incarceration and to aid Veteran reentry into the community post-incarceration.

VHA's Homeless Veterans Community Employment Services (HVCES) program assists Veterans in finding employment. Additionally, VHA has homeless patient aligned care teams (HPACT) that provide medical and primary care to homeless Veterans.

Due to the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, GPD grant recipients can receive supplemental per diem for Veterans who care for minor dependents and are enrolled in GPD services. Minor dependents are defined as an unmarried individual who is part of a Veteran's household and is either under the age of 22 or was considered permanently incapable of self-support before the age of 22. Currently, there are 25 GPD projects that have requested and have been approved to receive per diem payments for minor dependents. Although VA does not track minors in GPD through its program evaluation system, in FY21 GPD paid 1,969 bed days of care for minor dependents. Dr. Hooshyar expects that this law change will lead to an increase in women Veterans served through this program.

The SSVF program's Shallow Subsidy intervention initiative provides a modest subsidy for two years to extremely low-income Veterans who are homeless or at risk of

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homelessness. In fall 2021, SSVF expanded this service so that it is available in every county and equivalent in the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

HUD's Annual Homeless Assessment Report to Congress examining the Point-in-Time from 2010–2020 depicts a reduction in Veteran homelessness. Between 2010 and 2020, there has been a 49.7% decrease in homeless Veterans; a 49.2% decrease in sheltered homeless Veterans; and a 50.4% decrease in unsheltered homeless Veterans. This dramatic decrease has not been seen in the non-Veteran adult population. VHA anticipates completing its point in time count for homeless Veterans sometime in the upcoming weeks. Although the percentage of homeless women Veterans has increased from 2013 to 2020, the total number of homeless women Veterans has decreased. The number of unsheltered homeless women Veterans has slightly increased. Since FY19, 11% of Veterans served through VA's homeless programs have been women.

A study by the National Center on Homelessness Among Veterans has found that although Veterans with a lower income capacity are at increased risk of housing instability, this link is not direct; money management and financial literacy are key factors. Women Veterans are less likely to be under the Federal poverty line than women non-Veterans; however, women Veterans are more likely to be under the Federal poverty line than male Veterans.

According to VA's National Center for Veterans Analysis and Statistics' 2017 Profile of Veterans, 9.4% of women Veterans were under the Federal poverty line versus 6.4% of male Veterans. African American women Veterans were at the highest risk of being under the Federal poverty line. Among male Veterans, American Indian and Alaska Native (AI/AN) male Veterans were at the highest risk of being under the Federal poverty line. VA does not have current data on how race and ethnicity impact Veteran homelessness. VA is working to obtain data on how race and gender interact to impact Veteran homelessness. Male Veterans had the highest earnings, followed by women Veterans, male non-Veterans and then women non-Veterans. This pattern could also be found for median personal income.

HPO's strategic plan, Released in March 2021, outlines its vision for the future and its path to ending homelessness among Veterans and their families. This plan includes six fundamental objectives: 1) expand and increase housing stock; 2) prevent and resolve returns to homelessness; 3) enhance targeted services to address the needs of high acuity and vulnerable populations; 4) support the development of a highly skilled workforce; 5) use research and state-of-the-art analytic data evaluation tools and processes to make informed and timely decisions; and 6) provide equitable services and outcomes through all homeless programs and services. The first and second objectives have strategies that target opportunities for partnerships, such as developing initiatives towards enhancing and creating partnerships that expand housing stock and affordable housing opportunities, collaborating with communities to expand capacity and repurpose existing housing stock, developing shared housing and diversion

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opportunities (objective 1) and expanding access to employment and vocational training opportunities (objective 2).

ACWV members can email homelessvets@va.gov with questions and comments about VHA's homeless programs and can visit www.va.gov/homeless for more information on these programs and Veteran homelessness.

The Chair applauded VHA's efforts in applying the new law impacting the GPD Program and asked if Dr. Hooshyar believes this law will positively impact Veterans who are couch surfing. Dr. Hooshyar responded yes. VHA is heavily advertising this law change to GPD grantees. Vice Chair McLaughlin said that it would be helpful to see data comparing the percentage of women Veterans experiencing homelessness versus the percentage of male Veterans experiencing homelessness to understand if and why there are any trends. Dr. Hooshyar responded that VHA can conduct these calculations and explore any actionable issues. She added that caretaking duties and lower income capacity are risk factors that disproportionately affect women Veterans.

Ms. Wright commented that the HUD-VASH program currently has two big issues: HUD-VASH vouchers do not adequately cover housing costs in many areas and many developers are struggling to trust VA to have enough vouchers available to pay for big developments. Dr. Hooshyar commented that HUD and VA are aware of these challenges. Both HUD and VA Secretaries have released a joint statement recommitting to address these issues and other issues that factor into homelessness. HUD oversees the amount of money that goes into vouchers, whereas VA oversees connecting vouchers to housing and providing supportive services.

Dr. Mathewson-Chapman asked if VA's Homelessness Risk Screening Clinical Reminder (HRSCR) is being used, how often it is prompted and what is done if a Veteran screens positive? Dr. Hooshyar responded that the HRSCR is being used and is prompted annually. If a Veteran screens positive, the facility's homeless programs staff member will be alerted to work with the Veteran. Often, there is a warm hand-off between the medical provider and the staff member.

Ms. Miller commented that special funding for elderly homeless Veterans has not increased in several years and recommended that VA increase its focus on services for elderly homeless Veterans. Dr. Hooshyar responded that she will bring this comment back to VHA and encouraged Ms. Miller to continue advocating to VA on this issue. She added that elderly homeless Veterans are a specific target population for HPO. HPO is working on ways to help this population, including utilizing existing resources. Dr. Hayes commented on the importance of stratifying data by age, to properly understand the data and prepare for the aging of the population. Many women Veterans ages 50-65 did not serve during a time of war and so are not eligible for non-service-connected pensions. Dr. Bruce commented that intimate partner violence (IPV) is a risk factor for Veteran housing insecurity; VA's IPV Assistance Program (IPVAP) works closely with HPO. VHA's IPV assessments include questions about housing insecurity. The IPV program is working to build research on the relationship between IPV and housing

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insecurity. Dr. Hooshyar added that the Federal government considers anyone fleeing IPV to be homeless.

Ms. Tiglao asked if VHA has any plans to use the HRSCR during emergency room (ER) visits. Dr. Hooshyar responded that she does not believe that VHA currently uses the HRSCR during ER visits, however providers ask about housing status outside of the HRSCR. Ms. Tiglao asked if the HUD-VASH program fully utilizes HUD vouchers. Dr. Hooshyar responded that there have been some challenges, however HUD is actively working to increase utilization rates by exploring innovative practices to incentivize landlords to accept HUD vouchers.

CWV Brief Update on Women Veterans Survey/IPV/NDAA Research **Elizabeth Estabrooks, Deputy Director, CWV**

Ms. Estabrooks provided an update on several studies and surveys CWV is currently conducting. The 2020-2021 NDAA mandated that CWV conduct a study on unemployment in post-9/11 women Veterans in consultation with the Bureau of Labor Statistics (BLS) and Department of Labor (DOL). The study seeks to understand why post-9/11 women Veterans are at higher risk of unemployment than all other women Veteran groups or their non-Veteran counterparts. The study compares men and women as well as Veterans and non-Veterans. CWV is collaborating with a research team from Salt Lake City VA, led by research scientist (and Veteran) Dr. Mary Jo Pugh, to accomplish this mandate

Due to time constraints, CWV is unable to conduct a full study; rather, this will be a hybrid study that consists of secondary analysis of existing data sources as well as Quality Enhancement Research Initiative (QUERI) surveys designed by Dr. Andrea Kalvesmaki for this study. Congress mandated that 14 variables be included in the study, including: rank at the time of discharge, geographic location at the time of discharge, barriers to employment, education, and health. CWV decided to include MST and related mental health impacts as a study variable. MST and its mental health impacts are a risk factor for unemployment; however, many existing studies on unemployment and post-9/11 women Veterans do not include these as variables. Although not mandated, CWV will also include recommendations. CWV surveyed women Veterans and non-Veterans and will receive responses in January 2022. The secondary analysis of existing data is nearly complete. The study report will be delivered to SECVA in March 2022 for review and then to Congress in June 2022. CWV will present the report to the ACWV after it is received by Congress.

Section 5302 of the Deborah Sampson Act amended the ACWV's authority—and subsequently the ACWV's charter—to include an assessment of the effects of intimate partner violence on women Veterans. The ACWV consider IPV as it establishes recommendations and findings for its report and received updates on IPV during ACWV site visits. CWV was proud to report that the ACWV has regularly included recommendations and findings on IPV in its biennial reports for quite a while. CWV has completed both mandates.

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Section 5305 of the Deborah Sampson Act requires VA to conduct a national baseline study to examine the scope of IPV and sexual assault among Veterans and spouses and intimate partners of Veterans as well as a task force to develop a comprehensive national program to address IPV and sexual assault among Veterans. The study examines IPV and sexual assault among Veterans and spouses and consists of a secondary analysis of existing data sources. CWV, in collaboration with VHA's IPVAP, is responsible for implementation of Section 5305. CWV will the conduct a national baseline study on Veterans who are impacted by intimate partner violence and sexual assault and create a task force.

Given time limitations, CWV will not be able to complete a full survey. The study will include recommendations developed by an expert panel, which is being assembled by VA Health Services Research and Development (HSR&D) Service. CWV will collaborate with other VA offices to complete the mandated activities. The study is underway; a report will be sent to SECVA in September 2022 for review and then to Congress in December 2022. CWV anticipates that this study will be very beneficial for Veterans.

VA is required to establish the task force within 90 days of completion of the study. CWV is working with VA Leadership the Office of Families, Caregivers, and Survivors, the Office of General Counsel and the Office of Congressional and Legislative Affairs to begin preliminary work in developing legal requirements and structure on establishment of the task force. CWV will continue working with VA and other stakeholders to ensure establishment is on track.

CWV has been developing a survey with VEO to learn more about women Veterans who do not use VA benefits or services. The survey was released in English in November 2021 and will be released in Spanish and Tagalog in January 2022. CWV's goal is to receive responses from 20,000 women Veterans in a year. Survey questions include the Veteran's service branch, sexuality, gender, geographic location, and why the Veteran is or is not using VA services/benefits. The survey includes one question on MST; CWV worked with a MST specialist to structure the question in a way that does not trigger survey respondents. Preliminary results show a connection between MST and a lack of use of VA services/benefits and show that Marines are the least likely Service branch to apply for benefits. CWV will release the survey's first set of data at the partners meeting in January 2022. CWV has partnered with several different organizations and would ask the ACWV to help advertise the survey to women Veterans. Thus far, almost 5,000 women Veterans have responded to the survey, 3,000 of whom are not currently using VA services/benefits.

Ms. Black, from The American Legion, asked how VSOs can help advertise the survey on Veteran use of VA benefits/services. Ms. Estabrooks responded that CWV has distributed a flyer and QR code advertising the survey through the VSO Office and can send these items to Ms. Black if she has not already received them. CWV is also advertising the survey through social media. Ms. Wright asked if CWV believes it will meet its goal of 20,000 respondents for this survey. Ms. Estabrooks responded that it

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looks promising thus far. CWV is implementing several approaches to reach different populations of women Veterans. Ms. Wright asked if survey data is separated by state; Ms. Estabrooks responded yes. One of the survey's purposes is to understand trends of service/benefit use to better target outreach. Ms. Wright asked if CWV distributed the survey to state WVCs; Ms. Estabrooks responded yes. LTC McLaughlin thanked Ms. Estabrooks and CWV for its work in developing this survey and added that she thinks the survey results will be very helpful.

Overview of VA's Office of Rural Health

Dr. Thomas Klobucar, Director, Office of Rural Health, VHA

Dr. Klobucar provided an overview of VHA's Office of Rural Health (ORH). Congress created the ORH in 2006 to conduct studies on rural Veterans, develop innovative clinical services to address gaps in access to care for rural Veterans, and disseminate innovations system-wide. ORH does so through its Veterans Rural Health Resource Centers (VRHRCs) and partnering program offices such as the OWH. VRHRCs are located throughout the U.S. and conduct research on rural women Veterans. ORH has VRHRCs in White River Junction, Vermont; Iowa City, Iowa; Portland, Oregon; Salt Lake City, Utah; and Gainesville, Florida.

ORH's vision is that Veterans thrive in rural areas and its mission is to: improve the health and well-being of rural Veterans through research, innovation, and dissemination of best practices. Its strategic goals are to promote Federal and community care solutions for rural Veterans; reduce rural health care workforce disparities; and enrich rural health research and innovation.

ORH manages the Secretary's rural health initiative budget. Since 2012, ORH has funded \$2.5 billion in projects. For 2021, there are 42 Enterprise-wide initiatives (eight additional rural promising practices) adopted at 99% of VA health care systems. Rural Promising Practices are field-tested innovations developed by ORH's VRHRCs to increase access to care for rural Veterans. Enterprise-wide initiatives (EWI) are proven health care interventions that ORH disseminates systemwide. Promising practices criteria include increased access; evidence of clinical impact; customer satisfaction and patient experience; return on investment; operational feasibility; strong partnerships and/or working relationship. ORH leverages resources to study, innovate and spread EWIs through local and national partnerships.

ORH and the Veterans Rural Health Advisory Committee (VRHAC) declared 2020 as the year of the rural woman Veteran. In 2020, the VRHAC developed two recommendations around rural women Veterans' health care.

Nearly 26% of enrolled women Veterans live in rural areas. Since 2013, there has been a 52% increase of women Veterans 50 and older and a 79% increase of those 65 and older. Forty one percent of women Veterans over age 50 and 66% over age 65 live in rural areas. Sixty seven percent of rural women Veterans enrolled in VA health care have a service-connected condition.

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Since 2013, the minority women Veterans population has grown by 81% overall and 55% in rural areas. In many ways, the rural women Veterans population looks the same as the urban women Veterans population; however, there are some significant differences in distribution for different racial and ethnic groups between the two. Compared to urban women Veterans, rural women Veterans are more likely to have an income below \$35,000/year, less likely to be employed full time, less likely to report having been in combat after 9/11, less likely to have non-VA health insurance and less likely to use only VA providers. This data underscores differences between rural and urban women Veterans; a solution for rural women Veterans may look different than one for urban women Veterans.

The VRHRCs several programs for women Veterans on a variety of topics, such as: The Veterans Reproductive Health Engagement Program (VetRHEP) at the Utah VRHRC and Access to Voice and Communication Interventions for Rural Transgender Veterans at the Portland VRHRC. The Iowa City VRHRC has programs addressing suicide prevention, rural Native American women Veterans' utilization, food insecurity, facilitating access to health care for out-of-care rural women Veterans using combination outreach and wellness intervention and chronic pain care.

For FY22, ORH partnered with OWH to develop EWIs that provide clinical skills training for rural health care providers in skills unique to the treatment of rural women Veterans and training in women Veterans care coordination and management that creates, enhances and expands care coordination in the areas of maternity care, mammography, cervical cancer screening and breast cancer care. ORH's clinical skills training program has trained hundreds of providers in treatment of rural women Veterans. ORH has a broad distribution of women Veterans-centered programs across the country. By 2037, ORH anticipates that a significant number of women Veterans will be enrolled in largely rural networks.

The total Veterans population is projected to decrease, but the proportion of women Veterans is projected to increase. The number of enrolled Veterans and Veteran patients is projected to remain stable with an increase in proportion of women Veterans. ORH has seen significant increases in rural women Veterans population over the past several years.

The Chair said that the ACWV can collaborate with the VRHAC to review its recommendations on rural women Veterans; Dr. Klobucar agreed that this would be a good idea. The Chair asked if ORH has considered collaborating with VBA when conducting outreach to rural women Veterans to ensure rural women Veterans can access their benefits; Dr. Klobucar agreed that it is important to have this kind of consolidated effort. Ms. Wright asked if ORH has concerns about isolation and its mental health impacts in elderly rural women Veterans. Dr. Klobucar responded that ORH is concerned about and working to address this issue. ORH is working with VA's Office of Mental Health and Suicide Prevention to develop programs around rural suicide prevention; these programs are not specifically targeted towards women Veterans.

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Mr. McIntosh thanked ORH for its willingness to collaborate with other offices. Ms. Parker asked if ORH has concerns about rural Veterans' access to dentistry services. Dr. Klobucar responded that dental provider shortages in rural areas are a major issue. ORH is developing a teledentistry program to help address this issue, but this is only part of the solution.

Rapid Review of Intimate Partner Violence Research Requirement **Dr. Nicholas Parr, Associate Director, VA Evidence Synthesis Program** **Coordinating Center**

Dr. Parr gave a briefing on the rapid review of IPV research. The purpose of the rapid review was to synthesize what is known about the prevalence of IPV and sexual assault committed by intimate partners of Veterans or spouses of Veterans and the different forms of IPV and sexual assault. The review's report is independent and does not necessarily reflect the views of CWV, VA, or Federal government.

VA Evidence Synthesis Program (ESP) conducted the rapid review in response to a request by CWV. Given time constraints, ESP did not include data on non-partner sexual assault in the review. IPV includes physical violence, sexual violence, stalking, or psychological aggression by a current or former intimate partner. Women Veterans experience higher rates of IPV than women non-Veterans. It is not fully understood if male Veterans experience higher rates of IPV than male non-Veterans. It is also not understood if racial/ethnic minority and sexual and gender minority Veterans experience higher rates of IPV than non-minority Veterans.

The rapid review report aims to synthesize information on the prevalence of experienced IPV and sexual assault among Veterans and intimate partners of Veterans by type (physical, sexual, or psychological/emotional), timing (lifetime or past-year), and sociodemographic characteristics (gender identity) of the Veteran and intimate partner; the prevalence of past year IPV perpetration by Veterans by type and broken out by gender identity; and common recruitment strategies and data collection methods utilized in studies of IPV/SA prevalence among Veterans and spouses/intimate partners of Veterans.

The rapid review's overall findings were that there is considerable variation in sampling, recruitment, and data collection methods used among available studies, limiting the informativeness and quality of the overall body of evidence on IPV/SA among Veterans and spouses/intimate partners of Veterans. Moderate and low strength evidence suggests that psychological/emotional IPV is the most common form of experienced and perpetrated IPV/SA among both Veteran women and men, followed by physical IPV and sexual IPV. Most available evidence pertains to experienced IPV/SA among Veteran women and IPV/SA perpetrated by Veteran men. Experienced IPV/SA among Veteran men, IPV/SA perpetrated by Veteran women, and IPV/SA among minority Veterans and intimate partners/spouses of Veterans are understudied. Future studies of IPV/SA prevalence among Veterans should attempt to generate prevalence estimates that are applicable to Veterans of the range of ages, sexual and gender identities, races/ ethnicities, and geographic contexts present in the Veterans population.

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The review found a high prevalence of psychological and emotional IPV in both male and women Veterans. However, there are some caveats. First, there is no data available to make a lifetime estimate of psychological experienced IPV for male Veterans. Second, there is more and stronger evidence and research on experienced IPV by women Veterans than male Veterans. It is difficult to compare the two populations based on the quality of current data and the disparity in the amount of evidence.

The strongest data that exists is for experienced IPV among women Veterans. The review found that available evidence on perpetrated IPV is more limited in general than evidence on experienced IPV. Data suggests that lifetime prevalence of perpetrated physical IPV is about 33% and past year prevalence of perpetrated physical IPV is 18-22%. One would expect past year data to be higher or at least comparable to lifetime data; this difference could suggest poor quality studies. Past year perpetrated psychological and emotional IPV was found to be 60-75%; this elevated rate could suggest study bias. The most evidence was available for past year perpetrated physical IPV; data showed a prevalence estimate of 32%. Data on past year perpetrated psychological and emotional IPV appeared to be biased.

The review found very little evidence on the role of socio-demographic factors on IPV prevalence rates. Relevant studies identified by the review were rigorous but were small to moderate in size and only focused on women Veterans. Available evidence suggests that past year experienced IPV may decrease with age and may be more prevalent among lesbian, gay, and bisexual women Veterans than heterosexual women Veterans. The ESP did not find any data on gender minorities. A single study found similar past year experienced IPV rates among rural and urban women Veterans. Studies reporting differences in past year experienced IPV by race and ethnicity groups were inconsistent in their reported prevalence estimates and in their definitions of race and ethnicity groups. It is still unclear whether experienced or perpetrated IPV prevalence rates differ by race and ethnicity groups. The review found different issues in tools used to collect IPV data and in how and where that data is collected.

There were other limitations of evidence. Available studies used a variety of sampling, recruitment, and data collection methods. Some studies used random sampling methods to reduce biases in data collection, while others used convenience samples that are likely poorly representative of the Veteran population and could over- or under-represent the prevalence of various forms of IPV/SA among Veterans. IPV/SA prevalence was most collected via surveys using validated measures of IPV/SA, but measures varied across studies and several studies used unvalidated ad hoc measures. Inconsistency among, and limitations of, study sampling approaches and measurement instruments, modalities, and settings may also lead to inaccurate prevalence estimates.

In future research, methods should be used that would generate more applicable prevalence estimates that are applicable to a greater range of identities, ages, and

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geographic locations. One such method is stratified random sampling with oversampling of important subgroups. However, although rigorous sampling methods are necessary to develop generalizable and applicable prevalence estimates, they do not necessarily address reporting biases. ESP recommends that IPV prevalence estimates derived from health care data be interpreted in concert with rigorous survey research to ascertain if prevalence estimates derived from health care data are significantly over- or under-inflated. If there are changes considered for how IPV is measured in VA clinical settings, ESP would recommend using briefer assessment tools that minimize respondent burden and allowing respondents to choose from a variety of survey modalities. A major area for future data collection is ensuring that assessment tools are culturally appropriate for measuring experienced and perpetrated IPV among minority populations.

Ms. Wright asked, based on the information gathered in the rapid review, what the ACWV can do to help Veterans experiencing IPV. Dr. Parr responded that there is a need for IPV among underrepresented groups to be accurately counted to understand where resources and support are needed; the ACWV can help by encouraging and assisting these groups to share their experiences.

Veterans Benefits Banking Program/Financial Literacy for Veterans Christine Bensedira, Director, Office of Finance, VBA; Michael Ewald, Deputy Director, Office of Finance, VBA

Ms. Bensedira and Mr. Ewald provided a briefing on VBA's Veterans Benefits Banking Program (VBBP). A 2020 Federal Reserve report found that one out five adults in the U.S. were either unbanked (6%) or underbanked (16%) in 2019. Unbanked individuals do not utilize any financial institution for their banking needs; underbanked individuals may utilize a financial institution but also utilize alternative services such as paper checks and payday loans. Of all unbanked individuals, 55% are women. It is important to ensure Veterans are banked to protect their benefits, help them build wealth, give them more access to financial support services and inclusivity and to enable VA to pay benefits. Alternative services are costly and put Veterans at greater risk of having their benefits stolen. Additionally, all benefit payments are required by law to be paid by EFT.

The VBBP was created in 2019 through a partnership between VBA and the Association of Military Banks of America (AMBA). The VBBP offers Veterans and beneficiaries a no-cost or low-cost account through 37 military-friendly banks and credit unions with the goal of decreasing barriers to banking. All VBBP participating financial institutions are FDIC/NCUA insured. Veterans have access to bank and credit union services such as automatic bill pay and electronic statements. Through this partnership Veterans have opportunities to build credit and accumulate wealth. VBBP banks and credit unions accept Veteran IDs as proof of identification and the VHA address of a Veteran's counselor if the Veteran is homeless. Each VBBP bank and credit union has different enrollment criteria, but all require direct deposit. The VBBP website provides information on and links to participating banks and credit unions to help get started.

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Some of the program's accomplishments include: disseminating quarterly letters to all unbanked Veterans/beneficiaries and marketing of VBBP through social and print media; transmitting over 74,000 emails to unbanked via GovDelivery; conducting outreach to several Veterans service organizations/State and County Veterans Commissions/Federal Agencies; partnering with several internal VA program coordinators and advertising through a VBA public service announcement in community based outpatient clinics.

As of 2019, VA had 178,944 unbanked Veterans. Recent data shows 114,656 Veterans converted from unbanked to banked. However, VBA is noticing that Veterans who will receive benefits for the new presumptive illnesses are opting for disability payment via paper check. The most unbanked Veterans are in compensation and pension; VBA is developing compensation and pension education. VBA is working to get additional banks and credit unions to join VBBP and is working to develop affiliate relationships with foreign banks to assist unbanked Veterans living outside of the U.S. VBA is exploring other automation such as the U.S. Debit Card. VBA continues to conduct outreach and is exploring ways to expand VBBP's inclusivity.

On February 1, 2022, the VBA will be soft launching a free credit counseling program in partnership with the Association of Certified Credit Counselors. VBA is developing financial education and literacy resources with Prudential and other trainings to assist Veterans in learning more about banking and building wealth. VBA is working with the Federal Bureau of Prisons and the Treasury to develop accounts specifically for incarcerated Veterans.

The Chair asked if there is a correlation between the number of unbanked women Veterans and the number of homeless women Veterans and said that this could be an area for targeted outreach. Ms. Bensedira responded that VBA is working with VA's homeless Veterans coordinators to conduct outreach to homeless Veterans.

The Chair asked if there is a correlation between the number of unbanked women Veterans and the number of homeless women Veterans and said that this could be an area for targeted outreach. Ms. Bensedira responded that VBA does not have specific data regarding this correlation. She added that VBA is working with the VA's homeless Veterans coordinator to conduct nationwide outreach to homeless Veterans. Ms. Beldo-Lilley asked for clarification on how a Veteran can use a counselor's address to create an account through the VBBP. Ms. Bensedira responded that the Patriot Act requires all individuals creating a bank account to submit an address; P.O. Box addresses are not permitted. When creating an account through the VBBP, homeless Veterans can use their counselor's VA address to meet this Patriot Act requirement. The Veteran's mail can be sent to this address and collected by the Veteran when meeting with the counselor. Homeless Veterans tend to maintain regular contact with their counselor despite other instability; as a result, a counselor's VA address is a good option for homeless Veterans to use when creating an account through the VBBP.

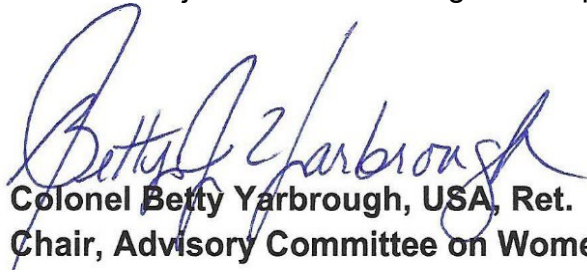
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Meeting Adjourned

Betty Yarbrough (Colonel, U.S. Army, Retired), Chair, ACWV

The Chair acknowledged that this meeting would be Ms. Harris's last meeting and opened the floor for ACWV, the DFO, ex officios and advisors to recognize her outstanding and impactful contributions to the ACWV, as the immediate past Chair and a member. Ms. Harris thanked the ACWV members for their service and commented on the importance of the ACWV's work.

The Chair adjourned the meeting at 1:48 pm EST.



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



Lourdes Tiglao

Designated Federal Officer, Advisory Committee on Women Veterans