Department of Veterans Affairs (VA)
Advisory Committee on Women Veterans (ACWV)
Site Visit: VA Maryland Health Care System (VAMHCS)
10 North Greene Street, Baltimore, MD 21201-1524
June 13-16, 2023

The Advisory Committee on Women Veterans (ACWV) conducted a virtual site visit with VA Maryland Health Care System (VAMHCS) and Veterans Integrated Service Network 5 (VISN 5): VA Capitol Health Care System. COL Betty Yarbrough, USA, Ret., Chair, presiding.

ACWV Members Present:
COL Betty Yarbrough, USA, Ret., Chair
COL Nestor Aliga, USA, Ret.
Dr. Jacqueleen Bido, USN Veteran
Delise Coleman, USMC Veteran
MG Sharon Dunbar, USAF, Ret.
COL Wistaria Joseph, USAF, Ret.
CAPT (Dr.) Cynthia Macri, USN, Ret.
LTC Shannon McLaughlin, Massachusetts Army National Guard, Vice Chair for Benefits Subcommittee
Sandra Miller, USN Veteran
MSG Lachrisha Parker, USAR, Ret.
COL Wanda Wright, USAF, Ret., Vice Chair for Health Subcommittee

ACWV Ex-Officio Members Present:
Dr. Janet Porter, Office of Women's Health, Veterans Health Administration (VHA)

Center for Women Veterans (CWV) Staff Present:
Lourdes Tiglao, CWV Executive Director/Designated Federal Officer (DFO)
Shannon L. Middleton, Committee Manager/ADFO

Other VA Staff:
Kelley Anthony, VAMHCS
Dr. Rachel, Austin, VAMHCS
Shana Balogun, Washington DC VA Medical Center
Jelessa Burney, Advisory Committee Management Office (ACMO)
Christopher Buser, VAMHCS
Dr. Christine Calm, VAMHCS
Alison Carmier, VAMHCS
Denise Colbert, VAMHCS
Craig Cook, VAMHCS
Catherine Cross, VAMHCS
Patricia Davis, VAMHCS
Johnny Delgado, VAMHCS
Seth Frejkowski, VAMHCS

Matthew Funke, VAMHCS
Dr. Michael Gatson, Annapolis Vet Center
Sharon D. Green, VA New England Healthcare System
Dr. Martin Garcia, VAMHCS
Anne T. Hall, VAMHCS
Jennifer Hawkins, Hershel "Woody" Williams VA Medical Center
Julianna Holt, Board of Veterans Appeals
Dr. Aaron Jacoby, VAMHCS
Nikole Jones, VAMHCS
Siobhan Kirksey, VAMHCS
Lori Lohar, VA Office of Inspector General
Dr. Sandra Marshall, VAMHCS
Zelda McCormick, VISN 5
Cherri Mercury, Huntington Regional Benefit Office (RO)
Dr. Abisola B. Mesioye, VAMHCS
Heather Mitchell, VAMHCS
Jeffrey Moragne, ACMO
Tiera Moore, VAMHCS
Amy Sanchez-Olivera, VAMHCS
Joseph Scotchlas, VISN 5
DeShaun Sewell, VBA
Eric Solomon, Baltimore National Cemetery Complex
Carolyn Stallings, VAMHCS
Dr. Catherine Staropoli, VAMHCS
Sonay Taylor, VAMHCS
Latarsha Tyler, VISN 5
Antione Waller, Baltimore VARO
Garcia Williams, Baltimore RO
Lindsey Williams, VAMHCS

Public Guest:
Cathy, public
Tiffany Daniel, public
Anonymous Caller, public (4)

Tuesday, June 13, 2023--VA Maryland Health Care System (VAMHCS), Room #3a-300; Baltimore, MD 21201-1524
Chair Yarbrough opened the meeting by giving a short introduction and background, and then had the rest of the committee members and Center for Women Veterans staff do the same.

Welcome
Christopher Buser, Acting Medical Center Director, VAMHCS
Mr. Buser welcomed the committee and provided brief comments about the upcoming presentations.

Purpose for Site Visit
Lourdes Tiglao, Executive Director, VA Center for Women Veterans/ ACWV Designated Federal Officer
Ms. Tiglao provided the purpose of the site visit, which is to provide an opportunity for Committee members to compare the information they received from briefings provided by the Administrations and Program Offices at VA Central Office with the activity in the field. The site visits allow Committee members to learn about the treatment, programs and provision of benefits and services in place for women Veterans in VISN 5, especially in Baltimore, Maryland. All presentations address how programs, services, and benefits relate to women Veterans.

She added that site visits are considered advisory in nature. This visit will give VAMHCS senior leaders an opportunity to discuss any special interests they would like to share with the Secretary or address any concerns regarding the welfare of women Veterans. It also gives them an opportunity to demonstrate how they address the unique challenges or barriers that the women Veterans in their area encounter in accessing VA's benefits and services.

Ms. Tiglao then noted the locations where the Committee conducted previous site visits.

Review Agenda
Betty Yarbrough, Chair, ACWV
The Chair conducted a general overview of the agenda for the Committee's consideration.

FACA 101 Briefing
Jeffrey Moragne, Director, Advisory Committee Management Office, Office of the Secretary
Mr. Moragne provided an overview of the Federal Advisory Committee Act (FACA), a Federal statute that governs the establishment, termination, and management of Federal Advisory Committees (FAC). FACA promotes transparency and accountability to regulate the number and duration of FACs. He further explained that FACA applies to all groups with at least one non-Federal employee established or utilized by an agency to obtain advice or recommendations, unless an exception applies.
FACs are required to have components such as: a signed/filed charter; a designated Federal officer (DFO); public meetings announced in Federal Register 15 days in advance of the meeting; an opportunity for public to speak or submit written comments; a balanced membership; and records maintained and available for public inspection.

Mr. Moragne further explained that FAC meetings are open to the public but can be closed or partially closed under limited circumstances, such as when discussing trade secrets, personal information, and criminal matters. Meetings can convene in person, virtually or a hybrid of both options (in person and virtual). A quorum (half the membership plus one) must be present, unless otherwise established in the Committee's charter or legislation. Meetings must also have an approved agenda.

FACs can only meet privately to conduct two types of work: preparatory work with two or more Committee or Subcommittee members coming together solely to gather information, conduct research, analyze relevant issues, facts in preparation for a FAC meeting or to draft papers for deliberation by FAC; and administrative work, with two or more Committee members gathering to discuss administrative items.

Mr. Moragne explained that Committee members can speak on FAC matters as private citizens, making sure to note that FAC members cannot testify on behalf of the Committee and cannot speak for VA.

He concluded by sharing several best practices for the Committee's consideration.

Overview of VISN 5 Facilities/Programs/Demographics
Joseph Scotchlas, Deputy Network Director, Veterans Integrated Service Network (VISN) 5: VA Capitol Health Care Network
Mr. Scotchlas provided an overview of Veterans Integrated Service network (VISN) 5's programs and services in its network of hospitals serving this geographic area. VISN 5 provides both administrative and clinical supervision and guidance to the medical centers under its responsibility, allowing for local decision making and local resourcing. It also allows for collaboration, sharing of best practices, and providing support between the hospitals. So for instance, if one of the hospitals in the network is having a particular leadership challenge or maybe a clinical opportunity, they can work together to find a resolution.

The facilities also work together on other projects. For instance, multiple hospitals in the VISN share laundry services, provide virtual care to enable them to share clinical services, and provide technical service to sites that may not have this type of support.

VISN 5 primarily includes Maryland, West Virginia, and the District of Columbia. However, it also includes several counties in Pennsylvania, Ohio, Kentucky and in the northern most portion of Virginia. It encompasses six main parent facilities: the Maryland Health Care System, of which the Baltimore VA Medical Center is the main component; the Washington DC VA Medical Center; the Martinsburg VA Medical Center, which includes most of western Maryland and the eastern portion of West Virginia; the Louis A. Johnson VA Medical Center in Clarksburg, covering the northern partition of West Virginia; Beckley VA Medical Center covering southeast West Virginia; the Huntington VA Medical Center includes the VISN's western portion of West Virginia, as well as southern Ohio and our Kentucky areas; each of those have associated hospitals and clinics related to them.

VISN 5's senior management team is led by network director Robert Walton, who supervises all the medical center directors. As deputy network director, Mr. Scotchlas oversees administrative operations, such as engineering, capital dollars, VA police, biomedical engineering, and supply chain. Dr. Michelle Buchanan Michelle Buchanan, the interim chief medical officer, oversees clinical programs like primary care, mental health, women Veterans, and care reports. The quality management officer and chief nursing officer oversee the quality programs to ensure compliance Joint Commission requirements, making sure that they are

doing things like peer review and utilization management reviews. She also oversees the nursing workforce, making sure that they are providing high quality care.

Mr. Scotchlas described the six markets in the seven states that the VISN oversees, which encompass 111 counties. They collaborate heavily with more than 20 Veterans service organizations (VSO), especially Disabled American Veterans, Veterans of Foreign Wars, and The American Legion. The VISN holds management assistance Council (MAC) meetings where they have discussions with VSOs about what they are seeing in the Veterans community.

Mr. Scotchlas noted that VISN 5 encompasses 16 House of Representatives congressional districts and that they work with twelve senators across the states they serve. They also coordinate with the states' Veterans Affairs offices too in addressing Veterans' needs. He noted that the recently met with the Secretary of West Virginia's Department of Veterans Affairs, where they discussed the state's emphasis on women Veterans' care across West Virginia. The areas they cover include highly rural areas where it is difficult for Veterans to access care--such as Clarksburg and Beckley, West Virginia--and very urban areas, like Washington, DC and Baltimore, Maryland, where Veterans can benefit from VA's affiliation with the best medical institutions in the country, like the University of Maryland, Johns Hopkins Hospital, Georgetown, Washington University

Mr. Scotchlas discussed VISN 5's 49 sites of care and their complexity levels. Facilities are classified into three levels, with level 1 representing the most complex facilities, level 2 moderately complex facilities, and level 3 the least complex facilities. Level 1 is further subdivided into categories 1A through 1C. VAMHCS has three 1B-level medical centers: the Baltimore VA Medical Center (VAMC), Lock Raven VAMC (both in Baltimore), and the Perry Point VAMC in Cecil County, along 95 going out towards Pennsylvania. The Beckley VAMC, which is in the southeastern portion of West Virginia, is a level 2 facility. Clarksburg VAMC, Huntington VAMC, and Martinsburg VAMC are all 1C facilities. The Washington DC VAMC is also an 1B level facility.

VISN 5 has 28 community-based outpatient clinics (CBOC) of varying different sizes, three of which are collocated with Department of Defense installations in Fort Meade, Fort Detrick, and Fort Belvoir. There are also six community living centers (CLC), or nursing homes, across the facilities. CLCs provide home-like environments for aging Veterans. There are four domiciliary programs across the network, where VA provides residential rehabilitation care related to substance abuse disorders, mental health, or homelessness; three community resource and referral centers for Veterans who may be experiencing homelessness or at risk of homelessness; and 14 Vet Centers especially.

He explained that VISN 5 is the smallest VISN in the country, serving about 250,000 Veterans, with about 3,000,000 outpatient visits; 17,000 admissions; 1502 operating beds; 13,021 employees; 945 physicians; and 2971 nurses.

Mr. Scotchlas discussed VA's Under Secretary for Health's priorities: hiring faster and more competitively; connecting Veterans to the soonest and best care; serving Veterans

with military environmental exposures; accelerating VA's journey to a high reliability organization; supporting Veterans' whole health, their caregivers, and survivors; and preventing Veteran suicide.

VISN 5 is engaged in conversations about its continued work with its academic affiliates, to improve access for rural Veterans. For instance, they have an academic affiliation with Marshall University in Huntington and West Virginia University to provide a pipeline of doctors, nurses, and professionals available to care for Veterans in West Virginia.

VISN 5's clinical resource hub allows them to provide virtual care with specialists in some of the higher density population areas where there are a lot of the specialists, to provide specialty care to Veterans across the system. They are significantly engaged with PACT Act and military, environmental and exposures, increasing staffing in areas like pulmonology for Veterans with lung cancer and in radiology and imaging.

They are working with staff to promote high reliability organization internally, working towards the ultimate goal of zero harm; providing a lot of demonstration projects to other VISNs on things that they have done to improve higher reliability; hiring high reliability officer, which does a great job and continues to improve our whole health for caregivers and their survivors.

They are hiring whole health coaches across the VISN and increasing their complementary and alternative medicine services to really focus on Veterans' needs and individual priorities. They are engaged in suicide prevention efforts too.

VISN 5 is a part of VA Northeast Consortium (VANEC), where VISNS collaborate on efficiency projects to increase the quality of care and reduce the cost to the taxpayer. VANEC is comprised of VA New England Healthcare System in VISN 1, serving Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; VA NY/NJ Veterans Healthcare Network in VISN 2, serving New York and New Jersey; VISN 4 Network, serving Delaware, New Jersey, Ohio, Pennsylvania; and VA Capitol Health Care Network in VISN 5, serving Maryland, Virginia, Washington D.C., and West Virginia. VANEC Board of Directors consists of the network directors from the four participating VISNs, who act as the approving body for recommendations presented by steering committee. VANEC Steering Committee champions projects at a regional and national level that have positive impact on medical center operations.

One example of the VANEC's benefit is in how it was able to collectively order hospital beds, saving several millions of dollars and making it possible for the hiring of more doctors and nurses who care for Veterans.

He shared that VISN 5 houses six VA clinical programs of excellence: the Seriously Mentally III Program (a network-wide initiative); the Health Care for the Homeless Program (Washington VAMC); the Home-Based Primary Care Program (now across all their facilities); the Epilepsy Center of Excellence (VA Maryland HCS); the Maryland

Exercise and Robotics Center of Excellence (VA Maryland HCS); and the Multiple Sclerosis (MS) Center of Excellence (Washington VAMC).

Additionally, VISN 5 houses one of two War-Related Illness & Injury Center (Washington VAMC); the Geriatric Research, Education and Clinical Center (GRECC) (VA Maryland HCS); the Mental Illness Research, Education and Clinical Center (MIRECC) (VA Maryland HCS); and the Eastern Pacemaker Center (Washington VAMC).

Mr. Scotchlas briefly discussed the age of VISN 5's facilities and infrastructure improvement projects. They are currently in the process of discussing upgrades and expanding their facilities. One of the biggest projects they are considering is a full-size replacement of the Washington, D.C. facility. It is starting to show its age and needs a wholesale replacement. They are in the process of expanding and upgrading CBOCs and CLCs across the VISN.

They are currently expanding a woman's clinic in Martinsburg to include a dedicated private entrance and working on a major lease that will bring significant number of primary care providers and mental health providers to Prince George County. They are also looking at establishing clinics in Prince William County (Virginia), Hagerstown (Maryland) and Baltimore City. These new expansion initiatives are extremely important for Women's Health and women's care. All the new expansions will be built to the latest primary care patient aligned care team models, which requires dedicated women's clinic spaces, which include dedicated Women's Health exam rooms with private bathrooms that are much larger and provide more spaces for women Veterans and will provide a better opportunity to provide more culturally competent and appropriate care for women Veterans in these spaces.

Overview of VISN 5 Women Veterans Services
Zelda McCormick, Lead Women Veterans Program Manager (WVPM), VISN 5
Ms. McCormick shared Women's health national mission of addressing the health care needs of women Veterans and working to ensure that their care is timely, equitable and high quality and comprehensive, provided in a sensitive and safe environment in all their VA facilities. VISN 5 is prioritizing staff engagement, education, training, routine needs assessments and the use of special purpose funding to elevate standards of care for women, so VA will be their health care provider of choice.

VISN 5 is fulfilling its mission by providing comprehensive primary care by proficient and interested primary care providers and Women's Health teams. They offer care using state of the art health care equipment and technology and promote high quality preventive and clinical care that is equal to the care that men receive. They want to ensure that women Veterans receive comprehensive primary care from proficient and interested staff who are interested in taking care of women. Many providers throughout

the VISNs made it clear that they are not interested in doing gender specific care for women.

Some of the ways other ways VISN 5 fulfills its mission is by providing national face to face staff trainings for staff through simulation and web-based courses for primary care, emergency, and mental health staff in our urban and rural catchment; offering designated Women's Health primary care providers and maternity care coordinators who stay connected with Veterans while they are under the care of a community obstetric provider, and nurse care managers that prioritize breast and cervical cancer screening and follow-up. Women's mental health clinicians have a specific interest and specialized training in women Veterans' mental health. Clinical pharmacy specialists ensure the unique medication needs of women are clearly communicated.

To address the privacy, safety, dignity and sensitivity to the gender specific needs, women Veterans program managers (WVPM) participate in environment of care rounds and staff education on the unique needs of women across the lifespan. Women's health partners with other program offices to leverage state of the art health care equipment and technology. They also used special purpose funding to update old equipment or purchase new items and in 2021-2022. The national radiology program partnered with the Office of Women's Health to ensure that the existing mammography units were either upgraded or updated completely.

Ms. McCormick shared that there are five full time WVPMs across all six VAMCs in the VISN; Martinsburg VAMC has a vacancy that it is trying to fill. There are five Women's Health medical directors; Beckley VAMC recruited and will have a director (a gynecologist) onboard July 1, 2023. Two facilities have in-house mammography and five have in-house gynecology. VISN 5 also offers VISN-level community of practice for Women's Health and IVF interdisciplinary team; designated maternity care coordinators designated cancer care nurse navigators and mental health champions at each facility; use of special purpose funding (WHISE) to enhance services. VISN 5 is prioritizing reproductive health implementation, to include medication abortions and abortion procedures, and improving the number of women assigned to a women's Health primary care provider.

Ms. McCormick provided a demographic snapshot (by age) of the 27,395 women Veterans in VISN 5. Women Veterans younger than 25 years (300 unique patients) and 85 years or older (222 unique patients) represent the smallest segments of the population served. There are 3,515 women Veterans aged 25-34; 6,101 are age 35-44; 6,185 are age 45-54; 6,682 are age 55-64; 3,617 are aged 65-74; and 773 are age 75-84.

Discussing reproductive health implementation, Ms. McCormick noted that changes in legislation allows VA to provide women Veterans access to abortion care and services and counseling for medication abortions. VA has always done pregnancy options counseling, but VA now offering abortion counseling for requested abortion.

In Washington DC, they connected a woman with a community provider so that she could receive that care timely, and everything went well. No more cases in VISN 5.

One challenge they face in improving the number of women assigned to a comprehensive Women's Health provider is that women sometimes opt to remain with their provider they are currently assigned to, instead of switching. They do not want to dissuade women from staying with the provider with who they are familiar and comfortable. However, they can continue to promote the benefits of being on the panel of a comprehensive provider and then hope for the best.

She identified the top diagnosis for women in VISN 5, which are essential hypertension (5,974 unique patients); chronic post-traumatic stress disorder (4,773 unique patients); low back pain (4,352 unique patients); anxiety disorder (3,916 unique patients); hyperlipidemia (3,886 unique patients); contact/suspected contact with hazardous substance (3,621 unique patients); gastroesophageal reflux disease without esophagitis (3,000 unique patients); unspecified obesity (2,910 unique patients); unspecified post-traumatic stress disorder (2,783 unique patients); and recurrent and moderate major depressive disorder (2,691 unique patients). Nationally, these diagnoses are also consistent throughout VA among women Veterans.

Discussion maternity care coordination, she noted that VISN 5 had a total of 489 pregnancies in 2022. Most of the pregnancies were at the DC VAMC (267). Baltimore had 128 pregnancies; Martinsburg had 71; Huntington had 14; Clarksburg had 13; and Beckley had 8. At the time of the site visit, VISN 5 coordinated care for a total of 319 pregnancies.

VISN 5's outreach to women Veterans included quarterly focus groups conducted at each facility (virtual and in person); bi-annual town hall meetings (virtual and in person); I AM Not Invisible displays; the White Ribbon Campaign to End Harassment; and community engagement with colleges/universities, Veterans service organizations, and community events.

Each VISN 5 facility has a women Veterans Health Committee that develops and implements a Women's Health strategic plan at a local facility level. It guides the Women's Health program and assists with carrying out improvements and providing high quality equitable care for women Veterans. There is representation from each of the departments or services; other stakeholders are invited and are integral parts of the committee. These are people who are in a decision-making capacity and members who can contribute to the conversation to make suggestions that could enhance care for women Veterans. Each facility has a very robust committee.

Overview of Baltimore and Strategic Partnerships
VAMHCS Executive Leadership Team
Christopher Buser, Acting Director, VAMHCS
Lori Rosenzweig, Associate Director of Operations
Kelley Anthony, Acting Deputy Director, VAMHCS

Patricia Davis, Deputy Director for Patient Care Services, VAMHCS
Mr. Buser began the discussion with some of VAMHCS's partnerships. He explained how his extensive social work experience shapes how he sees Veterans' living environment. He has a systems perspective lens and looks to partner with the community to meet their needs. They have partnerships with the Maryland National Guard and reserve units in the area that go back to late 2003 timeframe. When Veterans were returning from and Iraq and Afghanistan, they realized that they needed to meet them where they were.

Since there are not a lot of big military bases in the area that are big power projection platforms, like Fort Bragg or Fort Benning, Veterans in this area are largely coming out of the National Guard and the reserve units in our area. So, they made early inroads to work with the guard and reserve.

VAMHCS has a team of social workers, outreach workers and nurses going out to local reserve units to participate in pre-mobilization briefings, to talk to the Service members about what their benefits will be when they return. They are finding that many of the guard members are men and women who have been on more than one deployment; some are already coming to VA for care. Some will be eligible for the first time when they return.

VAMHCS also participates in post-deployment activities. Staff engages the Veterans after they have readjusted some at other times during the year, when the stress levels are not so high. For instance, they attend family activity events where they can engage family members who may seek information on behalf of their loved ones. Sometimes, reservists wait until after the events are over to approach VA. They are concerned about the stigma of asking about mental health care or services that make them appear vulnerable. Sometimes they wait until an event is over to follow-up on information, expressing concern about their Command seeing what they are doing. VAMHCS's outreach worker also routinely visits Aberdeen Proving Ground twice a month to meet Service members.

VAMHCS works closely with the Maryland Department of Veterans Affairs, which does a lot to help Veterans with their claims for service connection, pension, and other benefits. This assistance is often a bridge to getting Veterans access to VA health care. He noted that there is such a misconception about who is eligible for VA services and who is a Veteran. Many men and women do not realize that their service qualifies them as Veterans and eligible for VA care.

VAMHCS partners with the Maryland Center for Veterans Education Training (MCVETS), a local organization that provides housing and training for Veterans. MCVETS offers a single room occupancy program. It is considered permanent housing, and it is one of the programs for which women who are experiencing homelessness are eligible. It is on a different floor from the rest of the building, so it does have more security features. They have locked single rooms as opposed to the barracks style housing that men who are coming into the program will encounter on the lower levels.

Helping Up Mission is another local program. They are an entry point for emerging housing needs for our women Veterans who are experiencing homelessness.

HUD-VASH is a partnership with Housing and Urban Development (HUD) and VA that provides long term housing. HUD provides the voucher; VA provides the case management for that program. VAMHCS manages roughly 1200 to1300 Veterans in their HUD-VASH program right now at the Perry Point location. They converted 75 homes that were on the property. The Perry Point location is unlike most other VA facilities; it is 365 acres and had about 120 homes on the property. VAMHCS converted 75 of the homes over to HUD-VASH homes. They are now permanent housing for Veterans. They are single family homes there, and several women Veterans with children reside on that campus.

VAMHCS's annex is where they assist women Veterans who are entering homelessness. This is where they have their case management and where they begin the intake process. They provide separate and secure shower facilities for women Veterans who are coming through. They provide laundry services, clothing, and hygiene services for women there, and have the ability to connect them to female providers if they prefer.

VAMHCS has monthly meetings with the Veteran service organizations and Congressional representatives to discuss issues that they feel are important regarding Veterans health and benefits. If the VSOs or Congressional representatives have a question, VAMHCS makes the issue an agenda item and prepare presentations on those issues to be addressed at subsequent meetings. Those bonds keep the community about what VAMHSC is doing and keep them informed about what the VSO representatives are hearing from Veterans in the community.

Ms. Rosenzweig spoke generally about operations at VAMHCS. Regarding safety, she mentioned that the facility's security can assist women Veterans who may be assaulted outside of the facility or on the street.

Her office would be responsible for vans that shuttle Veterans to various facilities. I think it needs to be, you know, cleaned a little if those are the bands that are shoveling patients from the garage to the facility there. Regarding other things under purview, she did not have a problem with the Baltimore facility, but she observed that vans needed to be detailed and committed to making them more presentable for Veterans who must use them.

Environmental Management Services (EMS) hopes to procure $1,000,000 for a device that allows for reusable medical waste. The EMS team attends an annual conference to find innovative ideas and items back to the facility.

Ms. Anthony noted that the women Veterans population is the fastest growing Veterans population. VAMHCS is charged with being prepared when they come to VA, by having female providers that are ready and educated to receive them. VAMHCS is recruiting

the best and the brightest, but also looking for people who are gender sensitive too. Her office works closely with VISN 5 human resource partners to ensure that they have their partitioner choice.

She discussed an internal VA technical career field training program designed to draw Veterans to work at VA in occupations that are underrepresented. It is a 24 month/two-year training program offered to all Veterans in the technical fields of engineering, safety, fiscal--areas that women typically do not go into. VAMHCS is reaching out to its academic affiliations, universities, and sororities to look for women Veterans who want to work at VA in those underrepresented occupations.

Ms. Anthony discussed Green Environmental Management Systems or GEMS. It is more than a recycling system. It involves pollution prevention, environmental planning, and then continual improvement to make sure that they are environmentally friendly.

Regarding police services, Ms. Anthony clarified that jurisdiction does come into play for crimes against Veterans beyond VA property. If the incident occurs within a police jurisdiction that is outside of the Federal property, then Baltimore City police would take the report. If VA police are made aware of the incident, VA can respond to assist that person, but not necessarily take over the report.

Ms. Davis noted that VAMHCS strives to provide comprehensive care that is timely and accessible women Veteran that is compassionate and respectful. She provided general comments about VAMHCS's Women's Health program, which oversees care for women Veterans at their eight sites. The team includes a director, women Veterans program manager, three case managers, and navigators: one for breast care, one for cervical care and one for maternity care. Women Veterans do have a choice in the primary care division. Seven of the eight sites have primary care Women's Health comprehensive providers.

VAMHCS provides gynecological care, mental health, whole health, and in vitro fertilization for eligible women Veterans. It also provides maternity care, which does include childbirth education classes and postpartum support. They collaborate frequently with the University of Maryland Medical Center in supporting breast, cervical and maternity care.

The facility partners with the University of Maryland to hold an annual baby shower for women Veterans who gave birth during the year. Local media is usually present and the event is usually televised. All of the Primary Care division supports the event. It is always a very big event and the participating Veterans always express gratitude for VA providing this support to them.

They offer health promotion and disease prevention for our women in way of immunizations, cervical cancer screening, suicide, depression, post-traumatic stress disorder (PTSD), screening for breast screening and osteoporosis. Not only do they have restrooms that are near the examination rooms, but the restrooms also have baby

changing tables. The restrooms have signage on the outside indicating that it has a changing table, so that Veterans will know where they can go to take care of the young ones accompanying them. Understanding that some women Veterans did not want to come into the facility because of catcalls and unwanted attention form male Veterans, they stood up a clinic that is separate just for them, in terms of accessing the primary care section of that clinic.

Overview of VAMHCS Women's Health Program/Primary Care Shana Balogun, WVPM, Washington DC VA Medical Center
Jennifer Hawkins, WVPM, Hershel "Woody" Williams VA Medical Center
Dr. Catherine Staropoli, Women's Health Medical Director, VAMHCS
Ms. Balogun provided an overview of the Women's Health program at the Washington DC VA Medical Center. The goals of the program are to: ensure access to high quality, efficient, and patient driven healthcare; offer care that is seamless, wholistic, and collaboratively delivered; elevate VA as a national leader in women's health; and to offer care in sensitive and safe environments.

The medical center's catchment area encompasses Washington D.C., northern Virginia, and southern Maryland. To serve Veterans in those area, the medical center has site of care at the Montgomery County Community Based Outpatient Clinic (CBOC); the Southern Prince Georges; the Fort Belvoir/Virginia CBOC; the Southeast DC CBOC; the Charlotte Hall CBOC; and the Lexington Park CBOC.

Ms. Balogun shared that the medical center anticipates opening new sites of care or "super CBOCs" in the next few years. They are in the active planning stages for a new CBOC in Southern Prince Georges County, with an anticipated 2025 opening. They are also planning for a new CBOC in Northern Virginia, where there is huge projected growth. This location will offer radiology services. They anticipate opening in late 2025 or early 2026.

Ms. Balogun also noted the medical center's efforts to serve special populations. To better serve rural Veterans, they opened sites in Charlotte Hall in 2020 and Lexington Park in 2021. These sites offer primary care and gender specific care. For LGBTQ+ Veterans, the medical center is increasing collaboration across service lines. It also chartered a committee to address this population's unique needs and are ramping up outreach to increase awareness of services and resources available. For aging women Veterans, they are placing emphasis on post-menopausal needs; established support groups to explore interests, such as writing groups and creative arts; are working to narrow the gender disparity gap. For maternity Veterans, the DC VAMC is developing a robust perinatal support program, which includes cross collaboration for mental health support and perinatal education.

DC VAMC is expanding its Women's Health services. In Gynecology (GYN), they offer minimally invasive gynecology surgeons located in the medical center, offering in-office GYN consultation, procedures and GYN surgery. The GYN nurse practitioner (NP) is located at the medical and travels to three CBOCs. The GYN NP can provide in-office GYN procedures, tele consultations and preventative cervical cancer screenings.

Primary Care currently has 27 women's health primary care providers (PCP). The department is onboarding additional PCPs and ensuring all new staff participate in available women's health residencies. Pelvic health is now offered at an additional site, providing a wider range of treatment for various pelvic floor dysfunctions/diagnosis.

Ms. Balogna noted that the medical center's interfacility facility partnerships. The Rose Program, led by VAMHCS, is a support program designed to prevent postpartum depression. Veterans from DCVAMC are enrolled through consultation. This program is designed to enhance emotional and mental well-being during the perinatal period.

Regarding reproductive rights, the purpose is to preserve the life of Veterans in sensitive circumstances. The medical facility operates through shared Veteran care agreements, which enables them to coordinate care for Veterans across county and city lines. They can offer consultative care for Veterans enrolled at various sites of care.

Ms. Balogna shared that the medical center's cultural transformational efforts work to shift the culture of the environment of care. This includes increasing internal and external partnerships, sharing best practices, hosting the women Veterans forum, promoting the White Ribbon Campaign, and reiterating VA's Zero tolerance for harassment.

In her overview of the Hershel "Woody" Williams VA Medical Center women's health program, Ms. Hawkins noted that designated women's health primary care providers provide gender-specific care at each site of care, with ten providers across the health care system. Two additional primary care providers plan to participate in women's health mini residencies offered through the Office of Women's Health.

Through WHISE funding, they were able to hire a clinical coordinator to provide maternity care coordination. While obstetric care is provided in the community, women Veterans receive regular calls throughout their pregnancies and for a full year after delivery, to ensure their needs are met. The maternity care coordinator is currently following 16 women Veterans. The facility hosted its third annual Drive Through Baby Shower in May 2023, in collaboration with the Center for Development and Civic Engagement; they received donations from nearly 30 organizations. Ten pregnant or recently delivered women Veterans were showered with carloads of baby care necessities, such as strollers, diapers, handmade quilts, and afghans. They are also developing an interfacility consult with a VA lactation consultant in Erie, Pennsylvania to provide lactation support to women Veterans in their care when needed.

While the volume of Veterans seeking infertility evaluation and care is small in their health care system, the processes related to this care can be complex. They recently organized a local IVF interdisciplinary team (IDT) of local subject matter experts to coordinate referrals and participate in VISN 5's IVF IDT.

The Women's Health team at Hershel "Woody" Williams continues its commitment to providing women of reproductive potential the right care, in the right place, at the right time. Now, more than ever, contraceptive options--including the provision of emergency

contraception--and prenatal planning are essential. They are expanding pregnancy options counseling and planning for the provision of abortion care in some circumstances. Gynecology services, including surgical services, are available part time, with outpatient offices housed in the Women's Health clinic.

Preventive care is an important component of comprehensive care. Vaccines and screenings for cervical cancer, colorectal cancer, and osteoporosis are provided at the facility. The clinical coordinator tracks breast and cervical cancer screening to ensure timely patient notification of results and seamless follow up.

As COVID-19 restrictions waned, Women's Health clinic staff sent a letter to patients who may have neglected self-care during the pandemic to invite them back to the facility for safe care. A review of the chart provided information for an individual's inventory of health and preventive care that was due or past due, prompting women Veterans to call and schedule an appointment.

Ms. Hawkins explained that women Veteran's care and whole health principles are well-aligned. Talking with Veterans about their goals and priorities and providing Veteran-centric care based on that is congruent with the I CARE principle of respect. Validating what is important to the Veteran enhances the customer experience principle of trust and leads to better outcomes. The facility's Whole Health program holds women's group meetings. The MOVE! weight management coordinator also has an exclusive women Veteran's group.

The Huntington facility is the site of the primary care telehealth hub. While these providers do not have permanently assigned panels of patients, they provide coverage of panels across the VISN, to include women Veterans. There are currently five telehealth providers who have completed women's health training and another will participate in the women's health mini-residency in later in the month.

Mental health services are an essential component of wellness as well. Hershel "Woody" Williams enjoys robust patient-aligned care teams (PACTs) including primary care mental health integration (PCMHI). PCMHI is problem-focused short-term therapy. In the Women's Clinic, it is also instrumental in connecting women Veterans with other mental health resources they may need. A women's mental health champion acts as a subject matter expert, advocate, and liaison.

The Women's Health program enjoys a strong collaborative relationship with Care in the Community (CITC) services and community providers who provide essential women's health services like obstetric care, breast imaging, and other care not provided at the medical center.

Women's Health teams across the enterprise invite women Veterans to quarterly focus groups to engage in discussions to elicit valuable information from women Veterans about their perceptions of the care and services that VA provides. These small group discussions are used to learn if they feel respected as women at VA sites of care, if they

have had experiences of harassment at VA sites of care, and to receive any recommendations they may have to enhance care.

Some Women Veterans have said they didn't feel comfortable presenting to the mental health building on the campus. They said they did not have any specific unpleasant experience, but they stopped going because they just did not like going to that location. With the collaboration of the chief of Mental Health Services and the support of leadership, they anticipate receiving a mental health provider in Women's Health clinic soon. The hope is that the additional provider will increase access to mental health services for women Veterans in the health care system and that those women Veterans who expressed dissatisfaction will re-engage with mental health care.

The Women's Health team collaborates with every service area to ensure that women Veterans receive the quality care they have earned and deserve. For example, at the Hershel "Woody" Williams facility, WHISE 3.0 funding provided in FY23 was instrumental in the addition of pelvic floor physical therapy to the service line at the medical center. This initiative required the collaboration of multiple service areas, including physical therapy, logistics, and fiscal.

As VA strives to enhance care for women Veterans who are enrolled for care, it also strives to connect eligible women Veterans with the programs and services. It also strives to increase access and enrollment through biannual women Veterans' public forums and ongoing outreach events. Hershel "Woody" Williams is currently planning an exciting Women Veteran Appreciation Event for September that will serve as a public forum and an outreach.

As the facility begins to actively engage in ongoing community events, Women's Health maintains a presence at all outreach opportunities, connecting women Veterans to VA, where clinicians recognize and respect their contributions as women who served in the military.

Ms. Hawkins acknowledged how the support and leadership at the National, VISN, and local level; the collaboration of many at the service and community level; and the support and assistance of many others allowed Hershel "Woody" Williams to accomplish its goals.

The objective measure of our success is often made through performance measures and other data. These are reviewed and reported to various councils, including senior leadership. Hershel "Woody" Williams also explores the data for gender disparities, discusses V-Signals and patient experience responses, and reports the information provided through focus groups. The team listens to women Veterans and identifies actionable items.

Dr. Staropoli provided a brief history of VAMHCS's women's Clinic and the Women's Health program, which was established in 1985. The clinic uses a split care model where a nurse practitioner and an internal medicine physician saw women Veterans half day per week for

ambulatory GYN issues. A contracted gynecologist saw women half day each month. The total enrollment was 125 women at the Baltimore VAMC clinic, which served as a teaching site for medical residents from the University of Maryland.

By 1992, the program expanded to include mental health as part of the team and continued to grow include a NP, a physician, a psychologist, a psychiatrist, and a gynecologist who provided services for women for a total of 3 ½ days each week. The GYN clinic increased to half day per week, with weekly surgical time at the Baltimore VAMC. The clinic expanded to a full day of service weekly at Perry Point VAMC.

By 2007, women's health clinics were established at each VAMC and CBOC, staffed with providers having additional training in women's health. By 2008, full time women Veterans program managers were appointed. In 2010, women's comprehensive health clinics were opened, providing both gender specific and general primary care through one provider. As of 2023, the program has 29 women's health PACTs.

VAMHCS serves almost 12,000 women Veterans. Most of these women are between the ages of 40-44 (just over 1,600 women). The next highest representation is in women Veterans aged 60-64 (just over 1,400 women). Women Veterans under age 25 (just over 100 women) and over age 80 (approximately 100 women) have the lowest representation. There is almost equal representation in women Veterans aged 35-39, 45-49 and 50-54 (approximately 1,350 women in each age group). There are about 500 women aged 25-29; just over 1,000 women aged 30-34; approximately 1,400 women 55-59; just under 1,000 women 65-69; about 500 women aged 70-74; and just over 200 women aged 75-79.

Top 10 diagnoses seen in women Veterans who come to VAMHCS include: essential hypertension; hyperlipidemia; chronic PTSD; chronic anxiety disorder; contact and exposure to hazardous substance; low back pain; obesity; major depressive disorder; presbyopia; and GERD without esophagitis.

Dr. Staropoli provided an overview of the program's internal resources. VAMHCS provides surgical breast services (mastectomy, lumpectomy, and biopsies); plastic surgery (breast reconstruction); GYN/urogynecology (stress incontinence); pelvic floor physical therapy; plastic surgery (breast reconstruction); GeriPACT; endocrinology (transgender care); radiology (mammography, DEXA, ultrasound, and breast MRI). It also provides GYN; a menopause clinic; a maternity team; a registered nurse coordinator; a women's health pharmacist (teratogenic medications, chronic disease, contraception, and maternity screening). The women's health social worker provides anger management groups and maternity screening. Mental health is co-located in primary care/women's health, offers a "Warrior Moms" support group, and provides services during maternity screenings.

VAMHCS outsources services it does not provide internally, such as ultrasound guided breast biopsy; stereotactic guided breast biopsy; pregnancy services; gynecology/oncology; fertility; and genetic counseling and testing.

Dr. Staropoli gave a breakdown of the where they are seeing women Veterans. At the Baltimore VA Medical Center, they serve 1,991 women; at Perry Point VAMC: 712 women; East Baltimore CBOC (new since 2012): 380 women; Loch Raven CBOC: 482 women; Glen Burnie CBOC: 945 women; Pocomoke City CBOC: 137 women; Cambridge CBOC: 343 women; and Fort Meade CBOC: 1,602 women. They are also seeing 33 women Veterans in geriatric PACTs and six in home-based health care. Approximately 87% of VAMHCS's women Veterans are on WH PACTs.

Regarding quality metrics, women are doing better than men on most issues. Women lag men on immunizations (especially pneumonia and shingles); however, this impacts a small number of women over age 65. There are issues with validation of electronic quality measurement for breast and cervical cancer screenings.

In Ms. Kirksey's VAMHCS Women's Health program overview, she noted that newly enrolled women Veterans receive a monthly list, a welcome packet, and they are partnered with a women's health provider and initial appointment. She identified the facilities that comprise VAMHCS.

More women are choosing VA health care than ever before, with women accounting for over 30% of the increase in Veterans served over the past five years. The number of women Veterans using VHA services has tripled since 2001, growing to over 550,000 today. VA is committed to providing high quality equitable care to women Veterans at all sites of care.

With WHISE funding, they can address significant gaps in staffing that support women's health care and coordination, to improve services and access for women Veterans. They increased access by hiring more providers and women's health staff. They hired three additional women's health providers and seven additional women's health staff members, to include a cervical care coordinator, breast care coordinator, senior social worker, psychologist, physical therapist, health technician, and advance medical support assistant (MSA).

WHISE enabled them to conduct training for lactation counseling, eye movement desensitization and reprocessing or EDMR and perinatal mental health. Additionally, they purchased equipment and supplies, such as lactation pods, pelvic floor equipment, women's health educational resources, outreach items and aromatherapy.

The Women Veterans Program team includes a WVPM, women's health social worker, maternity care coordinator, breast care coordinator, women's health pelvic floor physical therapist, women's health technician, women's health radiology MSA, women's health mental champion, and women's health champions.

The program offers several meetings: women Veterans program meetings, WH clinical staff meetings, women's health committee meetings, one on one with women's health staff and clinical leadership.

VAMHCS's Women's Health program provides breast care coordination with CITC. They track results of tests from CITC services, participate in a national mammography call and participate in a national data call. Coordination of care is accomplished through partnerships with community providers, VAMHCS Imaging Department, community imaging partners and the breast surgeon.

It also provides cervical care coordination, which includes tracking and monitoring of results, Veteran follow-up, and care through PACTs. Coordination of care is accomplished through partnerships with GYN, lab and pathology service, and community providers. Women's Health leverages its social media platforms (Facebook and Twitter) to promote women Veterans' awareness of services and women Veterans-related health issues.

Ms. Kirksey noted some of the community collaborations they participate in and entities they partner with to reach women Veterans, such as post deployment events, Vet Centers, Maryland Department of Veterans Affairs activities (Women Veteran Recognition Day; focus groups); sororities (Shero Program); and the Baltimore Health Expo. They also participated in the I Am Not Invisible initiative and the I Belong campaign to promote recognition and awareness of the contributions of women Veterans.

Comparing FY21 and FY21 women Veterans' experience data from VSignals, she notes that women Veterans indicate improvement with ease and simplicity in utilizing services at the facility, satisfaction, and confidence/trust. However, women Veterans indicated a decrease in efficiency, quality of service, employee helpfulness, equity/transparency.

Sexual Assault and Harassment Prevention/Cultural Transformation
Johnny Delgado, Chief, VAMHCS Police, VAMHCS
Mr. Delgado expressed that VAMHCS is committed to a culture where everyone is treated with civility, compassion, and respect. It has zero-tolerance for harassing, disruptive, abusive, or violent behavior and it takes reported harassment allegations seriously. VAMHCS will investigate and take actions as appropriate.

He provided information on designated points of contact for anyone who experiences or witnesses harassment. Veterans can tell a VA employee or contact a patient advocate. Employees can tell a VA manager, supervisor, or contact the facility's equal employment opportunity (EEO) manager, harassment prevention coordinator; they can also contact VA's Harassment Prevention Office. Visitors can inform VA employees or VA police. In cases of sexual assault, individuals should notify VA police on site or call 911 for local police.

He provided a high-level snapshot of the reporting process. VA employees are expected to give a non-judgmental acknowledgement of the incident, noting important details of the incident, and recognizing if the Veteran needs immediate care. If physical touching is involved, VA police should be notified. Veterans are made aware of VA services, such as mental health services or the Intimate Partner Violence Assistance Program. A case

is created in the Patient Advocate Tracking System and designated management officials are notified. The incident is then provided to the Disruptive Behavior Committee. Finally, they closed the loop with the Veteran. Mr. Delgado discussed the prominent signage in the medical centers and the Vet Centers that notes VA's zero-tolerance culture and identifies the designated points of contact to report harassment or sexual assault.

He defined harassment and gave examples of prohibited behavior. Harassment is conduct that creates an intimidating, hostile, or offensive work environment and becomes a condition of continued employment to reasonable people. Examples include bullying; threat of assault; intimidation or ridicule; jokes, slurs, epithets; insults or put-downs; objects, images, videos; and degrading comments or materials about a person's sex, sexual identity, gender identity, transgender status.

Sexual harassment is harassment of a sexual nature; it is prohibited by the Harassment Prevention Policy for Federal agencies. It includes conduct or behavior seen, such as leering or ogling; gestures or expressions; objects, images, videos; and intentional body exposure. It also includes catcalls; whistles; jokes, teasing, flirtations, name calling; pressure for sex, sexual favors; emails, text messages, graphics, notes, and internet content. Sexual assault is physical contact or behavior that occurs without the consent of the individual, grabbing, hugging, stroking; intentional brushing/rubbing up against someone; fondling or unwanted sexual touching; and attempted rape or forced sexual acts. Mr. Delgado explained that harassment is a form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, Americans with Disabilities Act of 1990 (ADA), and Age Discrimination in Employment Act of 1967 (ADEA). Allegations reported to the Harassment Prevention Program do not preserve one's rights to file an EEO complaint. The aggrieved has 45 days to contact an Office of Resolution Management, Diversity, and Inclusion EEO counselor at 1-888-566-3982 to report an alleged harassing event.

Wednesday, June 14, 2023--VA Maryland Health Care System (VAMHCS), Room #3a-300; Baltimore, MD 21201-1524

Chair Yarbrough opened the meeting by giving a short introduction and background, and then had the rest of the committee members and Center for Women Veterans staff do the same.

Women's Rural Health Initiatives Zelda McCormick, Lead WVPM, VISN 5
Ms. McCormick began her presentation by stating the Women Veterans Program's mission, emphasizing the commitment to providing timely, equitable, high-quality, and comprehensive healthcare services in a safe environment at VA facilities nationwide. She outlined VISN5's focus on staff engagement, education, training, routine needs assessment, and the utilization of special purpose funding to enhance care standards for women Veteran.

Discussing the impact of rural health funding, Ms. McCormick noted how the funding helped remove barriers to timely, quality care for rural Veterans, reduced the necessity for community care, and expanded home-based primary care. This includes adding new teams and clinicians, enhancing care and access.

She then discussed the specific barriers to care in rural communities, such as significant transportation challenges, where Veterans might travel extensive distances to reach VA facilities. The strategy includes limiting face-to-face appointments and increasing virtual care options, although this is often complicated by Veterans' limited access to technology and poor connectivity in rural areas.

Ms. McCormick provided a snapshot of the program offices supporting rural health initiatives, listing various services like home-based primary care, technology-based eye care, and tele-dermatology. These initiatives are part of a broader effort to bring comprehensive healthcare services closer to rural Veterans.

Highlighting the specific projects funded in 2023, she detailed the allocation of over $9 million for rural projects, including the addition of clinical pharmacy specialists and initiatives to improve suicide prevention and transportation. These funded projects are instrumental in enhancing access to essential healthcare services and reducing travel times for Veterans.

She elaborated further on the resources needed to support rural Veterans, Ms. McCormick emphasizes the importance of transportation shuttles, IT support to increase bandwidth, and improved Wi-Fi connectivity. These enhancements are crucial for enabling Veterans to access VA Video Connect and other telehealth services, potentially including the provision of tablets or phones to Veterans lacking technology.

Overview of VAMHCS Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Program, Amy Sanchez-Olivera, LGBT Veteran Care Coordinator, VAMHCS
Ms. Olivera-Sanchez presented an overview of the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) program, emphasizing the collaboration with the Women's Veterans Committee and the expansion of her role to support the program more effectively. She highlighted the achievements, including the top rating in the Healthcare Equality Index and active participation in community events like Pride. Next, she detailed areas needing improvement, such as the clarity in referral processes, especially concerning transgender care, and the need for more mental health providers trained specifically for LGBTQ+ care. She also discussed the challenges with internal communication and coordination across various departments within VA.

Ms. Olivera-Sanchez then proposed the creation of an interdisciplinary workgroup to enhance the service delivery, aiming to meet national mandates and improve the healthcare quality rating. This group would standardize referral processes and improve training for providers in LGBTQ+ competent care, starting with the Women’s Health program due to their proactive involvement and interest.

She also shared the recent initiative to collect data on Veterans' sexual orientation, aiming to improve understanding and support for LGBTQ+ Veterans. The upcoming sexual health inventory was mentioned as a future step to gather comprehensive data on sexual health and identity, which will be initially rolled out in collaboration with the Women's Health program.

Overview of VAMHCS Mental Health (MH) Services
Dr. Aaron Jacoby, Mental Health Program Director, VAMHCS
Dr. Rachel, Austin, Champion, Women Mental Health, VAMHCS
Dr. Austin, serving as the women's mental health champion at Van Max, provided a comprehensive overview of the mental health services available for women Veterans, emphasizing the integration of these services into primary care and the ongoing development of specialized programs.

Dr. Austin outlined her role and the scope of services provided to women Veterans, emphasizing the focus on access to care and the development of new programs tailored to their specific needs.

She highlighted the significant growth of the women Veteran population within VA system, noting that a substantial percentage have been diagnosed mental health conditions, underscoring the need for specialized, gender-specific programming.

Explaining her responsibilities, Dr. Austin described her position as a Women's Mental Health Champion, emphasizing her role in national mental health initiatives with local implementation and making sure that staff receive up-to-date training on gender-specific mental health issues.

Regarding reproductive mental health and identifying gaps at the facility, Dr. Austin is advocating for the development of targeted programs and partnerships to enhance care for women Veterans.

Dr. Austin discussed her advocacy role, how she assists women Veterans with any concerns or issues, facilitating their access to mental health care and ensuring their voices are heard at the leadership level.

She explained the PCMHI model, which is her main area of focus, illustrating how it facilitates immediate access to mental health services in the Women's Health clinic--aiming for early identification and comprehensive treatment. She explored the PCMHI approach, emphasizing the importance of same-day access, breaking down stigma, and ensuring a team-based, trauma-informed care environment that raises immediate and effective mental health interventions. She discussed, addressing behavioral medicine concerns, and facilitating interventions like tobacco cessation, highlighting the comprehensive nature of the care provided.

Dr. Austin described the Mental Health Triage Clinic as an alternative access point for mental health services, outlining its function and availability to women Veterans seeking mental health support outside the primary care pathway.

She used the continuum of care model to illustrate the range of mental health services, from primary care to specialized inpatient and residential treatments, ensuring that women Veterans have access to the necessary level of care.

She provided an overview of the inpatient and residential services available, including acute psychiatry and specialized programs for substance abuse and psychosocial rehabilitation, tailored to the spectrum of mental health conditions. The intensive outpatient programs and other specialized services ensure comprehensive support for conditions such as PTSD, substance abuse, and other mental health challenges, with a focus on adapting these services to meet the needs of women Veterans.

Dr. Austin touched on the neuropsychology and health psychology services available, which assess and address cognitive and psychological needs related to chronic medical conditions, trauma, and life adjustments.

Finally, she noted upcoming developments, including the launch of an eating disorder treatment program and ongoing enhancements in maternity mental health care, reflecting the continuous evolution of services to meet the diverse needs of women Veterans.

Military Sexual Trauma (MST) Program
Dr. Christine Calm, MST Coordinator, VAMHCS
Dr. Calm presented an overview of the care for women Veterans who have experienced MST, defining MST as experiences of sexual assault or sexual harassment during active duty, which can occur on or off base, regardless of the perpetrator's identity or the context of the assault. She emphasized the broad range of behaviors MST encompasses, from verbal harassment to sexual assault, and clarified that compliance under coercion does not equate to consent.

She discussed the MST clinical reminder, a tool used within VA to identify Veterans who have experienced MST and thereby qualify them for related services free of charge. Dr. Calm noted that MST is more common among women Veterans, with a significant number of Veterans acknowledging MST only after they have been in the system for some time. She pointed out the importance of reassessing Veterans' MST status to provide necessary care.

Dr. Calm highlighted the comprehensive care provided to MST survivors, which includes outpatient, inpatient, residential care, and medications, emphasizing that most mental health and substance use issues can arguably be related to MST. VA aims to accommodate Veterans' preferences for the gender of their health care providers, whenever possible.

As the MST coordinator, Dr. Calm described her role in ensuring that Veterans who experienced MST can access the care they need, and addressing barriers to treatment. She mentioned the importance of ensuring all Veterans are screened for MST and that all mental health and primary care staff have completed MST training.

Dr. Calm outlined the evidence-based therapies available for common mental health conditions, such as PTSD, depression, substance use, and relationship problems, including specific therapies for couples and support groups. She also discussed the interventions for physical health concerns associated with MST, like pelvic floor therapy and pain management.

She introduced various VA resources and tools designed to support Veterans who have experienced MST, including informational SharePoint, the Beyond MST app, and Make the Connection videos, which share Veterans' treatment experiences.

Dr. Calm concluded with VAMHCS's data specific to women Veterans with MST, indicating high screening rates and significant engagement in mental health treatment for these Veterans.

Intimate Partner Violence Assistance Program (IPVAP) Lindsey Williams, IPVAP Coordinator, VAMHCS

Ms. Wilson introduced herself as one of VAMHCS's IPVAP coordinators. She provided an overview of intimate partner violence (IPV), referencing VHA Directive 1198, which defines IPV and outlines the program's establishment. She emphasized that IPV could occur in any romantic context, regardless of sexual intimacy or cohabitation, and includes a range of abusive behaviors.

Ms. Wilson explained the division of clinical duties she shares with her colleague, covering different regions of Maryland and their respective VA facilities. They also share administrative responsibilities to support Veterans affected by IPV.

IPVAP operates on four core principles: being person-first, Veteran-centric, recovery-oriented, and trauma-informed. These principles guide the program's approach to offering respectful, empowering, and sensitive support to Veterans.
Ms. Wilson detailed their work across five action areas: raising awareness, building community partnerships, serving those who experience IPV, addressing the needs of those who use IPV, and supporting VA staff. She highlighted efforts in public awareness, staff training, and community collaboration to provide comprehensive support and resources for IPV-affected individuals.

Screening for IPV is a significant part of their program, using the Relationship Health and Safety screen. Ms. Wilson discussed the expansion of screening initiatives and the importance of safe screening environments. The screening process includes a primary screen with specific questions about IPV experiences, followed by a secondary screen for those who indicate IPV exposure, assessing the risk levels more closely.

Ms. Wilson shared screening data, illustrating the program's reach and the prevalence of IPV among screened Veterans. She emphasized the higher rate of positive screens among women Veteran compared to males, despite a larger number of males screened, and discussed the referral processes and variety of sources from which they receive referrals for IPV support.

The presentation also covered interventions for Veterans who use IPV, particularly highlighting the Strength at Home group interventions, designed to help Veterans manage aggression in relationships. Ms. Wilson discussed the success and aims of these groups, including the relatively new Strength at Home Couples group, and their adaptability based on the specific needs of participants.

Ms. Wilson outlined plans to expand screening, enhance clinical services, improve support group attendance, and implement additional clinical interventions. She stressed the ongoing effort to strengthen internal partnerships to support VA employees impacted by IPV and the anticipation of Domestic Violence Awareness Month activities to further promote awareness and education.

Suicide Prevention Program
Nikole Jones, Suicide Prevention Coordinator, VAMHCS
Ms. Jones began her overview of the services offered by VA by addressing the sensitive nature of the topic, acknowledging the emotional impact it may have, especially on those with personal experiences related to suicide, and assured the availability of support resources like the National Suicide Prevention Lifeline.

She provided an update on the Veterans Crisis Line’s new, simpler phone number (dial 988; then press 1); it is a new number, with the same support. The crisis line ensures immediate access to local suicide prevention hotlines and specialized support for Veterans, who are connected to VA responders assessing their risk and providing necessary interventions. It is accessible through phone, text, and online chat, which caters especially to younger Veterans comfortable with texting.

Ms. Jones outlined VA's five pillars of suicide prevention, focusing on awareness, access to services, enhanced care delivery, training, collaboration, and research to understand trends and risk factors affecting Veterans.

She presented a timeline showcasing the program’s evolution, the launch of the online chat service, and rebranding efforts to make the hotline more approachable for Veterans not actively considering suicide but in crisis.

She also shared significant statistics about the call center’s activity, including the total calls, chats, texts, referrals, and emergency dispatches since the program’s inception, underscoring the critical impact of these services on Veterans’ safety and crisis intervention.

She discussed Operation S.A.V.E. breaks down the essential tasks and activities an employee can perform to assist someone who appears to be in crisis.: signs of suicidal thinking; ask questions; validate the Veteran's experience; and encourage treatment and expedite a referral. She explained S.A.V.E. training's scope, emphasizing its widespread implementation across various provider settings, educating on suicide risk indicators, and promoting resources for assistance. The online training is facilitated through a partnership with the Psych Armor Institute, providing accessible, ongoing education for community partners, Veterans, and their families.

Ms Jones stressed the collective responsibility in addressing suicide, highlighting the alarming prevalence of suicide in the U.S. and the specific risks faced by Veterans, and noting the essential need for continuous dialogue and proactive intervention. She corrects misconceptions about suicide, clarifying that discussing suicide does not plant the idea but can provide crucial support, encouraging open conversations and attentive responses to potential warning signs.

She then discusses protective factors against suicide and the limitations of no-harm contracts, advocating for comprehensive safety planning that empowers individuals to recognize warning signs and implement personal coping strategies. She emphasized the seriousness of suicide expressions, urging attentive responses to all indicators, highlighted the need for awareness of risk factors, including personal and familial history, mental health, and access to lethal means.

She detailed Veteran-specific risk factors, with a focus on the impact of military service, deployment stressors, and the particular vulnerabilities of women Veteran and those with significant injuries or stress. She discussed the warning signs, how to recognize them and the immediate action to take when such signs are observed, emphasizing the importance of being alert of changes in behavior, mood, or expressions indicating suicidal ideation.

Further discussion addresses the community outreach imperative, driven by data revealing the majority of Veteran suicides were among those not engaged in VA care, prompting extensive public education and provider training on suicide prevention. She explained the critical importance of discussing and mitigating access to lethal means, especially firearms--given their high fatality rate in suicide attempts—and advocating for responsible storage and safety measures like gun locks. VA's proactive strategies include universal screening for suicide risk, tailored interventions, and the distribution of gun locks and safe storage solutions to mitigate risk factors associated with firearms and medications.

Ms. Jones concluded by summarizing VA's comprehensive approach to suicide prevention, which includes regular risk assessments, personalized outreach, safety planning, and community-wide education efforts to support Veterans and reduce suicide incidences, inviting any final questions or discussions.

Healthcare for Homeless Veterans/ Veterans Justice Outreach
Craig Cook, Director, Community Reintegration Services (CRS), VAMHCS
Mr. Cook reflected on the growth of VA's homeless programs, from its humble beginnings with just a small team to its significant expansion over the years. He emphasized VA's proactive approach in developing new programs to meet the evolving needs of homeless Veterans.

Mr. Cook detailed the historical development of VA homeless programming, starting from basic outreach efforts to the establishment of specialized services addressing the needs of Veterans reentering society from prison. He noted the expansion of justice-related programming and the establishment of Veterans Treatment Courts, which offer rehabilitative alternatives to incarceration for eligible Veterans.

The Health Care for Returning Veterans (HCRV) and Veterans Justice Outreach (VJO) programs were developed to provide Veterans involved with the justice system with alternative programming options. HCRV deals primarily with Veterans returning from state and Federal prisons. VJO deals primarily with local jails and Veterans newly entering the justice system. The main emphasis is to assist Veterans by offering alternative programming to courts. There are Veterans Treatment Courts in Baltimore City, Anne Arundel County, and the Eastern Shore.

Mr. Cook discussed various components of homeless programming, including outreach, case management, transitional housing, emergency housing, employment assistance, and justice-related programs. He explained the Grant and Per Diem (GPD) program, which provides transitional housing, and mentions the specific focus on emergency housing solutions. VAMHCS has six partnerships for transitional housing, four in Baltimore metro area and two in Cecil County. It also has three current contracts operational for emergent housing.

He described employment services within VA homeless programs, focusing on the support provided to Veterans ready to reenter the workforce. Mr. Cook outlined the roles of employment development specialists and community employment coordinators who assist Veterans in finding suitable employment and connecting with supportive employers. Employment Services consists of one employment development specialist and two community employment coordinators.

Mr. Cook shared the current statistics of the program's occupancy and highlights the ongoing efforts to address the specific needs of women Veteran. He points out the limited availability of dedicated housing options for women Veteran and expressed hope for future programming that includes Veterans with children and family housing solutions.

Whole Health
Matthew Funke, Clinical Director, Whole Health, VAMHCS

Mr. Funk introduced his role in implementing whole health VAMHCS, emphasizing that whole health is a top priority and represents a cultural shift rather than a mere program. He described the envisioned successful whole health culture as one that intertwines professional care, management, employee engagement, and the enhancement of Veterans' experiences.

He further explained the decentralization of whole health implementation, where each service within the health care system incorporates whole health practices, fostering a cultural transformation rather than operating as a separate service. Mr. Funk highlighted the integration of whole health into various clinical services and the support from leadership to ensure its pervasive adoption.

The discussion transitioned to the comprehensive approach of whole health, which extends beyond medical treatment to include empowerment and equipping Veterans with resources, emphasizing the shift from asking "What's the matter with you?" to "What matters to you?" This encompasses a wide array of services and programs, from virtual clinics to local community offerings, all aimed at enhancing Veterans' overall well-being.

Mr. Funk detailed the evolution of whole health from its inception as a design site in 2017, focusing on creating a system that supports Veterans holistically. He outlined various components of the whole health system, including clinical care, pathways for Veteran empowerment, and the broad spectrum of complementary and integrative health practices offered both within VA and the community.

Mr. Funk showcased the growth and success of whole health programs, highlighting significant Veteran participation and the wide range of health modalities available. He emphasized the importance of continuing to expand and adapt these services to meet the evolving needs of Veterans, ensuring they receive comprehensive, personalized care.

In closing, Mr. Funk shared resources and tools developed to sustain and disseminate whole health practices, including SharePoint sites for staff and Veterans. These platforms serve as repositories of valuable information and exemplify the commitment to maintaining and advancing whole health initiatives within the health care system.

Post 9/11 Military2VA Case Management Program
Anne T. Hall, Assistant Chief of Social Work, Acute and Ambulatory Emergency Care Clinical Center, VAMHCS

Ms. Hall explained that the Post 9/11 Military to VA Case Management Program was designed to ensure a seamless transition for service members into VA's health care system. This program, initiated during the Iraq War, focuses on providing immediate care without waiting for discharge paperwork, emphasizing the need for uninterrupted healthcare during the transition from military to civilian life.

She detailed the program's evolution, its comprehensive approach to integrating Veterans into VA's health care system, and its expansion beyond combat-deployed individuals. The team comprises case managers who assist with health care coordination, addressing primary, mental health, and specialty care needs, and ensuring no gap in services post-military.

Referrals come from various sources, including DoD liaisons, VBA outreach, and the InTransition coaching program. The program aims for Veterans separated after 9/11, focusing on the crucial first 12 months post-separation but is available to any post-9/11 Veteran needing support. The case management process involves a thorough assessment, goal setting, and a focus on empowering Veterans to navigate their health care and social needs independently, with a gradual transition to less intensive support.

The program's statistics indicate a significant number of women Veteran served, reflecting a growing trend. The case management team actively connects Veterans with both VA resources and community support, tailoring assistance to individual needs, including legal aid, employment support, and specialized programs for women Veterans.

Ms. Hall highlighted a new education series aimed at newly transitioning Veterans, particularly focusing on women Veteran, and underscored the ongoing effort to adapt and connect with relevant resources and supports to meet the evolving needs of Veterans.

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Chair Yarbrough opened the meeting by giving a short introduction and background, and then had the rest of the committee members and Center for Women Veterans staff do the same.

Long Term Care/Inpatient Care for Women Veterans
Dr. Abisola B. Mesioye, Director, Geriatrics and Extended Care Clinical Center
Dr. Mesioye began by sharing that not many women Veterans seek medical assistance from the Geriatrics and Extended Care Clinical Center (GECCC). She then discussed the various inpatient services offered at VA facilities focusing on geriatric care. They emphasize creating a home-like atmosphere, especially for women Veterans. The continuum of care is a key concept, recognizing that as people age, they might require different levels of assistance--from staying in their own homes to institutional care. They offer services to help Veterans remain at home as long as possible but also have community living centers (CLCs) for those needing more care. CLCs are not just nursing homes; they are places where residents live and receive a range of specialized care, including respite care, long-term care, short stays for rehabilitation, and hospice. She explained that Veterans are assessed to ensure they are stable enough for long-term care, not requiring hospital-level care, and that discharge plans are made from the

day of admission, aiming to help residents enjoy their golden years to the fullest.

Dr. Mesioye briefed on the attributes of GECCC's age-friendly CLCs, underscoring the significance of using "what matters" to individuals as a core principle of the age-friendly movement. She expressed the importance of personal preferences, especially how to address individuals respectfully. For example, women may not appreciate being called 'sweetheart' or 'sweetie.' Some people may wish to be addressed with specific titles reflective of their past roles, such as "Staff Sergeant," respecting their service and identity. Staff should address residents by their preferred names or titles as a mark of respect and to honor their individuality. It is important to call them by their chosen identifier, demonstrating the center's commitment to individual preferences and dignity. Some residents may prefer to be addressed by their first name, suggesting a more casual or personal interaction. For women residents, understanding their social preferences is crucial. Some may enjoy the company of men, while others may not.

Dr. Mesioye talked about a women Veteran with severe dementia who prefers to stay in her room rather than socialize. Instead of insisting that she socialize, the staff at the CLC respected her preference for solitude. To support her, they identified a woman employee—a Veteran and caregiver to a Veteran—who could understand and relate to her. The employee was given additional time to spend with the isolated Veteran, providing companionship on her terms. This approach shows the center's dedication to creating a supportive environment that adapts to the unique needs and wishes of its residents, reinforcing the principle of an age-friendly community.

Dr. Mesioye discussed the thoughtful gestures and amenities offered to welcome and comfort women Veterans within the CLCs. The welcome bundle containing shampoos and feminine products, along with pretty banquets and quilts, illustrates the organization's attention to creating a nurturing and gender-sensitive environment. Incorporating a recreation therapist's expertise, they explore activities catering to women's interests, always mindful of individual choices and independence. The approach is not one-size-fits-all. The therapist gauges interest in group activities, respecting that while some may enjoy communal engagement, others may prefer solitude or smaller, more intimate gatherings.
Unfortunately, the COVID-19 pandemic severely interrupted these efforts. Dr. Mesioye acknowledged the exceptional challenges faced by geriatric patients during the pandemic, suggesting that the progress in their specialized care, including that for women Veterans, may have faced setbacks. Nonetheless, she expressed relief and hope with the advent of a cure and treatments, suggesting a turning point that could allow the CLCs to return to offering full supportive services and activities for their residents.

Pandemic aside, the emphasis remains on personalized care and the recognition of personal choice, ensuring that every Veteran feels respected and valued in their living environment. The presentation's progression to the next slide likely continues with

exploring the adaptations and perseverance of geriatric care in the face of pandemic challenges.

Dr. Mesioye discussed resuming various services in the CLC. She mentions that previously, a barber coming in to provide haircuts was the extent of the cosmetic services offered due to restrictions. However, residents expressed a desire for more than just haircuts, including hair coloring and other personalized services. She acknowledged these requests and will coordinate with residents and their families to facilitate additional offerings. She also discussed resuming manicures, pedicures, and activities that were halted due to COVID-19 precautions. Residents were previously confined to their units to prevent the virus's spread, but now they can move around more freely as activities and visitations have resumed.

She closed by noting the importance of the resumption of these services and activities for the well-being of the residents, many of whom are women and appreciate these offerings. It is about accommodating their preferences and resuming care practices that contribute to their sense of normalcy and satisfaction.

Overview of Baltimore National Cemetery
Eric Solomon, Director, Baltimore National Cemetery Complex
Mr. Solomon noted that there are about 5.3 million Veterans and family members under the National Cemetery Administration’s (NCA) care, managing approximately 9,200 acres of national cemeteries. He highlighted the collaborative efforts in providing interments to Veterans and in maintaining these cemeteries.

NCA’s provides burial space in national cemeteries and administers Federal grants to state and tribal cemeteries. The grants cover 100% of the developmental costs for these cemeteries, with the state taking over some of the costs after opening.

Mr. Solomon also mentioned the Memorial Products Services (MPS), through which Veterans and private cemeteries obtain their government markers. He touched on the Presidential Memorial Certificate (PMC) program, started by President Kennedy in 1962, which issues a commemorative certificate to anyone who has lost a Veteran loved one.
He described NCA's responsibility for the First Notice of Death program, which updates Veterans’ benefits and terminates any payments posthumously. Some examples of different markers include the iconic white marble marker common in Veterans cemeteries, a bronze medallion for Veterans with private markers, and examples of bronze and marble flat markers.

Mr. Solomon discussed NCA's workforce, providing details such as the total number of employees, where they are located, and the Veteran makeup of the staff. He compared NCA's staff size to that of a medium-sized VA hospital, demonstrating that the entire agency's workforce is equivalent to that of one such hospital.

Mr. Solomon then discussed the eligibility criteria for interment in a national Cemetery. He provided a simple rule of thumb, stating that eligibility for VA health care typically translates into eligibility for burial benefits. The criteria include any Veteran without a dishonorable discharge, including National Guard members and reservists who complete their deployment term. Spouses, minor children, and dependent adult children also qualify for interment in national cemeteries.

Mr. Solomon talked about the role of the National Cemetery Scheduling Office in St. Louis, which operates seven days a week to coordinate all scheduling at national cemeteries. He outlined the burial benefits provided by NCA, explaining that families are usually responsible for arrangements before arriving at the cemetery, while NCA covers opening and closing of the grave, perpetual care, a headstone or marker, a burial flag, and a Presidential Memorial Certificate, all at no cost to the family. There may also be a burial allowance depending on the individual's eligibility.

Mr. Solomon discussed the Pre-Need Program, launched by NCA in 2016. This program allows Veterans and their spouses to check their eligibility for burial in a national cemetery in advance. It aims to assist Veterans who may have concerns about their eligibility due to issues such as problematic discharges. The pre-need authorization program is particularly useful for Veterans whose records may have been destroyed in the 1973 St. Louis fire. Veterans with honorable discharge papers can apply for pre-need eligibility, which simplifies the process for their loved ones at the time of death. Applications can be made online, by mail, or via fax. Approved applicants receive a letter of eligibility. He highlighted the importance of communicating burial wishes with family and ensuring discharge documents are accessible to them. Pre-authorization does not reserve a specific gravesite. Gravesites are assigned on a next-available basis without regard to military rank--except if both spouses are Veterans, in which case a gravesite can be reserved for them together.

Mr. Solomon shared information about the Baltimore National Cemetery Complex. It has 48,000 Veterans and their loved ones interred across 38,000 gravesites. Though the cemetery officially stopped in-ground burials for first interments in 1970, it revised to changing needs and re-opened in 2018 to accommodate cremated interments. This allowed for more Veterans and their family members to be laid to rest within the 72-acre grounds of this revered cemetery.
He explained that the grounds maintenance in Baltimore is contracted out, but interment and headstone settings are handled in-house. Mr. Solomon emphasized the importance of upkeep, especially due to the age of the cemetery. With a budget of $2.7 million and a workforce of 19 employees, the cemetery functions efficiently. He mentioned the inclusion of two cemetery apprentice caretakers (CAPs), highlighting that they provide opportunities for homeless Veterans. He also mentioned the employment of two individuals from the Compensated Work Therapy (CWT) program run through the Baltimore VA hospital, which provides patients with work as part of their health care and mental health therapy.

Mr. Solomon also has administrative responsibilities for a total of five cemeteries, which include two of President Lincoln's original 14 national cemeteries: Annapolis National Cemetery and Loudon Park National Cemetery, located just a few miles from Baltimore. He also oversees about 900 plots within the Congressional Cemetery in Washington, DC, which is a private cemetery.

While highlighting the history and details of the Annapolis National Cemetery, he gave its background as Ash Grove National Cemetery before its renaming in the late 1800s when Union Veterans convinced the army to designate it officially for Veterans. The cemetery saw its first interment in 1861 with Private Clifton Haley. The cemetery was closed for new interments in 2001, but in 2018 it hosted an interment for a spouse of a Veteran already buried there. Mr. Solomon mentions the original grave markers being wooden boards painted white rather than the marble markers common today.

Most of the 3,005 interments at the Annapolis cemetery were individuals who came from military hospitals around the city or the parole camp used for prisoner swaps during the Civil War. He shares that there are 211 unknown soldiers, at least eight nurses who died from disease while caring for the wounded, and one child buried there.

Mr. Solomon provided various parts related to historical cemeteries and their connection to the Civil War. He mentions the rendering of the parole camp in Annapolis post-Civil War, which was a significant source of interments at that time. He then moves on to describe the entrance of the cemetery, pointing out the Superintendent lodge currently undergoing renovation.

Park National Cemetery was established in 1862 and initially located within the bounds of a private cemetery, separated by a large iron fence. Most of the original interments in Loudon Park came from Baltimore hospitals during the Civil War; it includes the graves of 39 Confederate soldiers who died at Fort McHenry. He explained that Fort McHenry served as a prisoner-of-war camp during the war, housing as many as 7,000 Confederate soldiers in 1863 following the Battle of Gettysburg. Because the soldiers' graves are not individually marked, there is a monument listing their names inside the cemetery.

Mr. Solomon discussed, in detail, the Congressional Cemetery, highlighting its distinctiveness compared to federally operated national cemeteries. Stating that it is privately managed by a nonprofit organization, he clarifies that the cemetery is owned by the Episcopal Christ Church in Washington Parish. The U.S. government, over many decades, purchased about 900 plots within the cemetery, and Mr. Solomon is responsible for overseeing them. The Congressional Cemetery was established in 1807 and is notable for holding NCA’s oldest gravesite, the final resting place of Connecticut Congressman Uriah Tracy since 1807.

Mr. Solomon expanded on the cemetery's history, mentioning that although the federal government funded expansions and additions, the Congressional Cemetery never actually became a federal burial site. It experienced a period of decline in the late 1800s

and was not revitalized until the 1970s, during which time it had become overgrown and was misused for illegal activities. A turnaround occurred when a nonprofit was formed to manage the cemetery, and efforts to renovate the grounds escalated in the 1990s with the help of volunteers from the five military branches. These efforts substantially contributed to the preservation of the Congressional Cemetery.

Mr. Solomon noted significant interments in the Baltimore complex, highlighting the cemetery's historical and cultural legacies. Three members of the 6888th Central Postal Directory Battalion (the "Six Triple Eight"), notable for being the only all-women, all-Black battalion sent overseas during World War II; a Buffalo Soldier and two Tuskegee Airmen are buried there. His is working with NCA's history department to install civil rights interpretive signs to better recognize and honor the contributions of African Americans and civil rights history.

Mr. Solomon discussed an important aspect of cemetery operations: customer satisfaction. The American Customer Satisfaction Index (ACSI) provides a national measure across various industries that gauges how satisfied customers are with services or products they receive. In the 2022 ACSI survey, NCA achieved the highest score of any participating entity for the eight time, including private sector companies like Google, FedEx, and Lexus. With a score of approximately 97%, it indicates a very high satisfaction rate, suggesting exceptional service delivery.

Mr. Solomon attributes this success to the dedicated workforce in Baltimore and emphasized that customer satisfaction is ingrained as a culture within NCA. He asserted the crucial point that in their line of work, they only have one chance to get it right.

Mr. Solomon notes that NCA partners with organizations that engage in activities to honor Veterans. Carry the Load, a volunteer organization that hosts two significant annual events focusing on honoring Veterans and first responders. They organize a Memorial Day cross-country relay, where relay teams either walk or bike as they travel from the north all the way to Dallas, visiting various national cemeteries along their route. Each participant carries with them the memory of a specific Veteran or first responder whom they wish to honor. Carry the Load also organizes Patriot Day of Service, occurring the Friday before 9/11. This event involves volunteers coming to the cemetery to clean headstones. Mr. Solomon specifically noted that the 2023 event at Baltimore National Cemetery will be on Friday, September 8th, and he extended an invitation for more people to participate. Lastly, Mr. Solomon noted that Wreaths Across America holds an event in mid-December, where members of the public are invited to place wreaths on graves. These wreaths are funded by public donations, corporate sponsors, or relatives of Veterans interred at the cemetery.

Mr. Solomon highlighted the community's involvement and the importance of honoring and memorializing those who have served their country. Regarding 2023 Memorial Day events of in Baltimore, the ceremony featured Baltimore Mayor Brandon Scott as the keynote speaker. In Annapolis, VA Under Secretary for Memorial Affairs, Mr. Matthew

Quinn, spoke to volunteers who were placing flags. Mr. Solomon described a touching scene of the Under Secretary and volunteers paying tribute with a wreath at the grave of an unknown soldier.

Mr. Solomon mentioned that Loudon Park's traditional Memorial Day gathering had not yet fully bounced back from a two-year hiatus due to COVID-19. He expressed his ambition to organize a larger event next year and spoke of the smaller wreath-laying ceremony he had with them that year as being 'wonderful'. Mr. Solomon also mentioned the 'Carry the Load' event in Baltimore, showing a photo and noting the beautiful day and impressive appearance of the bus. 'Carry the Load' is a non-profit organization that provides active ways to honor and celebrate our nation's heroes by connecting Americans to the sacrifices made by Military, Veterans, First Responders, and their families. Mr. Solomon concluded by stating there were two stops for the event, one in the morning in Baltimore and another in the evening in Annapolis.

Mr. Solomon concluded his presentation by summarizing the considerable historical context surrounding the National Cemetery Administration's efforts to honor fallen soldiers. He mentioned the mass grave of over 3,000 Confederate soldiers at Point Lookout and how, post-Civil War, the government worked diligently to disinter soldiers from battlefields and reinter them in national cemeteries, reflecting on the careful handling of both Union and Confederate soldiers.

Overview of the Baltimore VA Regional Office (VARO) Business Lines Antione Waller, Director, Baltimore VA Regional Office

Mr. Waller emphasized the importance of accurate and inclusive care for all Veterans, including women Veterans. He noted that upon his arrival, the narrative surrounding the regional office (RO) was negative, highlighting a lack of proper care for Veterans and poor employee relations. His efforts to establish a clear vision and building a solid foundation were crucial initial steps in changing the office's direction.

He expressed the importance of leadership in sustaining care for Veterans, supporting employees, and nurturing relationships vital to the organization's mission. Moreover, Mr. Waller indicated that establishing a stable leadership core was a significant focus, due to the history of continuous turnover, which had eroded trust within the organization. Through these efforts, the leadership aimed to improve the organization's service and trustworthiness.

Mr. Waller highlighted the vision of creating a culture of change, effective communication, and shared information as critical to his organization. Emphasizing the importance of showing appreciation for employees, continuous training, and holding oneself and others accountable, he mentioned that this vision is significant to the current discussion. He noted that there are women Veterans serving in the RO's leadership.

Mr. Waller also mentioned the operational footprint of his organization across the state of Maryland, the National Capital Region, and some of Northern Virginia. The RO

oversees 15 out-based locations with approximately 31 full-time employees. He then shared demographic information about numbers of Veterans served in Maryland and Virginia era of service and gender. In Maryland, 52,302 of the 355,787 Veterans served are women; in DC 4,208 of the 28,003 Veterans served are women.

The Sergeant First Class (SFC) Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act expanded VA benefits and health care for Veterans exposed to burn pits, agent orange, and other toxic substances. This enabled the RO to create an additional 20 positions to support PACT ACT related claims. To date, they hired eight rating Veterans service representatives (VSR), two VSRs, one human resources program specialist and one support services specialist.

Mr. Waller outlined the key responsibilities and goals of the RO, which are to provide non-medical benefits to Veterans in Maryland and the District of Columbia. The substantial aspect of their work is through the Veterans Service Center (VSC), responsible for the Compensation program for Veterans and their dependents in Maryland, Washington, DC, and Northern Virginia. This involves determining eligibility for benefits and services provided by Veteran Readiness and Employment, the Veterans Health Administration, and the National Cemetery Administration.

The VSC supports the Integrated Disability Evaluation System (IDES) program in partnership with the Department of Defense through staff at seven out based locations: Fort George G. Meade, (Ft. Meade, MD); United States Naval Academy, (Annapolis, MD); Naval Air Station Patuxent River, (Patuxent River, MD); Walter Reed National Military Medical Center, (Bethesda, MD); Joint Base Andrews, Joint Base (Andrews, MD); Fort Belvoir, (Fort Belvoir, VA); and Marine Corps Base Quantico, (Quantico, VA). Teams are comprised of claims intake staff, processors, claims assistants, military service coordinators (MSC), and quality review specialists. MSCs assist Service members transitioning from military to civilian life, particularly those who have become disabled. MSC are located in several out based locations, strategically positioned near active military bases within the region covered by the RO.

Mr. Waller emphasized the IDES ensures that Veterans receive their benefits promptly at the time of their discharge. The ultimate goal here is for Veterans to maintain a high quality of life following their service.

He discussed how the focus on disability compensation remains strong, with over 7,000 claims rated and a significant increase to 1.8 million claims filed FY23 to date. This represents a 30% uptick from the previous year, with projections to complete even more by end of year. These figures highlight higher productivity and commitment to serving Veterans effectively.

Mr. Waller talked about success in delivering benefits partly due to the PACT Act, which enabled them to hire more staff and increase operational capacity. Training and onboarding new employees swiftly have also been keys to achieving these outcomes. There has been a substantial financial impact resulting from their efforts; specifically,

the RO distributed over $139 million in benefits, including $25 million in compensation to women Veteran and over $12,000 to their beneficiaries. He noted that the staff's commitment to precision and care in processing claims is reflected in the RO's high-quality rating of 97%.

He emphasized the importance of collaboration with both nonprofit organizations and Veteran service organizations (VSO). The success in reaching Veterans effectively is credited to these strong relationships. Several VSOs, such as Veterans of Foreign Wars, The American Legion, and Disabled American Veterans, operate near the medical center at 31 Hopkins Plaza, within the Federal building. These organizations play a crucial role in supporting the mission by helping their members and the public to receive their benefits, and by being well-informed about the responsibilities and rules affecting Veterans.

Mr. Waller reported on the activities completed to date. The organization has successfully held 164 outreach events and served over 5,818 Veterans, active-duty service members and their families as of May 31, dedicating over 480 manhours. The RO used the Visitor Engagement Reporting Application (VERA) to serve over 2,300 Veterans through in-person and virtual appointments in the Public Contact Offices in Baltimore and Washington, DC.

The RO enjoys a great partnership and collaboration with the local VAMC in jointly delivering consistent messages and benefits, particularly with regard to accessing health care services. The efforts focused on helping homeless Veterans through initiatives like the Winter Haven stand down, addressing the needs of women Veterans with active claim clinics, and giving briefings on the PACT Act. Special emphasis has been placed on Women's Health and addressing MST. Mr. Waller stressed the importance of the established relationships and specialized focus as they continue to support and make a difference in the lives of Veterans.

Mr. Waller stated the importance of the Women Veterans Program in providing support to women Veterans. There are women Veteran coordinators (WVC) located in the Public Contact division of the VSC who function as the primary contact for women Veterans nationwide. WVCs provide specific information and comprehensive assistance to women Veterans, their dependents, and beneficiaries concerning VA benefits and related non-VA benefits. WVCs serve as advocates within VA and in the general public. They also serve as a liaison with other Federal, state, and local agencies, and organizations. Women Veterans who require special services under the WVC program are immediately warm-routed to the designated WVC for assistance. The WVC determines the appropriate assistance required and appropriate program contact person based upon the nature of the situation.

He continued by explaining that their organization collaborates with many other agencies at the state level to effectively serve these Veterans. While the majority of their Full-Time Equivalent (FTE) staff are focused on direct compensation matters, they also have collateral duties to perform. Mr. Waller also mentioned a coordinator who has

been with the organization since 2010, named Miss Lisa Dawson, who plays a key role in building community relationships and is often the first point of contact for women being introduced to the organization. MST coordinators, also in the Public Contact division of the VSC, provide MST counseling and treatment services. When a Veteran requires special services under the MST program, they are warm-routed to the designated MST coordinator for assistance. If necessary, meet in very private areas to protect the privacy of the Veteran. The RO in San Juan, Puerto Rico has oversight of MST claim processing operations across five national sites.

Highlighting the Veteran Readiness and Employment (VR&E) business line, he emphasized the RS's commitment to assisting eligible Veterans in finding suitable employment or promoting independent living and self-employment. Eligibility for VR&E requires honorable service and a service connection rating of 10% or more. They expedite participation by using proposed ratings. Mr. Waller also mentioned that representatives assist at military locations and counselors are available at educational institutions to support Veterans actively engaged in schooling.

Mr. Waller talks about two significant outcomes of the program: job-ready decisions, and positive outcomes. VR&E ensures that Veterans are positioned in roles aligning with their established goals from the outset. The RO prioritizes maintaining contact to ensure the Veterans' ongoing success within these roles.

In the past, their efforts in VR&E innovation focused on leveraging technology to enhance the timely delivery of benefits with exceptional quality. Specifically, within the VR&E business line, they actively pursued technological advancements to align with other program areas. Utilizing tools like the e-VA platform, they aimed to reduce the administrative burden on Veterans, ensuring smoother communication and processes. e-VA is a virtual assistant that supports communication between Veterans and their assigned Vocational Rehabilitation Counselor. e-VA has been integrated with Veteran Benefits Management System (VBMS). Approximately 3,000 Veterans are successfully utilizing the platform. The latest feature that has been added is e-sign which allows Veterans to electronically sign documents.

Invoicing Payment Processing System streamlined the payment process for institutions of higher learning. Nationwide, there has been approximately $2.7 billion paid successfully to academic facilities. In the past, they encountered challenges with payment timeliness, causing stress for Veterans and educational institutions. However, through improvements, they have achieved significant success in this area, relieving Veterans of financial worries and allowing them to concentrate on their educational pursuits.

Mr. Waller gave an update on operational renovations, particularly the newly renovated VSC space. Despite the Biden Administration's push for Federal agencies to bring employees back into buildings, the RO found success with a minimal two-day-per-pay-period, in-person requirement, thanks to the achievements gained during the COVID.

Flexibility remains key as they continue to evaluate opportunities for bringing employees back into the office.

Prosthetics for Women Veterans
Seth Frejkowski, Chief, Prosthetic Department, VAMHCS
Mr. Cooper presented on the increasing number of women Veterans seeking health care services at VA, particularly focusing on Women's Health and maternity care. With a rising number of women joining the military and subsequently accessing VA services, there is a growing demand for items such as breast pumps, feeding bags, nursing bras, and nursing pads. Mr. Cooper emphasized the importance of providing support items alongside prosthetic supplies for maternity care. He also mentioned the collaboration with lactation consults and women's clinics. Additionally, Mr. Cooper discussed the process for getting supplies, the involvement of vendors for efficient delivery to Veterans.

Mr. Cooper discusses the variety of breast pump accessories, emphasizing that they come in different sizes and from different manufacturers. He advised women to consult their doctors to determine the specific items they may need, as everyone's needs differ. Mr. Cooper then discussed post-mastectomy items, detailing the different types of prosthetic devices available, including external and internal options, as well as swimwear and bathing suits with incorporated prosthetics. He also mentioned the availability of lymphedema sleeves and garments, highlighting the comprehensive support offered for post-mastectomy needs.

Mr. Cooper shared the diverse options available for prosthetic devices, emphasizing personal choice and the importance of accommodating different shapes and sizes. He explained that some wigs are designed specifically for substantial hair loss and provide comfort for sensitive scalps. Care instructions for wigs are also provided, including using cold water and regular cleaning to prolong their lifespan. Mr. Cooper mentioned that wigs are typically prescribed by dermatologists based on medical necessity and that Veterans are provided with vendor lists to choose from. He further explained the procedure for obtaining wigs through prosthetics, involving consultations and selections facilitated by Veterans themselves. Additionally, Mr. Cooper explained the involvement of prosthetics in gynecological procedures, such as fittings and placements for devices like Nexplanon and intrauterine devices (IUD), which are coordinated through gynecology consultations.

Mr. Cooper noted prosthetic items for transgender and gender nonconforming Veterans, emphasizing their importance in providing gender affirmation and safety. He presented vocabulary related to transgender health care and explained the role of these medical devices in alleviating gender dysphoria. Mr. Cooper outlined the process for obtaining these items, including the need for a medical diagnosis of gender dysphoria and a treatment plan involving the Veteran's input and follow-up.

Mr. Cooper explained the process for obtaining wigs for transgender individuals based on medical necessity and treatment plans. Wigs may be provided for transgender

women, if the medical provider documents a need for a female-style wig due to hair loss meeting specific criteria. For transgender men, haircuts, and styling to support a male appearance are considered. Mr. Cooper also mentions other prosthetic items available, such as breast forms, Packers, and compression vests, which can be provided based on medical necessity.

Reproductive Health Program
Siobhan D. Kirksey, MSN, RN, Women Veteran Program Manager
Ms. Kirksey highlighted the goal of the Reproductive Health Program, which is to ensure women Veterans have access to optimal reproductive health services across the life cycle. The mission is to offer holistic, interdisciplinary care to enhance access and address all reproductive health needs effectively. She defined reproductive health as a state of complete physical, mental, and social well-being, not just the absence of reproductive disease. Pelvic floor physical therapy, healthy aging, and family planning (infertility, contraception, preconception, and maternity care) are priority areas of the program.

Ms. Kirksey discussed how WHISE funding helps to get the Pelvic Floor Physical Therapy program started. They were able to hire a pelvic floor physical therapist and a pelvic floor health technician. This growth helps to accommodate the increasing demand from women Veterans. She outlined plans to further extend these services beyond Baltimore, aiming for inclusivity and accessibility for all patients, including transgender individuals.

Pelvic floor rehabilitation assists with improving and correcting dysfunctions, which encompasses conditions affect voiding, continence, and sexual function. Dysfunction is caused by many factors, such as trauma, obesity, childhood voiding disorders, radiation, surgery, childbirth, comorbidities like irritable bowel syndrome, constipation, endometriosis. Pelvic floor dysfunction is common but not normal.

Ms. Kirksey shared the outcomes of a national chronic pelvic pain campaign, mentioning the success of a Facebook Live session that engaged a wide audience. She detailed the ongoing focus on family planning and the expansion of abortion services, ensuring the Women's Health team is well-trained to provide comprehensive care across all specialties.

Regarding family planning, she explained that, under the reproductive health interim final rule, VA can offer abortion counseling and provide abortions when the life or health of the Veteran would be endangered if the pregnancy were carried to term, or when the pregnancy is the result of rape or incest. There will be no burden of proof for women Veterans, enrolled for VA health care, in need of a medically necessary abortion for rape or incest. VA offers two training options for providers to enhance their understanding of reproductive health options: one on pregnancy counseling options, including abortion and one on patient center reproductive health care. These training options aim to improve the knowledge and communication skills of providers in reproductive health matters. They have medication on hand for abortions, if needed; are following up on the reproductive health trainings; have national training opportunities for

GYN providers; and have evaluations of staff willing to perform the procedures, community care partners, and medical instruments. The Long-Acting Reproductive Contraception (LARP Clinic) started in March 2020. Before then, Veterans needed to make an appointment in GYN clinic to access services. The clinic is led by a doctor who is training other colleagues. There is a second clinic located at Ft. Meade, which is staffed by a nurse practitioner.

Ms. Kirksey detailed the maternity care coordinator's responsibilities and described the staff on the maternity care team. She explained the critical role the maternity care coordinator plays in supporting maternity patients and detailing the comprehensive coordination of care from preconception to postpartum. She underscored the importance of the shared drive tracker for monitoring patient status and ensuring effective care coordination.

Ms. Kirksey highlighted the maternal outcomes tracker, showcasing the positive results in supporting women Veterans. She expressed pride in the coordinated efforts of the maternity care team, which collaboratively addresses varied needs of maternity patients, ensuring comprehensive support and positive health outcomes.

She provided a brief overview of the Reach Out Stay Strong Essential (ROSE) program, which includes four prenatal sessions and one post-natal booster session. Topics include managing the transition to motherhood; managing relationships; self-care, assertiveness, and goal setting; and psychoeducation on postpartum depression. Sessions are offered in group format or one-on-one sessions and can be in person or virtual. They also offer Postpartum Warriors group therapy that supports birthing parents from birth one year postpartum. Sessions occur first and third Monday every month. It offers psychoeducation, skills, and open process/support group on topics related to postpartum adjustment.

Ms. Kirksey discussed VAMHCS's five lactation pods. There are three in the Baltimore Campus (second floor near the women's health clinic and in the dining hall location; one near the surgical clinic); one at the Loch Raven facility (Building 5 waiting room) and one at the Perry Point facility (Building 361 waiting room). The utilization data of these pods is monitored quarterly to optimize their placement and ensure they meet the users' needs.

Ms. Kirksey discussed the organization's upcoming baby shower and annual event to celebrate women Veterans, planned for Mother's Day weekend. She highlighted the support from volunteers and donations from various sources, emphasizing the personalized invitations and crafted items prepared for the attendees. Additionally, she outlined future plans for maternity care services, including lactation consultant services, childbirth education programs, and the integration of the Pacify app, which offers 24/7 access to lactation consultants and doula services, tailored to the organization's needs.

Regarding healthy aging, Ms. Kirksey highlighted the operations of the pharmacy menopause clinic within the Women's Health department, noting its establishment

alongside a separate GYN clinic arm. She detailed the involvement of pharmacists, interns, and fellows in providing care and conducting research. The clinic has seen numerous initial visits and follow-ups, with patients primarily recruited from primary care, pharmacy, and other referrals. The focus is on patients around 54 years old, emphasizing the need for a formal menopause diagnosis for continued care in the clinic.

Ms. Kirksey discussed a compiled list of common questions and needs expressed from patients. The clinic provides a platform for patients to feel heard and discuss their health holistically, focusing on what matters most to them and how the clinic can assist in managing their health based on their input.

She outlined successes and areas for improvement in the clinic, such as enhancing clinic flow, expanding access, and ensuring that patients without a formal diagnosis are properly referred. The clinic's virtual nature allows for multi-site access and multidisciplinary collaboration. Future goals include opening more clinic slots, refining the referral process, and maintaining visibility on social media to improve access and awareness.

Finally, Ms. Kirksey described the referral processes within the clinic, where patients may receive additional support referrals like nutrition, physical therapy, or integrative health. She shared plans to expand the clinic's services to include interdisciplinary collaboration with a pelvic floor physical therapist and a Women's Health provider specializing in osteoporosis research, aiming to enhance comprehensive care for aging healthily.

Readjustment Counseling/Baltimore Mobile Vet Center
Dr. Michael Gatson, Annapolis Vet Center Director
Dr. Gatson began with some background on how Vet Centers were initially established to help Vietnam War Veterans with readjustment issues and to provide an environment of care where they would not be stigmatized. Today, eligibility is extended to other Veterans who face challenges readjusting from service in theaters of conflict and those who experienced MST. Vet Centers are a part of VHA, under Readjustment Counseling Service (RCS). Located in communities, Vet Centers are available to help Veterans and their families develop tools to build meaningful connections.

Dr. Gatson serves as the Annapolis Vet Center director. His staff currently comprises three counselors (one position vacant), a Veteran outreach specialist and a program support assistant. Staff provides individual, group, couples, and family counseling to talk through problems, brainstorm solutions, discuss what resources are available, and work with Veterans to create effective and practical plans for personal growth. They make referrals to connect Veterans with medical, benefit, employment, and other VA and community services, to help Veterans and their families navigate time consuming tasks, like applying for VA benefits or finding a job.

Dr. Gatson explained that the Vet Center’s priority is to provide Veterans with treatment that is safe and confidential, Records cannot be accessed by other VA or DoD offices,

military units, or other community networks and providers without your permission or unless required to avert a life-threatening situation. The counselors and team members are highly trained, most of whom have served in the military service and can understand the military and Veteran experience. Vet Center services are available at no cost, regardless of discharge character, and there is no prerequisite of VA health care enrollment to receive care or service connection for a disability.

Dr. Gatson described their core benefits, which are providing a welcoming environment where everyone feels respected and safe; offering practical and therapeutic services where the team works with the Veterans to identify individual goals and creates plans to meet those goals; and providing a community of support with people who understand them.

In his overview of eligibility requirements, he explained that Veterans or current Service members, including members of the National Guard and Reserve components, are eligible if any of the following applies:

- Served on active military duty in any combat theater or area of hostility;
- Experienced MST (regardless of gender or service era);
- Provided mortuary services or direct emergent medical care to treat the casualties of war while serving on active military duty;
- Performed as a member of an unmanned aerial vehicle crew that provided direct support to operations in a combat theater or area of hostility;
- Accessed care at a Vet Center prior to Jan. 2, 2013, as a Vietnam Era Veteran;
- Served on active military duty in response to a national emergency or major disaster declared by the president, or under orders of the governor or chief executive of a state in response to a disaster or civil disorder in that state;
- Are a current or former member of the Coast Guard who participated in a drug interdiction operation, regardless of the location;
- Are a current member of the Reserve Components assigned to a military command in a drilling status, including active Reserves, who has a behavioral health condition or psychological trauma related to military service that adversely effects quality of life or adjustment to civilian life.

He added that even Veterans who do not meet that criteria can call them and they will help them find the care needed. Additionally, Dr. Gatson noted that services are also available to family members when their participation would support the growth and goals of the Veteran or active duty Service member. If the Veteran considers them family, so does the Vet Center. Family members of Veterans who were receiving Vet Center services at the time of the Veteran's death and the families of Service members who died while serving on active duty are eligible for bereavement services.

RCS has a fleet of 80 Mobile Vet Centers. They provide outreach and services to Veterans, Service members, and families geographically distant from existing VA services. They provide Veterans newly returning from war early access to Vet Center services via outreach to demobilization active military bases, National Guard, and

Reserve locations nationally. Each Mobile Vet Center is equipped with a state-of-the-art satellite communications package that includes fully encrypted teleconferencing equipment, access to all VA systems and connectivity to emergency response systems. Requests for the Mobile Vet Center should be coordinated through the local Vet Center.

Dr. Gatson provided information on the Vet Center Call Center (VCCC), an around the clock confidential call center where combat Veterans and their families can talk about their military experience or any other issue they are facing in their readjustment to civilian life. The VCCC leverages technology to condense a national system of toll-free numbers into a single modern center. The staff is made up of combat Veterans from all eras and family members of combat Veterans. Warm handoff capacity has been established with all Vet Centers, as well as VA Crisis Hotline. The VCCC can be reached at 877-WAR-VETS (927-8387).

He noted that RCS has Vet Centers in Maryland: Silver Spring, Prince Georges County, Annapolis, Dundalk, Elkton, Baltimore. He also noted the VAMHCS and community access points at the Baltimore VAMC, Glen Burnie CBOC and Ft. Mead VA Outpatient Clinic.

Briefing for Biannual Women Veteran Forum
Siobhan D. Kirksey, MSN, RN, Women Veteran Program Manager
In Ms. Kirksey's overview, she explained that the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020/Deborah Sampson Act (Section 5101) requires VA to hold a biannual public forum for women Veterans that occurs outside the regular business hours. To design the content for the forum, Women's Health tapped into various sources, such as focus groups; patient advocacy complaints; national policy changes; common reoccurring care issues, and Women's Health program improvements. They created an expert panel consisting of VAMHCS's leadership and staff, Women's Health medical director and WVPM, MCC coordinator, the Women's Health mental health champion, and Women's Health social worker.
To inform women Veterans about the event, they created a Listserv for enrolled women Veterans and sent an email invitation to the forum. They also posted information about the event on their social media platforms. VAMHCS hosted forums in March 2022 (68 live attendees, 309 streamed views); October 2022 (181 live attendees; streaming unavailable for this meeting); and April 2023 (37 live attendees; 37 streamed views).
In lieu of VAMHCS conducting a women Veterans town hall meeting during the site visit, Ms. Kirksey shared a brief clip from forum during her briefing. This allowed the ACWV to have an idea of the questions women Veterans presented, as well as how VAMHCS addressed the questions.

Friday, June 16, 2023--VA Maryland Health Care System (VAMHCS), Room #3a-300; Baltimore, MD 21201-1524

The Committee bid farewell to Dr. Patricia Hayes, Chief Consultant for Women's Health, who served as the ACWV's ex-officio member representing VHA for more than 15

years. Members and other staff expressed great appreciation for the transparency she extended when explaining challenges and policies governing VA's care for women Veterans, and for her stellar guidance in assisting the Committee with forming sound recommendations for its congressionally-mandated report.

The Committee conducted an out-briefing with VAMHCS's executive leadership team and women Veterans program manager; the Baltimore Regional Office leadership; and Baltimore National Cemetery Complex leadership.

The Chair began her opening comments by thanking VAMHCS leadership and staff for hosting the site visit. Although the committee is advisory in nature, many of the recommendations are approved by the Secretary and Congress. They get the opportunity to meet so many wonderful and caring professionals across VA; that is one of the benefits of serving on the committee. Without their transparent sharing of information, the committee would be hard pressed to develop their recommendations. She noted that hosting the committee for a site visit takes highly coordinated and orchestrated event management to make it happen. VAMHC's leadership involvement was evident in the quality of the briefings and the facility's quick turnaround in responding to questions.

Chair Yarbrough gave accolades to everyone for the presentations, especially to Ms. Kirksey for doing an excellent job coordinating the briefings for the site visit. She thanked Dr. Porter, who was the acting VHA ex-officio member, for her outstanding support to the health subcommittee and the committee as a whole.

She thanked VAMHCS's acting director and the executive leadership team and staff for their insightful overview of the programs and initiatives provided to the women Veterans in the catchment area. She noted Ms. Stallings's and Ms. Kelly's thoughtfulness and attentiveness in arranging daily transportation for the group, designated parking for local members who commuted daily, and finding meeting space that accommodated members and presenters who could only participate virtually.

Next, she thanked the VISN 5, especially Mr. Scotchlas, for providing the overview of the programs for the Veterans in the VISN and Ms. McCormick for providing the bird's eye view of how VA is serving women Veterans in VISN 5.
She also expressed gratitude for Mr. Waller's overview of the programs, services and challenges the RO faces in serving the women Veterans population, and Mr. Solomon for providing the comprehensive overview of memorial affairs services provided to the Veterans in the area.

She concluded her remarks by thanking the staff behind the scenes that made the site visit a success; the committee members for their questions, the advisors and ex-officios and CWV who provide excellent support to the committee, as well as the public members and women Veterans advocates who observed the meeting.

The Chair then asked the Health Subcommittee Vice Chair to share the health subcommittee's key observations on the visit. Vice Chair Wright noted that the subcommittee was really impressed by professionalism, dedication, and commitment of VAMHCS team to Maryland Veterans, especially women Veterans. It was apparent that quite a bit of effort was put into preparing and executing the presentations on each topic; they appreciated how thorough they were, even in comparison to other site visit presentations.

They would have liked to see more data on women in the programs, to have a deeper understanding of who is enrolled the programs and to ensure that everyone has the same equitable health care. However, they appreciated all the work done to answer questions asked to tease this information out.

It appeared that VISN 5 is a highly reliable organization and, based on that data that was presented, it seems like overall the health of VAMHCS is good. The facility's use of the WHISE funding was excellent; their creativity and innovation of parsing out those funds for all the women Veterans was outstanding.

Regarding Ms. McCormick's overview of VISN 5, the subcommittee appreciated learning that much of the comprehensive care is provided in-house. However, the members would have liked to see more services available for women Veterans in-house so they would not have to use community care. Overall, the maternity program had great success in bringing children into the world--with zero infant mortality--and it appears that the maternal health of women Veterans is also excellent.

She encouraged them to continue to work with women Veterans who may be overburdened using community care, to make sure that they are not stressed out about debt collection and billing issues.

VAMHCS leadership team discussed its partnership with local entities. The Baltimore Strategic Partnership with the University of Maryland is an asset for care. Having that option brings more women Veterans to VAMHCS. Utilizing trainees builds VA's brand and promotes availability of well-trained future VA doctors with a passion for Women's Health. Bringing trainees in to work with Veterans is a best practice that VAMHCS should share with other health care systems.

It is important to include Veterans, as key stakeholders, in high-level leadership meetings when possible. Including them in in lower-level meetings is good, but it might be beneficial to leadership to hear the voices directly.

Regarding the women's health program and primary care, Vice Chair Wright gave kudos on the number of in-house resources and the steady growth of women Veterans utilizing the health care system. Maternity care coordination is an asset. She noted how there is a real emphasis on special populations. This is important to the trust and utilization of health care system.

She noted that there is limited staff to support anticipated growth of women Veterans using the health care system that will; they need more full-time employees (FTE) to handle the impact. Some of the graphs should be more descriptive depicting women Veterans. There were lots of graphs but they were not specific to women Veterans.

Vice Chair Wright lauded Ms Kirksey's outstanding work on behalf of women Veterans, her broad lens for demographics, and her astute comprehension of how other factors impact the Women's Health program. It was quite evident that she understands the women Veterans she serves. The packets that the program sends to newly enrolled women Veterans is a good practice.

Communication planning is important. The facility uses social media to communicate with women Veterans, but it they should also explore using other types of communication. They should also engage women Veterans to see how they best accept information. Leadership should ensure that all programs are scalable to accommodate the growth of women Veterans utilizing the health care system.

Leadership should problem solve for better warm handoffs when providers leave VA. Vice Chair Wright noted that women Veterans identified this as an issue in the recording of their recent Women Veterans' Forum that the committee reviewed. Other suggestions for Leadership's consideration included: performing dental screening during pregnancy for the health of the mother; providing pill packs to so older women Veterans will remember to take their pills; ensuring that they spell out all acronyms on their slides moving forward so those who are not familiar with certain terminology will understand the data better.

She was impressed by the sexual assault and harassment prevention and culture transformation presentation because it came from law enforcement's lens. It gave a more operational perspective than the policy office would give. The collaboration at the facility between law enforcement and the policy office that manages these issues is very effective. The committee noted that the signs addressing sexual harassment prevention were prominently displayed. The facility created relationships to change the culture, which is an excellent practice to be shared with other health care systems. She added that the Website intake forms for complaints could be easier to access. Even though there are other ways to communicate those complaints, every method should be as "low barrier" as possible. When discussing harassment, it might be advantageous for the facility to add language in talking points clarifying that harassment can also occur between women and women, women and men, and transgender.

The rural health transportation grant is used very well. The subcommittee appreciated that there are eligibility requirements specific to rural Veterans; that gives great support to rural Veterans and helps them have better access to VA for appointments. Providing transportation to community providers is a good best practice; not everyone does that. She suggested that they utilize the county departments of health to collaborate on women's health care issues in the rural areas and to utilize more centers of worship, community centers, educational institutions to provide opportunities for outreach.

Addressing the overview of Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ+) Program, she noted that there is a strong commitment to providing LGBTQ+ centered care and congratulated them on achieving the Health Care Equity Index. Not every health care system has that and it says a lot about how this health care system performs. The orientation screening for Veterans should be a best practice in every health care system, if it is not already an established practice. The subcommittee suggested that the facility have a full-time position for the LGBTQ coordinator. Effective outreach is very important for this community. They also suggested moving the coordinator to PACTs instead positioning it in Mental Health, to reduce stigma that LGBTQ+ Veterans have mental health issues based on their gender identity or that their orientation is as a mental illness.

Overall, mental health services, integration and collaborations across functional specialty settings was excellent. VAMHCS has a full breadth of mental health services. A best practice is offering pay adjustments, to assist with the retention of psychiatrists. Health care providers cost a lot of money and it is a stressor on retention and a stressor when facilities have vacancies.

The universal screening for MST is a great practice to understand how much work needs to be done to assist Veterans. Intake for IPV screening was effective. Having the Employee Assistance Program available as a resource for employees to discuss IPV creates a caring environment. IPV is one of those things that people kind of know about in the back of their minds, but they do not think about until it pertains to them. However, Vice Chair Wright suggested that the facility provide more communication about the IPVAP, like in newsletters.

VAMHCS's suicide prevention coordinator was very committed. S.A.V.E. training is an important piece of assisting employees on how to deal Veteran suicide. Vice Chair Wright commended the facility for working with the Maryland Governor's challenge. It would be enlightening for other States to see how VAMHCS is working with the State of Maryland for this initiative. Calling Veterans between appointments to check in on them would be a great best practice. To determine if the interventions are helping, the subcommittee suggested working with the Governor's challenge to educate coroners and medical examiners about inquiring on miliary service history, to help determine if a deceased individual served in the military.

Community resource and referral centers are great intake places for homeless engagement. It is nice that VAMHCS has more than one. The facility's community partnerships and intensive outpatient therapy are best practices. One suggestion was to create a pathway to VA employment for homeless Veterans. There are some programs available, but the health care system should really open its doors to support the homeless.

Vice Chair Wright complemented VAMHCS's excellent whole health training. The evidence-based programs are well documented and there are a lot of options on the

website for all types of interests. The in-person meeting participants noted that the banner posted in the meeting room was very inclusive and respectful—and left a very good first impression of the program. The coaching component of the program is important and could use more emphasis. It is also important to make options available for working Veterans, either before, after work or on the weekends. The committee observed that there many virtual activities that Veterans could do that on their own, but social interaction is important.

VAMHCS's Post-9/11 Military2VA case management program 90-day follow-up with Veteran after case management is completed is a best practice. The subcommittee suggested better disaggregation of data provided to better understand why Veterans may deny case management initially.

Vice Chair Wright noted that Dr. Mesioye is an asset to the long-term care program. Her love for the residents was evident; she openly acknowledges it. She could immediately share the demographics of the women in both facilities, which means she is very attentive. She is creating a unique experience for each of her residents, particularly with the buddy program for the resident with dementia who was isolating and the lady's tea. The committee was concerned about community living center residents being prohibited from smoking on the premises. Although it is not the greatest for their health, it is what brings some of them enjoyment at this stage of life.

The subcommittee thought the queer and trans 101 vocabulary document provided by the prosthetics office was very helpful. Every health care system should use it as a best practice. The subcommittee suggested that the department ensure that culturally proficient for wigs. There is a small vendor list. The facility should challenge the vendors or procurement system to make sure women have the right have appropriate options. It is important for self-identity and self-esteem.

The reproductive health program has an excellent maternity care coordination team and good maternal and infant statistics. The subcommittee enjoyed learning about the baby shower events—a good practice. The lactation pods are beautiful, but they wished the pods were put to more frequent use. She suggested more outreach about it may increase utilization.

Vice Chair Wright noted that Readjustment Counseling Service utilization of local churches and community centers as places for counseling is a best practice that other departments in the facility should consider. Additionally, there could be more outreach in the catchment area to educate Veterans about Vet Centers.

Next, the Chair asked the acting Benefits Subcommittee Vice Chair, Ms. Joseph, to share the benefits subcommittee's key observations on the visit. She expressed the benefits subcommittee's appreciation for VISN 5's, VAMHCS's. Baltimore RO's and national cemetery's enthusiasm, professionalism, dedication, and service, especially since they had short notice to prepare for the site visit.

Beginning with comments on the national cemetery, she noted that it was great to see that it scored so high on the American customer service satisfaction index, with it being the highest of any organization. She also congratulated them on having a very high percentage of employees who are Veterans. The subcommittee thought the high number of homeless Veterans, women Veterans, and disabled women Veterans it employed was impressive and a very good best practice. They were also impressed by how the cemetery works with the Homeless Program to ensure that the homeless Veterans they employ receive therapy if they need it.

She noted that Mr. Waller's dedication and support of the RO's work are evident and very personal to him, as a Veteran with long military service and the RO. The subcommittee thought the outreach efforts with the VSOs was a great and they liked the way the RO utilized technology to create more seamless processes.

Ms. Joseph highlighted another best practice, having the women Veterans coordinators within the contact division do a warm handoff with the medical center, so women Veterans get the care they need. This is a practice that should be shared with other ROs.

The benefits subcommittee suggested deeper dives into the data to figure out where there are indications of gaps/disparities for women Veterans. One of the things they did not see was a strategic communications perspective regarding how the RO's programs should disseminate information to women Veterans.

Ms. Joseph concluded her comments by thanking all the presenters, the entire staff and of course--especially Ms. Kirksey for her efforts and staunch support of women Veterans.

Following the subcommittee reports, Ms. Tiglao also thanked VAMHCS director, Mr. Jonathan Eckman, for accepting the invitation to host the site visit and dedicating professionals like Ms. Kirksey, Ms. Anthony and Ms, Stallings to work with CWV in planning the site visit. She thanked Mr. Buser who was acting director during the site visit, especially because of the quick turnaround in planning. She praised Ms. Kirksey, an asset to VAMHCS, for her dedication and the empathy she brings to her work; she thanked Dr. Staropoli for her leadership over the Women's clinic.

She thanked Ms. Stallings for working diligently with the ACWV committee manager to understand the members' concerns, working with the chief of police to provide parking for the local committee members, working with transportation and logistics to make sure the group had daily transportation. She thanked Ms. Anthony for being instrumental in making sure that the group's needs were addressed.

Ms. Tiglao thanked Mr. Scotchlas for understanding the importance of VISN-level participation and ensuring that the leadership or a representative was available to discuss the services provided to the Veterans. She especially thanked Ms. McCormick, who proactively lent her historical lens on the ACWV's last visit to Baltimore to guide the

host facility in planning. She also thanked Mr. Waller for shifting his obligations to participate; Ms. Garcia Williams for serving on the planning committee and liaising with CWV to keep the RO informed; and Mr. Solomon, for shifting his obligations to participate in the site visit and participating on the planning Committee.

Finally, Ms. Tiglao thanked the ACWV vice chairs and members, for presenting thought provoking questions that generated impactful discussions on how to improve opportunities for cross collaboration--not only within the facilities participating but also with local community partners—for their passion, and for asking the hard questions and identifying solutions with the direct correlation for improved services for women Veterans.

She also thanked the ex-officios and advisors who supported the committee during the site visit—especially Dr. Janet Porter, who participated in-person, provided insightful guidance to the health subcommittee, and made sure that committee received real time responses to questions. Additionally, she thanked the committee manager for coordinating the site visit and all the presenters for their informative briefings.

The Chair then adjourned the meeting.

/s/ April 10, 2024
Colonel Wanda Wright, USAF, Ret.
Current Chair
Advisory Committee on Women Veterans

/s/ April 10, 2024
Lourdes Tiglao
Designated Federal Officer
Advisory Committee on Women Veterans