

**Department of Veterans Affairs (VA)  
Advisory Committee on Women Veterans  
Meeting Minutes  
Site Visit to Washington, DC  
July 27-30, 2010**

**VA Advisory Committee on Women Veterans (ACWV) Members Present:**

COL Shirley Quarles, USAR, Chair  
COL Matrice W. Browne, USA, Retired  
CDR Rene' Campos, USN, Retired  
Lindsay Long, USMC  
Kayla Williams, USA

PO2 Davy H. Coke, USN, Retired  
Valerie Cortazzo, USN  
Karen Etzler, USAF  
SFC Gundel Metz, USA, Retired  
Barbara Ward, USAF

**ACWV Excused:**

CMSgt Helena R. Carapellatti, USAF  
COL Gloria Maser, USAR

**ACWV Ex-Officio Members Present:**

Cheryl Rawls, Director  
North Little Rock VA Regional Office  
(VARO)  
Veterans Benefits Administration (VBA)

**ACWV Ex-Officio Members Excused:**

Denise Jefferson, Competitive Grants Specialist  
Veterans Employment and Training Service  
Department of Labor (DOL)

LtCol Rose M. Jourdan  
Interim Military Director, DACOWITS  
Department of Defense

**ACWV Advisors Present:**

Raynell Lazier  
Chief, Executive Correspondence  
Division, National Cemetery  
Administration (NCA)

**ACWV Advisors Excused:**

Dr. Patricia Hayes, Chief Consultant,  
Women Veterans Health Strategic  
Health Care Group (WVHSHCG),  
Veterans Health Administration (VHA)

CAPT Angela M. Martinelli, Division of  
Treatment and Recovery Research,  
National Institute of Alcohol Abuse and  
Alcoholism, National Institute of Health,  
Department of Health and Human  
Services (HHS)

**VA Staff Present:**

Carolyn Bryant, Compensation and Pension  
Service, VBA  
Meri Mallard, Deputy Field Director  
Women Veterans Health Strategic Healthcare Group (WVHSHG), VHA  
Lauren Menard, VA Intern

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**Center for Women Veterans (CWV)**

Dr. Irene Trowell-Harris, Director  
Dr. Betty Moseley Brown, Associate Director  
Desiree Long

Shannon Middleton  
Michelle Terry  
Juanita Mullen

**Guests**

Ann Duarte  
Sharon Hodge, Vietnam Veterans of America  
Robin Patrick

Karen Riggle, National Association of County  
Veterans Service Officers

The entire site visit package with attachments is located in the Center for Women Veterans, Washington, DC

**Tuesday, July 27, 2010**

**Opening, Veterans Benefits Office, 1800 G Street, NW**

- Dr. Quarles, Chair of the Advisory Committee on Women Veterans (ACWV) opened the meeting with greetings and introductions.
- Meeting minutes from previous meeting were approved.
- Dates reviewed for the upcoming Advisory Committee on Women Veterans meeting; date set for October 26-28, 2010.
- In addition, she thanked the Veterans Benefits Administration leadership team for time invested in preparation for this visit.
- Dr. Irene Trowell-Harris, Designated Federal Official, provided purpose of the site visit:
  - To provide an opportunity for Committee members to compare the information they received from briefings, provided by the Administrations at VA Central Office, with the activity in the field.
  - Committee members will be able to gain first-hand knowledge about treatment, programs, and the provision of benefits in place for women Veterans in Washington, DC. All presentations are to specifically address how programs, services, and benefits relate to women Veterans. Site visits are considered advisory in nature.
  - This visit will give Washington, DC officials an opportunity to discuss any special interests they would like to share with the ACWV, or address any concerns regarding the welfare of women Veterans.

**Entrance Briefing/Welcome of Leadership and Introduction, Bonnie Miranda, Associate Deputy Under Secretary for Management**

- Washington, DC Women Veterans Coordinator's (WVC) duties have been repositioned to the Benefits Assistance Service.

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- Washington, DC regional office (RO) is currently supervised by the director of the Appeals Management Center (AMC).
- Veterans Benefits Administration (VBA) has made WVCs available at every RO.
- VBA staff has training on handling claims for military sexual trauma (MST)/personal trauma.
- WVCs receive a binder explaining how to process MST claims and how to identify MST markers.
- There is no special review for MST claims, but all claims are subject to quality assurance.

**Overview of Post 9/11 GI Bill, Alison Rosen, Assistant Director, Program Management, Education Service**

- VA education programs serve to:
  - Provide readjustment assistance and restore educational opportunities lost because of service to the country.
  - Extend benefits of higher education to qualified persons who may not otherwise be able to afford it.
  - Aid military recruitment and retention of highly qualified personnel.
  - Encourage membership in the selected reserve.
  - Enhance the national work force.
- Requirements for Montgomery GI Bill—Active Duty (MGIB, or Chapter 30):
  - Initial active duty service after 6-30-85.
  - Military pay reduction of \$1200 for one year during military service.
  - Current monthly rate for full-time training is approximately \$1368.
- Requirements for Montgomery GI Bill—Selected Reserve (MGIB-SR, or Chapter 1606):
  - Serve six year selected reserve obligation.
  - Completion of initial active duty training.
  - Current monthly rate for full-time training is approximately \$333.
- Requirements for Survivors' and Dependents' Educational Assistance (DEA, or Chapter 35):
  - Spouses and children of Veterans or service members.
  - Current monthly rate for full-time training is approximately \$925.
- Reserve Educational Assistance Program (Chapter 1607):
  - Program established in 2005 by Department of Defense.
  - Designed to provide education assistance to members of the Reserve components called or ordered to active duty in response to a war or national emergency.
  - Up to approximately \$1094 monthly, dependent upon period of service and training time.

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- Post-9/11 GI Bill (Chapter 33):
  - Created for individuals with active duty service after September 10, 2001 who served a period of at least 90 aggregate days--to include those currently serving on active duty--or served at list 30 days and received a disability discharge.
  - Benefits can be paid for training pursued on or after August 1, 2009.
  - Those who use Post 9/11 GI Bill have to revoke Chapter 30 benefits.
  - Program allows for three separate benefit payments:
    - Tuition and fees charged.
    - Monthly housing allowance.
    - Stipend for books and supplies.
  - Period of eligibility:
    - 15 years from last release from active duty of at least:
      - 90 consecutive days.
      - 30 consecutive days, if released for disability.
  - If eligibility is based on aggregate service of less than 90 consecutive days, individual will have 15 years from the last period of service used to meet the minimum service requirements for eligibility.
- Approved programs:
  - All programs approved under MGIB *and* offered at an institution of higher learning (IHL).
  - Individuals who were previously eligible for chapter 30, 1606, or 1607 may continue to receive benefits for approved programs not offered by IHLs (i.e. flight, correspondence, APP/OJT, preparatory courses, and national tests).
- Tuition and fees payments:
  - Paid directly to the school.
  - Individuals are eligible for the applicable percentage (based on aggregate active duty service) of the lesser of:
    - Tuition and fees charged; or
    - Highest amount of tuition and fees charged for full-time, undergraduate training at a public IHL in the State the student is attending.
- Yellow Ribbon Program:
  - Degree-granting institutions voluntarily enter into agreement with VA to fund tuition costs above the highest in-state public undergraduate tuition rate.
  - VA will match each additional dollar that an institution contributes toward an eligible student's tuition costs, up to 50 percent of the difference between the student's tuition benefit and the total cost of tuition and mandatory fees.
  - Only individuals entitled to the 100 percent benefit rate (based on service requirements) may receive this funding:

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- Individuals receiving transferred benefits from a service member may also be eligible for the Yellow Ribbon Program.
- Monthly housing allowance:
  - Paid directly to the student.
  - Equivalent to the basic allowance for housing (BAH) for an E-5 with dependents:
    - Amount determined by zip code of the IHL where the student is enrolled.
    - Prorated based on the percentage of the maximum benefit payable.
    - Active duty service members and anyone training at half time or less, and those pursuing distance learning are not eligible for the monthly housing allowance.
- Books and supplies stipend:
  - Paid directly to the student.
  - Up to \$1,000 per year, prorated based on the percentage of the maximum benefit payable.
  - Paid proportionally for each quarter, semester or term attended.
  - Active duty members are not eligible.
- Transfer of entitlement eligibility:
  - Department of Defense determines eligibility.
  - Service member or Veteran must have served in military on August 1, 2009.
  - Served at least six years in armed forces and agrees to serve at least another four years.
  - Spouses may use transferred benefits after sponsor's six years of service; children may use benefit after sponsor's 10 years of service.
  - Fry Scholarship Program available for children of service members who die in the line of duty after September 10, 2001; benefit is retroactively effective to August 1, 2009.
- What VA has experienced:
  - Longer processing time:
    - Inefficiency in IT systems beyond initial estimates:
      - Functionality more limited than originally expected, resulting in a highly manual process.
      - IT tools are complex and therefore training is time consuming.
    - Substantial chapter 33 workload increase without associated decrease in other programs resulted in large overall claims workload:
      - Use of existing programs remains consistent with past years.
      - Chapter 33 allows beneficiaries who exhausted other programs and maintain eligibility to chapter 33.
      - Transfer of entitlement-eligible individuals.
      - Post-9/11 GI Bill challenges.

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- Complexities in program:
  - Payment differences between chapter 33 and other benefit programs required significant modifications to IT systems and business processes:
    - Multiple benefit payments to multiple entities.
    - Lack of a set payment “rate.”
  - Differences in eligibility criteria also resulted in modifications:
    - Data interfaces and procedural changes to support Transfer of Entitlement beneficiaries.
    - Different eligibility criteria for chapter 33 benefit program in general, as well as for each type of payment.
    - Post-9/11 GI Bill challenges.
- Confusion over housing payment schedule:
  - Post-9/11 GI Bill pays each month in arrears, consistent with other education benefits.
  - Students expect housing payments at beginning of month instead of after each month of attendance, or full housing payment after only partial month of attendance:
    - Contributed to financial hardships among students.
    - Increased demand on VA customer service.
    - Receipt of books and supplies stipend at the beginning of each term contributes to complexity.
- Use of maximum tuition and fee rate per state to pay benefits:
  - Requires time consuming research to ensure maximum possible rates – no authoritative source for tuition and fee data:
    - Dependent upon state budget cycle that typically does not start until July.
  - Prevented some claims from being processed early, as final rates were not available for all states prior to program implementation.
  - Complicated Yellow Ribbon Program development and implementation because schools could contribute varying amounts.
  - Complicated claims processing because each student could potentially have a different payment amount that must be verified by claims processor.
- New IT system development:
  - Long term solution will deliver an end-to-end solution to support delivery of Post 9/11 GI Bill that will be:
    - Released in four to six month intervals, delivering incremental capability.
    - Developed in a distributed application architecture framework.
    - Supportive of a service oriented architecture.
    - Developed using an agile methodology.
    - Rules-based to ensure reusability and flexibility.

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- Development began in fourth quarter fiscal year (FY) 2009.
- Completed solution development environment in first quarter FY 2010, with subsequent quarterly releases.
- Final long term solution release expected by December 2010.
- Over 596,149 students have been provided certificates of eligibility for Post 9/11 GI Bill since August 1, 2009; \$4.1 billion in benefits paid to date.

**Briefing on Claims Processing and Appeals, Edna McDonald, Acting Deputy Director of Operations, Compensation and Pension Service**

- There are 1.8 million women Veterans, representing 8 percent of the U.S. Veteran population.
- Over 250,000 Women Veterans are receiving compensation or pension benefits, representing 7 percent of the total Veterans receiving benefits.
- Approximately 15 percent of all awards of service connection since 2002 have been to women Veterans.
- To maintain a Veteran Centric VA, VBA has:
  - Increased service.
  - Made regulatory and policy changes.
  - Improved service delivery.
- Every Regional Office employs a WVC to provide outreach and claims assistance to women Veterans.
- WVCs collaborate with the Department of Defense's Sexual Assault Prevention and Response Office (SAPRO) to obtain documentation for claims based on MST:
  - DD Form 2910, *Victim Preference Reporting Form*, is accepted as evidence of report of sexual assault in claims based on MST.
  - VBA provides compensation payments for service-connected disabilities that are related to MST.
- Unique disability compensation evaluation criteria for women Veterans are provided in the VA Schedule of Rating Disabilities.
- Benefits are provided to the children of women Veterans who served in Vietnam for disabilities due to covered herbicide-related birth defects.
- Special monthly compensation (SMC) is paid to women Veterans who suffer a service-connected loss of 25 percent or more of breast tissue from mastectomy or radiation treatment, and for loss, or loss of use, of a creative organ.
- Through the Benefits Delivery at Discharge and the Quick Start Claims programs, women Veterans can submit claims for service connection prior to their discharge from active duty.

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- Quick Start program in St. Petersburg allows for some claim issues to be paid when there is enough evidence to rate them, as others remain in the claims process.
- Currently averaging 161 days for processing claims; the target is 125 days.
- VBA provides benefits information, including MST, to separating service members at the transition assistance programs.
- Provided overview of VBA's claims process and appeals process.
- Appeals statistics:
  - In FY 2009, VBA completed action on 977,219 rating claims; ended with more than 92,000 NODs pending at field offices; had an appeal rate of nearly 10%.
  - End of FY 2009 Appeal inventory in all stages is 178,000 claims.
  - Over 21,000 cases were resolved in field stations, without requiring BVA review.
  - Of those, more than 11,000 were settled through the decision review officer (DRO) process.
  - In FY 2009, slightly more than 38,000 cases were certified to the Board of Veterans' Appeals (BVA).
- 21<sup>st</sup> Century VA:
  - Veteran centric.
  - Results driven – “Break the Back of the Backlog.”
    - Deciding claims with 98% accuracy in no more than 125 days.
  - Forward looking.

**Overview of the Benefits Assistance Service, Karen Gooden, Chief, Client Services**

- Role of Benefits Assistance Service (BAS) to:
  - Facilitate outreach and client-service activities.
  - Provide support to all VBA's services, staffs, and regional offices.
  - Coordinate outreach and public affairs activities with Veteran Health Administration (VHA), National Cemetery Administration (NCA) and staff offices through Office of Public and Intergovernmental Affairs.
- VBA outreach tools include the Web site, social media, benefit videos, mailings, published materials, briefings, conference booths and exhibits, Benefits Assistance Service.
- eBenefits:
  - A one-stop shop for benefits-related online tools and information for Wounded Warriors, Veterans, service members, family of service members, and those who care for them.
  - Account holders must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) to create account mailings.
  - “My eBenefits” is a personalized workspace giving quick access to online tools integrated into eBenefits.

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- eBenefits will be enhanced to provide mobile access in the future.
- BAS conducts targeted outreach to women Veterans:
  - VBA conducts national and local outreach to women Veterans through the efforts of its WVCs.
  - There are designated WVCs at Regional Offices, Pension Maintenance Centers and National Call Centers.
  - WVCs conduct outreach and provide guidance on benefits and services to which this population may be entitled.
  - In collaboration with BAS, VBA's national women Veterans program manager maintains frequent and consistent communication with all WVCs in the field offices.
- Role of the WVCs:
  - Participating in local women Veterans events.
  - Providing training to organizations that may include women Veteran members.
  - Acting as the point of contact for VA and other service providers and women Veterans with special needs (women Veterans who experienced sexual trauma while on active duty).
  - Establishing a network among community service providers, women Veterans program managers at VA Medical Centers (VAMC), vet centers, and other community organizations.
  - Being a liaison with women Veterans organizations and/or those with predominantly women members.
  - Maintaining rosters of the primary contacts, and providing speakers for meetings and special events, when appropriate.
  - Maintaining a resource directory of service providers within the community that provide services specifically for women and distributing the directory as appropriate.
  - Advertising information about VA's benefits and services in places where women Veterans live or frequently visit.
- National communication:
  - VBA increased the frequency of WVC conference calls from quarterly to monthly.
  - VBA conducts site visits to field offices to assess outreach activities and compliance with policy by WVCs and other field personnel.
  - VBA established a SharePoint site to facilitate and provide immediate, frequent feedback and information to all WVCs.
  - The first VBA pamphlet for Women Veterans is completed, but pending approval.

**Overview of the Appeals Management Center (AMC), Emmett O'Meara, Assistant Director, AMC**

- Provided basic overview of the AMC.

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- Mission is serving Veterans all over the country whose cases are remanded to by the Board of Veterans Appeals.
- AMC works to make cases compliant with the Veterans Claims Assistance Act (VCAA) compliant; does research on claims to find additional supporting information so regional offices can make a rating.
- Currently takes approximately 434 days to complete appeals process; goal is 410.
- Addressed logistical issues associated with transferring of files, and scheduling of exams.
  - Multiple transferences of claims between regional offices and AMC.
- Discussed progress made in performance via training and accountability.
- Stressed the importance of communication with all involved parties to facilitate resolution of challenges.
- Improving backlog:
  - Holding people accountable for their work.
  - Ensuring staff understands purpose of the organization.
  - Thirty one new Veterans Service Raters (VSR) added to staff; 31 in process of completing training.
  - Increasing rating capacity by providing additional training for existing staff.
- AMC responding more quickly to Congressional inquiries.
- Improving work space to make it more personal.
  - Anticipate commencement of construction by August 16.
  - Expect renovations to be completed by October 1.
- AMC remains driven to improve the service provided to Veterans.

**Overview of the Board of Veterans Appeals, The Honorable James P. Terry, Chairman, Board of Veterans Appeals**

- BVA was established in 1933, and is more than 75 years old.
- Staff: 545 employees, 529 full time employees (FTEs) (funding vs. numbers)
- Currently 60 Veterans Law Judges (VLJ); four more have been approved.
- Judges are rated on their knowledge before there are hired.
  - Candidates undergo a selection process; non-lawyers are included on the interview panel.
  - The Panel's recommendations are submitted to the Chairman, then the Secretary.
  - President of the United States has sole authority to appoint BVA judges.
- BVA has 335 attorneys (journeyman rate is GS-14), 145 support personnel.
- There are four teams of 12 line judges, three supervisory judges, two senior counsel. Each team is assigned 80 attorneys assigned.
- BVA has a large appellate group (Quality Review; Litigation Support; Privacy Office; Labor Relations).

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- Discussed:
  - Appointment of Judges.
  - Productivity:
    - Appeals decided last year by the Board: 48,804.
    - Up more than 5,000 from the total of 43,757 in 2008.
- Hearings:
  - In FY 2009, there were 11,629 hearings, an all-time high; will exceed 12K this year.
  - Appellants can choose a video hearing which often can be arranged more quickly.
  - Expected it will be approximately 32% this year; aiming for 35% next year.
- Judges and attorneys expected to complete fair share of work.
- Evaluations:
  - Each attorney and judge is evaluated for the quality and timeliness of their work (attorneys mid-year and final VLJs final).
- Quality of our decision making:
  - The Quality Review Office, headed by our Chief Counsel for Policy, reviews five percent of all decisions on appeal (50 per week) to determine whether a substantive error would result in remand.
- Other considerations at BVA:
  - Training.
  - Writing clear, concise, coherent, and correct decisions.
  - Veterans Law Review.
  - Student Loan Repayment Program.
- New initiatives:
  - Expedited Claims Adjudication Initiative.
  - Paperless appeals.
  - Development of electronic case/appeals tracking system for Veterans—ebenefits.
  - Enhance video hearing capacity.

**Wednesday, July 28, 2010**

**Women Veterans Forum, Women's Memorial, Arlington, VA**

The Committee attended the daylong Forum on Women Veterans at the Women's Memorial. They received briefings on enhancements to VA benefits and services for women Veterans and gathered information from almost 30 exhibitors. Agenda is attached.

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**Thursday, July 29, 2010**

**Welcome, VISN 5 Network Director, Sanford Garfunkel, FACHE**

- Discussed commitment to providing the highest quality healthcare:
  - Strategic focus on quality care for all Veterans.
  - Transformation to patient-centered medical home and comprehensive care for women Veterans.
  - Privacy dignity, security, and safety.
  - Lead women Veterans program manager started January 2010.
  - One full-time nurse practitioner for each facility serving as women Veterans coordinator in rural community based outpatient clinics (CBOC).
  - Office of Rural Health funding \$3.1M for CBOCs serving rural communities.
  - Collaborative outreach efforts for women Veterans.
  - Stressed emphasis on patient centered Medicare home.
  - Discussed My HealthVet secure messaging.
  - Goal is to have a fourteen day appointment wait.

**Overview of VISN 5 Facilities, Programs, Demographics, Archana Sharma, MD, Chief Medical Officer**

- Discussed VISN 5 women Veterans program strategic goals:
  - Transform heal care delivery for women Veterans.
  - Define objective measurable outcomes.
  - Increase services and access for women Veterans.
  - Develop, implement and influence health education initiatives.
  - Enhance communication and outreach efforts.
- Patient center medical home (PCMH):
  - Develop Veteran focused teams.
  - Relocate or renovate to provide services.
  - Implement system redesign principles for flow.
  - Create space and infrastructure.
  - Women Pavilion – DC VAMC.
  - Women Center – Martinsburg VAMC.
- Comprehensive care for women Veterans:
  - Offer comprehensive provider.
  - Provide parity for all women Veterans.
  - Track women-comprehensive health care implementation plan (W-CHIP).
- Define objective measurable outcomes:
  - VISN 5 data Warehouse/Dashboard.

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- Ongoing composite calls.
- Monthly performance measures meetings.
- Monthly primary call meetings.
- Qualitative interviews for needs assessment and metric identification.
- Continuing performance improvement:
  - Data Warehouse/Data Dashboard.
  - Rapid cycle reports.
  - Satisfaction:
    - SHEP.
    - TruthPoint.
  - Gallup focus group.

**Overview of VISN 5 Women Veterans Services, Veronica Thurmond, PhD, Lead Women Veterans Program Manager**

- Increase Services and Access:
  - Office of Rural Health funded projects:
    - Women Veterans health program.
    - Mobile mini-residency training program.
    - Qualitative interviews; needs assessment/metrics, starts in August.
    - Tele-podiatry.
    - Homeless services and education.
    - Congestive heart failure/chronic obstructive pulmonary disease.
- Three nurse practitioners, women Veterans coordinators, in rural areas.
- Secure messaging.
- Transportation rural health project.
- Develop, Implement, and Influence Health Education:
  - Task three and task four of rural project:
    - Needs assessment.
    - Training/education for health care providers.
    - Training/education for women Veterans.
- Rural mobile mini-residency for gender specific training; community provider included.
- Rural nurse practitioner women Veterans coordinators.
  - Provide presentations in the community.
- Enhance communications and outreach efforts:
  - Participate in strategic planning.
  - Two rural health outreach coordinators.
  - W-CHIP.
  - VISN 5 women Veterans SharePoint site.
  - Qualitative interviews – Gallup and women Veteran rural health project.

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- Weekly 1.5 hour meetings with program managers.
- Medical center and CBOC staff meetings.
- Quarterly site visits to CBOCs with WVPMS.
- Lead WVPM attends Yellow Ribbon reintegration events.
- Chair VISN 5 women Veterans liaison group.
- Chair VISN 5 OEF/OIF and women Veterans liaison group.
- National effort to develop women Veteran Dashboard.
- Ladies Night outreach initiative.
- Leading National fast track efforts:
  - W-CHIP tracking log.
  - Privacy, Dignity, and Security for Primary Care tracking log.
  - Privacy, Dignity, and Security for Inpatient tracking log.
  - Providing chaperones.
  - Implementing mammogram process.
  - Notification / follow-up of screening results.
  - Maternity care.
  - Point of Care: urine testing for pregnancy.
  - Plan B emergency contraception.
  - Specialty services in facilities/CBOCs tracking log.
  - Women Veterans standardized VISN presentations
  - Women Veterans data Dashboard.

**Overview of DC VAMC Facility/Programs/Demographics, Fernando Rivera, FACHE, Medical Center Director**

- Discussed uniqueness of DC VAMC:
  - Test site E HR advancements.
  - Host VIP CPRS demonstrations.
  - Champion outreach marketing.
  - Four medical school affiliations.
  - Polytrauma network site.
  - War Related Illness and Injury Study Center.
  - Pacemaker center.
  - Decon unit.
  - Alpha site.
  - DES pilot expansion.
  - My HealtheVet.
  - Partnership with childcare facility (La Petite Academy) that allows Veterans to drop off their children so that they can make their appointments.

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- Extensive collaborative partnerships.
- HUD/VASH vouchers (350).
- Established interagency agreement to partner for case management and placement.
- Community coordination resource center for homeless; moves programs from VAMC to community.
- Building three new clinics.
- DC VAMC has a Veteran population of 74,855. Women Veterans represent 9 percent of DC VAMC Veterans.
- Services for women Veterans:
  - Dedicated women's clinic.
  - Women's Pavilion coming in fall 2011.
  - Comprehensive care in the community: four CBOCs.
  - Specialty services offered through:
    - Fee basis.
    - DOD sharing agreements.
    - Memorandums of Understanding (MOU).
  - Case management for:
    - Homeless assistance.
    - Mental health.
    - OEF/OIF.

**DC VAMC Women Veterans Health Clinic, Robin Peck, MD-Medical Director, Women's Health/CBOC Team Leader**

- Evolution of women's health care DC VAMC:
  - Consisted of a single nurse practitioner (NP) and registered nurse (RN) in a few rooms at the end of an inpatient hallway; offered gender specific care.
  - In 2003, moved to 1,300 sq ft space and with 2 FT NPs with more support staff; offered gender specific care.
  - In 2009, offered comprehensive care with a single provider, women's health primary care physician (WH-PCP), delivering primary and gender specific care.
  - In 2010, included patient center medical home model.
  - August 2011, anticipate completion of 5,000 sq ft Women's Health Pavilion.
  - Handbook 1330.1 Health Care Services for Women Veterans.
- Comprehensive care in the CBOCs:
  - Alexandria CBOC--5,000 sq ft:
    - Largest CBOC with 3 providers.
    - Co-located with a Vet Center.
    - Rapidly expanding; 50-100 new uniques/month.

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- Has 0.8 FTE MD WH-PCP; started March 2009; now has a full panel-- 57% of her patients (609) are women.
- Adding a .8 FTE PA WH-PCP as soon as space allows.
- Additional services on site:
  - Psychiatry, substance abuse counseling, mental health NP, homeless coordinator, CCHT, nutrition.
  - MST counseling done by V-tel.
- Moving fall 2011 to Ft. Belvoir Army Hospital--11,000sq ft.
- Greenbelt CBOC:
  - Seeking a larger location to accommodate WH-PCP (n=216).
  - Gender specific care once a month NP from WHC.
  - Additional services on site.
    - Psychiatrist, substance abuse counseling, psychologist, nutrition.
    - MST counseling done by V-tel.
    - Tele-derm.
- Southern Maryland CBOC at Charlotte Hall:
  - Rural health grant NP WH-PCP and outreach (n=238).
  - Additional services on site:
    - Psychiatrist, substance abuse counseling, psychologist, nutrition, audiology, tele-derm , tele-retinal visits.
    - MST counseling done by v-tel.
    - Rural health grants for social worker, case manager, exercise physiologist.
- Southeast CBOC:
  - Has .5 FTE MD WH-PCP (74 women on panel ~14%).
  - Additional services on site:
    - Substance abuse, mental health NP, nutrition.
    - MST counseling done by V-tel.
- Coming in 2011, Prince Georges County CBOC:
  - FT MD WH-PCP
  - Additional services on site:
    - Psychiatrist, substance abuse counseling, psychologist, nutrition, audiology, CCHT and dental.
    - MST counseling done by V-tel.
    - Tele-derm.
- Expected growth in female population:
  - Female Enrollees Washington DC VAMC:

FY2010	10,888.9
FY2015	13,272.6

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FY2020      15,417.0

- Documented growth in women Veterans population:
  - Female users of the DC VAMC:
    - FY 2008      2,634
    - FY 2009      3,391
    - FY 2010 through March- 3,070
- Documented growth in female population:
  - Fee basis referrals for obstetrical care:
    - FY 2008                      30
    - FY 2009                      48
    - FY 2010 through July      36
- The migration of women Veterans into comprehensive care:
  - Need to have the services in place:
    - New pavilion.
    - New WH-PCP (pavilion, and CBOCs).
  - As current providers leave PC, reassigning women to NP WH-PCP at the main facility.
  - Allow for choices and not interrupt on-going relationships.
  - Public Relations has already created a brochure introducing the concept....mailed out.
  - Keep in mind tenets of comprehensive care and primary care mental health as we design new primary care clinic space at main facility and CBOCs.
- Gender specific services and fee basis:
  - Breast imaging (mammography, US, MRI, biopsies).
  - Obstetrical care.
  - GYN and GYN-ONC surgery.
  - Infertility evaluations and treatment.
  - Genetic counseling and testing.
  - GYN office visits/procedures DOD sharing agreement:
    - Colposcopy, EMB, IUD placements, complicated GYN pain management, pre-operative evaluations etc.
    - Contract expires fall 2010; will need to increase care provided to meet growing demand.
- Projects and goals beyond comprehensive care and patient centered medical home:
  - Multidisciplinary breast care team:
    - Oncology, surgery, radiation oncology, plastic surgery primary care, social work, mammogram and breast care coordinator.
    - Monthly tumor board.
    - WVHSHG mini-grant to attend John's Hopkins University CME.

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- New SW position:
  - Tracking pregnant Veterans and home visits to new moms.
  - Local expert in domestic violence and community services.
  - Partner with OIF/OEF, trauma service, breast care team.
- Educating current staff both PCPs and WH-PCPs:
  - In 2009, eight PCPs and a pharmacist completed a 3 day contraceptive management course; course repeats in 2011.
  - Twice Monthly PC Journal Club –WH relevant articles.
  - Monthly pathology conference for abnormal cervical pathology.
  - Sexual Assault CME....Local SANE partners.
  - Meeting concerns of clinicians re. pregnant and lactating Vets:
    - VISN set up call with pharmacy and general counsel.
    - Purchasing reference guides to distribute to clinics.
- Handbook 1330.1 Health Care Services for Women Veterans:
  - Lab service:
    - Decentralizing running of urine pregnancy tests.
  - Pharmacy service:
    - Availability of Plan B PCCs, ER and CBOCs.
  - Trauma service:
    - Partnering with MST coordinator.
  - ER service:
    - Women's Health Clinic offer support for non-emergent care.
    - Urine pregnancy testing.
    - Plan B.
- Transforming women's clinic staff into a PCMH team:
  - Weekly inclusive team meetings.
  - Monthly clinical meetings with WH-PCP.
- Making the women's clinic/pavilion the 5<sup>th</sup> PC team:
  - Representing with PC team leaders.
  - Representation with VISN PC committee.
  - Representation with CBOC Oversight Committee.
  - Working for recognition from the ER and specialty services.
- Next Steps:
  - Formally Implementing Women Veterans Health Committee.
  - Training 4 new WH-PCPs.
  - Performance Measure gender disparity data.

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**Presentation on Washington DC VAMC Women Veterans Program, Gale Bell, RN, Women Veterans Program Manager**

- Discussed medical centers focus:
  - Health promotion.
  - Disease prevention and management.
  - Emotional well being of women Veterans.
  - Providing comprehensive women's primary care.
  - Implementing patient centered medical home model of care.
- Fee Basis:
  - Washington Hospital Center:
    - Mammography, ultrasounds, MRI, biopsies.
  - Obstetrical care:
  - Howard University Hospital:
    - Genetic counseling and testing.
  - Walter Reed Army Medical Center:
    - Gynecology Surgery – GYN-Oncology.
    - 18
    - Infertility evaluations and treatment.
- WRAMC DOD sharing agreement – GYN office visits/procedures.
  - Colposcopy, endometrial biopsies, IUD placements, complicated GYN pain management, pre-operative evaluation.
  - Contract expires fall 2010 – will need to increase care provided to meeting growing demand.
- Comprehensive care for women Veterans:
  - Developed women's health brochure to introduce comprehensive care.
  - Same day appointments available / all walk-ins triaged and appropriately dispositioned.
  - Women-Comprehensive Healthcare Implementation Plan (W-CHIP.)
  - Ensuring parity for all women Veterans.
- Increase access and services:
  - Access:
    - Women's clinic opened 5 days/wk.
    - WH-PCP and gender specific appointments available within 3 days or less.
    - New and established patients seen within 14 days.
    - MD-WH-PCP provider approved.
    - Missed opportunity below National benchmark:

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Clinic Group	Benchmark	As of July 21
Gynecology	22.15	9.23
Women's Clinic	21.37	18.84

- Services Office of Rural Health funded projects:
  - Women Veterans health program.
  - Mobile mini-residency training program.
  - Qualitative interviews – needs assessment/metrics.
  - Tele-podiatry.
  - Homeless services and education.
  - Nurse practitioners- women.
  - Veterans coordinator in rural areas.
  - (DC-NP in final state of VetPro process.)
- Needs assessment of task three and four of rural project:
  - Training/education for health care provider:
    - Nurses attended facility triage workshop presented by nursing education.
    - Provider attendance to PCHM conference in Las Vegas.
    - New employee education.
    - Sexual assault nursing examiner as guest speaker.
    - Provider attendance to local CMEs related to women health services.
    - WH-PCP nurse practitioner to attend conference “*Ambulatory OB/GYN Nursing.*”
  - Training/education for women Veterans:
    - New patient orientation.
    - My HealtheVet/secure messaging.
  - Rural mobile mini-residency for gender specific training.
  - Rural nurse practitioner (NP) women Veterans coordinators.
- Enhance communications and outreach efforts:
  - Women's health weekly staff meeting.
  - Monthly primary care staff and team leader meeting.
  - DC VAMC:
    - Director's morning report.
    - CNE advisory.
    - Nurse Executive Committee bi-monthly meeting.
    - Nurse Professional Standards Board.
    - Multidisciplinary breast care team.
    - Environment of care rounds and meetings.
    - Performance measures workgroup meeting.
    - New employee orientation.

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- Pavilion design task force.
- VISN 5:
  - VISN 5 lead WVPM weekly.
  - VISN 5 lead validation quarterly visits to CBOCs.
  - VISN 5 composite calls bi-monthly.
  - VISN 5 PM workgroup monthly meeting.
  - VISN 5 OEF/OIF liaison monthly call.
  - VISN 5 women Veterans liaison committee monthly meeting.
- Regional Deputy Field Director monthly conference calls.
- National women Veterans program managers' monthly conference calls.

**Presentation on Baltimore VAMC Women Veterans Program, Linda Hudson, RN, Women Veterans Program Manager**

- Patient-centered medical home (PCMH).
  - Develop Veteran focused teams.
  - Relocate or renovate to provide services.
  - Create space and infrastructure.
- Comprehensive care for women Veterans.
  - One provider.
  - Parity for all women Veterans – even those who choose to stay with primary care provider.
- Restructured flow using system redesign principles:
  - LR women's room relocated closer to bathroom.
  - FH Women's room relocated closer to bathroom.
- Clinical measures of prevention:
  - Mammogram Screening-  
 Percentage of women age 50-69 who are screened in the past two years: target 77%

VAMHCS	YTD May 10	88%
	FY 09	83%

- Cervical Screening-  
 Percentage of women age 21-64 who are screened in past 3 years: target 86%

VAMHCS	YTD May 10	96%
	FY 09	86%

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- Ongoing process improvements:
  - Qualitative interviews for needs assessment and metric identification.
  - Data Dashboard for women Veterans.
  - Weekly meetings with program managers.
  - Monthly data collection tracking changes.
  - Monthly VISN meeting.
  - Five women Veterans liaison committee.
  - Medical center and CBOC staff.

**Presentation on Martinsburg VAMC Women Veterans Program, Amy Theriault, LGSW, Women Veterans Program Manager**

- Patient centered medical home:
  - Develop Veterans focused teams:

Martinsburg	12 teams	Cumberland	4 teams
Hagerstown	5 teams	Stephens City	4 teams
Franklin	3 teams	Petersburg	4 teams
Harrisonburg	4 teams		
- Relocate/renovate to provide services:
  - All Primary care rooms have been assessed for patient privacy and dignity.
  - Tracking installation of privacy curtains and positioning of exam tables.
  - Ongoing evaluation of privacy during check-in and visit.
  - Creating women's health suit at Cumberland.
- Create space and infrastructure:
  - MVAMC women's health space needs considered by space committee.
  - Plans under consideration.
  - Design phase for separate women's wellness center.
- Comprehensive care for women Veterans (WV):
  - Called 450 WV to educate regarding availability of comprehensive care.
  - Parity for All WV – developing plan for increased access.
  - Women-Comprehensive Healthcare Implementation Plan (W-CHIP).
  - Monthly data collection and dissemination to CBOCs and VISN.
- Privacy, dignity and security evaluations.
  - Exam tables, locks, privacy curtains.
  - Monthly reporting.
  - Part of bi-weekly EOC rounds.
- Needs assessment of task three and four rural project:
  - Training/education for health care providers:
    - PDS competency.

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- Grand rounds.
- Monthly calls on MST, PCMH, and others.
- Women's health conferences.
- Breast cancer awareness fair.
- New provider orientation.
- Training/education for women Veterans:
  - October 2010 women's wellness event.
  - Patient education classes.
- Rural mobile mini-residency for gender specific training.
- Rural NP women Veterans coordinators.
- Qualitative interviews needs assessment and metric identification:
  - Focused interviews at rural CBOCs.
  - In conjunction with Gallup.
- Women's health implementation team.
- Women Veterans advocacy group.
- Interdisciplinary patient care conferences.
- Monthly VISN 5 women Veterans liaison committee.
- Medical center and CBOC staff meeting.
- Ongoing process improvement:
  - Data Dashboard for women Veterans.
  - W/CHIP.
  - Regular monitoring of access, no show, and panel reports.
  - SHEP scores.
  - Gallup focus group results.
  - Bi-annual reporting to clinical practice council.
  - Data warehouse targeting patients needing health screening.
  - Action plan to address new Handbook 1330.01 requirements:
    - Privacy, dignity and security.
    - Point of care testing STI and urine pregnancy.
    - Procedure/test tracking.

**Washington, DC Vet Center, Tamia Barnes, MA, LCPC, NCC, Readjustment Counseling Therapist**

- Eligibility:
  - Veterans who have served in a combat zone (new legislation for Active Duty).
  - Family therapy for military related issues.
  - Survivors of MST (sexual assaults or sexual harassment).
  - Bereavement.

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- Vet Center Intel:
  - Confidential.
  - Community based.
  - Staff is 60% Veterans.
  - Staff is 41% female.
  - Family members involved.
  - Women Veterans on most teams.
  - Specialized MST therapists.
  - Reserves and National Guard.
  - Services are at no cost.
- Vet Center services:
  - Assessments.
  - Individual, group and family therapy.
  - Substance abuse assistance.
  - Employment services.
  - Benefits assistance.
  - Liaison with VA.
  - Recreational activities.
- Readjustment PTSD:
  - Readjustment is gender neutral and universal.
  - Most readjustment symptoms subside within 6 months; some can become problematic.
  - Symptoms indicate resilient coping mechanisms.
  - Approximately 15% will develop PTSD as a result of exposure to combat trauma.
  - For either readjustment issues or PTSD:
    - Not a personal weakness.
    - Help is available to attack problems early.
- When to seek assistance:
  - Feeling out of sync.
  - Jumpiness.
  - Worry.
  - Irritability.
  - Can't Sleep.
  - Relationship issues.
  - Sadness.
  - Low motivation.
  - "Need for speed."
  - Distressing thoughts.
  - Suicidal thoughts.
  - Substance abuse.
  - Work problems.
  - Isolating.
- Keys to readjustment:
  - Understand readjustment.
  - Capitalize on strengths.
  - Understand the impact of service.
  - Learn new strategies.

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- Set goals.
  - Interact with others.
  - Involve SO's.
  - Use supports ("Sucking it up" doesn't work long term).
- MST:
    - Free services to survivors.
    - Percentage of service women who have experienced MST: 8-20%.
    - Official reports belie extent of problem.
    - Many are discharged without treatment or awareness of eligibility for care.
    - Eligibility is based on Veteran's report.
    - MST therapists are specially trained to provide care.
  - RCS enhancements to services for women Veterans:
    - Enhanced access to MST counseling.
    - Improved access to family counseling.
    - Increased hiring of female Veteran staff.
    - Gender sensitivity training for all readjustment counseling service staff.
    - Partnering to facilitate women Veterans therapeutic retreats.

**Discussion/Wrap-up, Colonel Shirley Quarles, Chair.**

**Friday, July 30, 2010**

**War Related Illness and Injury Study Center, Michelle Kennedy Prisco, MSN, ANP-C, Nurse Practitioner**

- In 2001, the Department of Veterans Affairs approved two centers. In 2008, a third center was approved. To specialize in the study and treatment of war-related
- illnesses and injuries among Veterans:
  - Washington, DC-VA Medical Center.
  - East Orange, NJ-VA Medical Center.
  - Palo Alto, CA-VA Medical Center.
- Mission is to Improve the health of all Veterans who have Post-Deployment Health
  - Concerns:
    - Clinical care.
    - Education.
    - Risk communication.
    - Research.
- Deployment Health Concerns:

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<b>Male WRIISC Veterans</b>	<b>Female WRIISC Veterans</b>
Combat injuries	Environmental conditions
Industrial pollutants	Industrial pollutants
Environmental conditions	Reproductive health concerns
Post-traumatic stress disorder	Post-Traumatic stress disorder.
Vaccinations and anti-malaria Medication.	Military sexual trauma
Infectious diseases	Infectious diseases
Depleted uranium	Poor unit cohesion/support
Chemical and biological agents	Vaccinations
	Chemical and biological agents

- Female Veterans profile:
  - Percentage of all U.S. Veterans are female: 8 percent.
  - Average age of Veterans: 47 years for women; 61 years for males.
  - In FY 2008 and FY 2009, PTSD, hypertension, and depression were the top three diagnostic categories for women Veterans treated by VHA.
  - About 1 in 5 women seen in VHA respond "yes" when screened for Military Sexual Trauma (MST).
- Female OIF/OEF Veterans profile:
  - Represent largest group of women Veterans today
  - Make up 11.3 percent of OEF/OIF Veterans.
  - Percentage of female OEF/OIF Veterans who have enrolled with VA health care: 49.7 percent. Of this group, 47.8 percent have used VA health care 11 or more times.
  - Percentage of female OEF/OIF Veterans who used VA care during FY 2002-2009 who were under age 30: 47.3 percent, compared to 43.1 percent of male OEF/OIF Veterans.
- Age of OEF/OIF Female Veterans:

Age Group	Frequency	Percent %
16 – 29	60,794	47.3
30 – 39	39,368	30.7
40 – 49	21,013	16.4
50 – 59	6,628	5.2
60 – 83	571	0.4
Unknown	23	0.0

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- WRIISC female Veterans:
  - Approximately 3,500 Veterans have participated in WRIISC clinical programs.
  - Approximately 9 percent are female Veterans.
  - With respect to OIF/OEF Veterans, percentage is higher (13%).
  - Looking at the complimentary and alternative medicine program, percentage is higher (19%).
- Clinical care program:
  - Examine and/or manage Veterans with war-related:
    - Health concerns.
    - Difficult to diagnose illnesses and/or injuries.
- Provide consultation services to health care providers:
  - Second opinion resource.
- Clinical program: two components:
  - National referral program.
  - Deployment health clinic.
- National referral program:
  - Comprehensive history and physical examination.
  - Exposure assessment and risk communication.
  - Further diagnostic evaluation tailored to individual Veteran's needs.
  - Deployment health education.
  - Multidisciplinary meeting with Veterans.
  - Report and consultation to Veterans and primary care provide.
- Deployment health clinic:
  - Focused exposure assessment.
  - Health screenings.
  - Laboratory screenings.
  - Health education.
  - Assistance with VA benefits and claims.
  - Complementary and alternative therapy.
- Clinical care program:
  - Diagnoses may be the same:
    - Approach to care may need to be tailored.
- Female Veterans may have unique needs:
  - Gender specific: gynecological and breast screenings, pregnancy, female contraceptives.
  - Other: reproductive and fertility health concerns, family planning, family and work balance, eating disorders, MST.

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- Feedback from female Veterans played a crucial role in starting this program.
- Currently, we offer:
  - Individual and group acupuncture sessions.
  - Yoga therapy.
- Needs assessment survey to identify potential future services.
- CAM research studies underway.
- Education specific to female Veterans.
  - Developing educational materials that reflect the unique concerns of female Veterans.
  - Educating health care providers on the specific post-deployment health concerns of female Veterans:
    - Reproductive health concerns.
    - MST.
    - PTSD.
    - Family and childcare issues.
  - Implementing screening measures and assessment tools that recognize the unique concerns of female Veterans.
- Research program:
  - Longitudinal health of combat Veterans.
  - Neurological functioning.
  - Effects of traumatic brain injuries.
  - Estimates of cancer prevalence.
  - PTSD and complementary and alternative medicine.
  - Combat stressors.
- Research specific to female Veterans.
  - Vietnam Era Study of female Veterans addressing variety of physical and mental health outcomes.
  - Gender differences in psychological and deployment factors among OEF/OIF Veterans.
  - Interpersonal Psychotherapy for Women Veterans Exposed to Trauma.

**DC VAMC Oncology Services, Steven H. Krasnow, MD, Chief, Oncology Services**

- VA cancer care evaluation study:
  - Congressionally mandated review of cancer care in the VA system.
  - VACO study contracted to Harvard School of Public Health and Harvard Medical School.
  - Study of six cancers (lung, prostate, colorectal, lymphoma, myeloma, breast) assessed screening, prevention, diagnosis, treatment, supportive care.
  - Comparison to medicare patients outside VA.

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- Total breast cancer cases in va small (n=720 compared with >45,000 medicare cases).
- VA care generally matched that of medicare patients.
- VA should monitor rate:
  - postoperative radiotherapy use.
  - post-rx surveillance mammography.
- DCVAMC oncology program:
  - Fully accredited by American College of Surgeons Commission on Cancer:
    - Interdisciplinary cancer committee.
    - Tumor registry.
    - Quality improvement program.
    - Clinical trials program.
  - Represented by surgery, radiotherapy, hematology/oncology, pathology, radiology services (and others).
  - Comprehensive medical oncology care for most malignancies.
  - Teaching affiliate of lombardi cancer center (Georgetown University).
  - NCI clinical trials access.
  - Oncology section staffing:
    - Oncologists 4
    - Physician Assistants 2
    - Chemotherapy Nurses 5
    - LPNs 2
    - Chemotherapy Pharmacist 1
    - Social Worker 1
    - Clinical Trials Staff 3
    - Tumor registrars 4
  - Oncology services for female Veterans an interdisciplinary effort:
    - General surgery; plastic/reconstructive.
    - Radiotherapy service.
    - Laboratory and pathology service.
    - Imaging service.
    - Pharmacy service.
    - Womens' clinic.
    - Prosthetics service.
    - Rehabilitation service.
  - Pharmaceuticals largely directed to breast cancer treatment:
    - Trastuzumab (herceptin).
    - Tamoxifen.
    - Anastrozole (arimidex).

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- Letrozole (femara).
- Exemestane (aromasin).
- Pathology services for breast cancer patients:
  - Standard microscopic diagnosis.
  - ER/pr receptor status.
  - Her-2/neu status.
  - Genetic testing for brca1 and brca2.
  - Gene profiling (e.g.- oncotype-dx).
- Imaging services for female oncology patients:
  - Mammography.
  - Pelvic ultrasound.
  - Bone density imaging.
  - General imaging capabilities:
    - CT.
    - MRI.
    - PET/CT.
    - Radiopharmaceuticals.
- Essential ancillary services:
  - Nutrition service.
  - Social work service.
  - Psychology.
  - Psychiatry.
  - Pastoral service.
- Major risk factors for breast cancer:
  - Female gender.
  - Increasing age.
  - Family history (about 6-10%).
- Genetic counseling and testing:
  - For selected Veterans:
    - strong family history of cancer (1<sup>st</sup> degree relatives esp. with early age of onset).
    - cancer at an early age.
  - Risks vs. benefits of testing.
- Breast cancer susceptibility genes:
  - Six to ten percent of breast cancer cases.
  - Highest in ethnic groups.
  - Associated with:
    - Early onset breast cancer.
    - Bilateral breast cancer.

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- Aggressive breast cancers.
- Breast cancer racial disparity.
- Compared to Caucasian women, African American women have:
  - Later stage at presentation and worse survival.
  - Biologically more aggressive tumors.
  - Lower rates of screening mammography.
- Efforts needed to improve access to care for African American women.
- Colorectal cancer:
  - No gender predisposition.
  - Third in incidence/mortality in women.
  - Most colon cancers preventable or curable by screening.
  - VA offers routine stool heme testing.
  - Screening colonoscopy limited by current resources.
- Lung cancer:
  - Commonest cause of cancer death in men and women.
  - Less than 90% preventable by smoking cessation.
  - Non-smoking related lung cancer more common in women and Asians.
  - Non-smoking associated lung cancer: better response to RX and prognosis.
- Conclusions:
  - VA recognizes unique needs of women Veterans with or at risk for cancer.
  - Most needed services available in-house or by contract.
  - The number of female cancer patients in VA is increasing.
  - Increased resources will be needed to keep pace.

**DCVAMC OEF/OIF Services, Jean Langbein, OEF/OIF Program Manager**

- Five free years of health care:
  - Eligible combat veterans can receive five years of free health care for conditions that may be related to their active duty service.
  - OEF/OIF status is designated in CPRS by a pop-up window.
  - OEF/OIF Veterans are mandated to have their appointments scheduled to be seen within 30 days – weekly monitoring.
- OEF/OIF screening:
  - Iraq/Afghanistan post-deployment screen.
  - Traumatic brain injury (TBI) screen.
  - Screens for PTSD, depression, substance abuse, chronic illness, infectious disease, TBI.

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- Assesses the need for further evaluation.
- Positive screen indicates referral to specialty program or clinic.
- Current enrollment – 14,494.
  - Females- 2,347.
  - Males- 12,147.
- Unique issues:
  - Average age of female VA user: 48
- Among OEF/OIF female VA users:
  - Percentage below age 40: 78 percent.
  - Percentage below the age of 50: 47.3 percent.
- Accommodation needs:
  - Childcare.
  - Employment.
  - Schooling.
  - Housing.
- Case management:
  - Initial screening for case management needs.
  - Each OEF/OIF Veteran is assigned to a case manager, based on the Veteran's individual needs.
  - Care management review team consists of multiple programs.
  - OEF/OIF program consists of a program manager, social work case manager, nurse case manager, transition patient advocate.
- Outreach:
  - PDHRAs: held 90 days upon return home.
  - Yellow Ribbon Reintegration Program.
  - Welcome home celebration.
  - Conferences: 2010 health care summit.
  - Clergy Day.
  - Rural communities:
    - Oyster festival.
    - County fairs.
  - County musters.
  - VHA plans to utilize the OEF/OIF call center to reach out to women Veterans.
- Points to remember:
  - OEF/OIF Veterans are different from other combat Veterans – No front line, at risk for injury 24/7.
  - Group is diverse in age, race, gender and family dynamics. They are computer savvy, have high expectations for care.

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- Issues of concern: employment, school, housing, family, relationships, adjustment.

**DCVAMC Geriatrics/ECS/Palliative Care, Karen Blackstone, MD-Director Palliative Care Services**

- Discussed:
  - Geriatric and palliative care for women Veterans at the DC VAMC.
  - Community living center.
  - Post-acute rehabilitation.
  - Home-based primary care.
  - Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).
  - Ambulatory care/outpatient geriatrics clinic.
  - Palliative and hospice care.

**DCVAMC Polytrauma Services, Joel Scholten, MD, Associate Chief of Staff, Physical Medicine and Rehab Services**

- Many issues following deployment are not visible:
  - Ringing in ears- audiology.
  - Blurred vision/light sensitivity- eye clinic.
  - Poor memory/concentration- neuropsychology/speech.
  - Depression/PTSD- trauma services.
  - Back pain, headaches- primary care, neurology and PM&R.
- TBI screening program initiated April 2007:
  - All Veterans with separation date after 9/11/01 have TBI screen activated in electronic record.
  - Four question screen regarding trauma, immediate symptoms, and current symptoms. If all answers are positive then a Comprehensive Evaluation is triggered.
  - Evaluation by TBI specialist.
  - NDAA legislation mandates that all Veterans with TBI receiving ongoing rehabilitation have individualized treatment plan.
- Joint efforts with DoD.
- What does an individual with a history of TBI look like? Depends on:
  - Severity of injury.
  - Co-morbid conditions.
  - Time since injury.
  - Location of injury.
- Symptoms of concussion:

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○ Physical:

Headache	Vomiting	Fatigue
Nausea	Dizziness	Blurred vision
Sleep disturbance	Sensitivity to light/noise	Balance problems

○ Cognitive:

Attention	Memory	Judgment
Concentration	Speed of processing	Executive function

○ Behavioral/emotional:

Depression	Anxiety	Agitation
Irritability	Impulsivity	Aggression

- TBI Related Symptoms can affect family, school, or work:
  - Difficulty remembering appointments.
  - Easily distracted.
  - Unable to multi-task.
  - Now has a “short fuse” with everyone.
  - Gets stressed easily with anything out of the ordinary.
  - Headache may contribute to irritability.
  - Mood or Memory may get worse as day progresses due to fatigue.
  - Polytrauma system of care.
- VA Polytrauma Network Site (PNS):
  - Comprehensive interdisciplinary rehabilitation, medical care, and coordination of care for the severely wounded with complex injuries.
  - Coordinate services for Polytrauma patients for VISN 5 (Baltimore, Martinsburg, and DC).
  - Polytrauma Amputation Network Site (PANS).
  - CARF accredited rehabilitation unit in community living center.
  - Visual rehabilitation program.
  - Drivers rehabilitation program.
  - “TEAM APPROACH” to provide individualized treatment plan:

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Interdisciplinary Team	Case Manager, CRRN	Orthotist
Physiatry (Rehab Medicine)	Occupational Therapy	Prosthetist
Neurology	Physical Therapy	Blind Rehabilitation Outpatient Specialist
Psychology/Mental Health	Speech-Language Pathology	Social Work
Liaison with DoD and PRCs	Recreation Therapy	Drivers Rehabilitation
Psychiatry	Optometry	

- Comprehensive interdisciplinary team treatment for Veterans with vision impairment:
  - Low vision optometrist.
  - Daily living skills therapist.
  - Mobility and orientation specialist.
  - Computer training specialist.
  - Care coordination.
  - Low vision optometrist.
- Comprehensive interdisciplinary care for service members with amputations:
  - Care coordination.
  - Referral system
  - Enhanced education and clinical expertise.
- JIF Project with Walter Reed Army Medical Center:
  - Teams travel to both facilities to expand care options for Veterans and active duty service members.
  - Expand skills of teams.
  - Cost savings for VA and DoD.
- TBI day treatment program:
  - Active duty and Veterans with TBI and co-morbid conditions with functional deficits.
  - Individual and group sessions, depending on specific needs of patient.
  - Interdisciplinary team conferences and ongoing assessment of progress.
  - Interface with case managers at MTF with updates.
  - Includes family members/friends in sessions as possible.
- Day program treatment groups:
  - Interdisciplinary:
    - Multiple perspectives, feedback.
    - Variety of settings for generalization.
    - Maximizes strategy use.

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- Groups:
  - Adjustment.
  - Cognitive-communication.
  - Community reintegration and leisure.
  - Vocational/academic training.
  - Family support.

**DC VAMC Trauma Services, MST, Stacey Pollack, PhD, Chief, Trauma Services**

- Definition of military sexual trauma (MST):
  - VA term for sexual assault or sexual harassment occurring during military service.
  - Any sort of sexual activity in which someone is involved against his or her will.
  - May result from:
    - Pressure to participate in sexual activities (e.g., with threats of consequences; with implied better treatment; “command rape”).
    - Inability to consent to sexual activities (e.g., due to intoxication).
    - Physically forced into participation.
  - Can involve unwanted or threatening sexual advances and comments, touching, grabbing, sexual penetration of any kind. Physical force may or may not be used.
  - Definition in Public Law: “Physical assault of a sexual nature, battery of a sexual nature, or sexual harassment” [“repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character”] that occurred while a Veteran was serving on active duty or active duty for training.  
*US P.L. 102-585, 1992; 108-422, 2004*
- MST occurs in a setting where the victim lives and works; where the perpetrator is typically known; victim is taught not to question authority; threat of death is real. Peers are trained to kill in combat; distant from support system; and risk is typically ongoing.
- Important to screen MST because sexual trauma is rarely reported or disclosed in military or civilian settings.
- MST is associated with a variety of mental and physical health outcome.
- VHA implemented mandatory screening for MST in 2001’ all VHA patients are screened once for MST.
- VHA uses MST clinical reminder as well.
- VA offers free treatment (including medications) for MST related conditions to patients with positive screens regardless of service connection or eligibility;
  - Only requirements for eligibility: Veteran states he/she experienced MST; provider believes treatment provided is related to experiences of MST.
  - Incidents do not have to have been reported at the time.
- Trauma has negative effects on physical health:
  - Gastrointestinal difficulties.

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- Musculoskeletal difficulties.
- Problems with pain perception, pain tolerance and chronic pain.
- Cardiovascular problems.
- Hypertension.
- Artherosclerotic heart disease.
- Those with trauma are likely to have more physical health problems and higher utilization of medical services for physical problems than those without PTSD.
- FY2009 – National Data:
  - Nationally, 53,295 females screened positive for MST, having 384,431 MST-related encounters--308,609 were MST-related mental health (MH) encounters.
  - Nationally, the number of MST-related MH encounters ranged from 1 to 368 encounters.
  - The amount of MST-related MH services provided ranged from 1 to 2 encounters at the lowest 25% and ranged from 11 to 368 encounters among the top 25% of utilizers.
- FY2009 – Local Data:
  - Locally, 581 females screened positive for MST, having 3,927 MST-related encounters--3,204 were MST-related mental health (MH) encounters.
  - Females who screened positive for MST had an MST-related encounter: 65.1%.
  - Females who screened positive for MST had an MST-related mental health encounter: 45.1%.
- Roles of the MST Coordinator at the DC VAMC:
  - Increase access for Veterans through outreach, serve as a resource, monitoring outreach and treatment.
  - Educate staff with training on MST-related issues and about MST services available.
- Key Changes in new MST Directive:
  - Officially establishes the VISN-level MST Point of Contact role.
  - Extensively describes the MST Coordinator role, including a specification for adequate protected time to fulfill the responsibilities of the role.
  - Clarifies various issues related to eligibility for care (eg, because there are no length of service requirements to receive free MST-related care, individuals who served but who do not have Veteran status are eligible for care.)
  - Pays explicit attention to the importance of conducting informational outreach and staff training.
- The greater the exposure to trauma, the more likely one will develop problems:
  - Not everyone is at the same risk

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- More common in women, if you have pre-morbid mental health problems, if you have exposure to other traumas; and if you have recent major life stressors (i.e. divorce.)
- Common reactions to trauma include loss of innocence and trust; feelings of self-blame; issues of justice, power and control dynamics; and difficulties trusting self and others.
- Exhibit concerns about sexuality related issues.
- Issues with PTSD:
  - Those with PTSD stay constantly aroused as if emotionally prepared to fight or flee at all times – this arousal is a source of distress.
  - Fear is a normal response to trauma.
    - Avoidance prohibits emotional processing.
  - Symptoms are re-experiencing, avoidance, hyperarousal.

**DCVAMC Mental Health Services – Telehealth/Inpatient/CBOC, Nathaniel Banks, Chief, Domiciliary**

- Total of 28 Beds.
- Acute Psychiatry Unit - 27 beds, one room reserved for seclusion/isolation.
- Staffing list:
  - Attending Psychiatrists: 2.
  - Psychiatry Residents (2 from Georgetown) – (1 from Howard).
  - Recreation Therapists: 2.
  - Part-Time Psychologist.
  - Social Workers: 4.
  - Nurse Manager.
  - Registered Nurses: 13.
  - LPN's: 4.
  - Nursing Assistants.
  - Medical Students and PA Students rotate monthly: 4.
- Improvements made to accommodate women Veterans:
  - Women Veterans have special bathroom reserved.
  - Special pajamas and robes are provided to women Veterans
  - We protect their privacy and safety. Room assignments are strategically placed in one end of the hall close to nurse's station.
  - Women's coordinator meet with women Veterans weekly on the unit.
  - A new psychologist was hired to address women's issues.
  - Women Veterans are referred to counselors that specialize in MST.

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- McDermott House is a joint project of the VA, the District of Columbia Housing Authority, and the Chesapeake Health Education Program (CHEP)--a non-profit organization. Homeless Veterans enrolled in the CWT program are admitted to this transitional housing facility.
- Demographics:
  - Gender: 26 Male Veterans and four female Veterans (total of 30 beds).
  - Age: 18 years and older.
  - Veteran/Non-Veteran: Veteran.
  - Spouse/Children: non-residents but can visit.
  - Visiting Hours: 9am to 8pm in common areas.

**DC VAMC Social Work Services/Homeless/DOM, Sevena Boughton, Chief, Social Work Services**

- VAMC-DC female Veteran enrollment:
  - FY 08: 9,370.
  - FY 09: 10,813.
  - FY 10: 11,577 (as of April).
- Fact about female Veterans:
  - Number who received VA care in FY 09: 1.8 million.
- Percentage of female Veterans who screen positive for MST: 22 percent.
- Top 3 diagnosis:
  - PTSD.
  - Depression.
  - Hypertension.
    - HCHV services.
- Services available:
  - Outreach.
  - Walk-in clinic.
  - Grant and per diem.
  - Homeless dental initiative.
- HUD/VASH:
  - Refer homeless Veterans to PHA and assist them until they qualify and receive a HUD/VASH voucher from PHA. Then assist Veterans to locate a unit to use their voucher. Once a Veteran locates and leases a home, they will continue to receive case management:
    - HUD/VASH team also helps Veterans with their credit problems so that they will qualify for a lease. Help to find funds of down payment on apartments. Help Veterans secure furniture for their apartments.

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- Ad Hoc Social Work department to assist with family issues and relapse prevention.
- CHALENG:
  - The VA is required to hold at least one CHALENG meeting per year. This year VA held two. VA held a CHALENG meeting in Southern Maryland at the Pax River Air Naval Base in August 2009. Two CHALENG meeting reports were submitted.
- Grant and per diem:
  - Partner with community providers that provide housing to homeless Veterans.
  - Assigned liaisons to collaborate with providers.
  - Fiscal responsibility.
  - Coordinate annual facility inspections.
  - Provide case management.
  - Offer assistance to those providers who want to serve special populations (i.e., women, SMI).
  - NEPEC program evaluation.
- Goals for grant and per diem:
  - Increase number of Veterans that are permanently housed at discharge.
  - Ensure that Veterans in transitional housing health care needs are met:
    - Physical exams.
    - Mental evaluations/treatment.
    - Substance abuse treatment.
    - Dental care.
  - Provide resources/assistance:
    - Child support.
    - Credit counseling.
    - Internal revenue.
  - Provide clean and safe transitional housing up to 24 months.
  - Assist with employment/income.
  - Assist Veterans with community reintegration:
    - Developing social network.
    - Increased skill level for employment.
    - Self-determination.
- VA supported housing:
  - Five years assertive case management:
    - Population served:
      - Homeless Veterans.

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- Veterans with mental health diagnosis.
  - Females/families.
  - OEF/OIF.
  - Formerly incarcerated rates.
- Veterans permanently housed since 2008: 364 Veterans:
  - Vouchers issued: 140; 137 housed.
  - Vouchers issued: 245; 227 housed.
  - Vouchers issued in June for FY 10: 225.
- Intergovernmental agreement with DHS:
  - VHA, DHS and the Washington DC Public Housing Administration met at the White House to discuss ending homeless among Veterans in the District.
  - This agreement will use 105 HUD/VASH vouchers and provide permanent housing and case management services for approximately 105 chronically homeless Veterans in the District .
  - DHS has demonstrated success with housing chronically homeless individuals using Housing Choice Voucher Programs vouchers and intensive case management.
  - The collaboration will be used as a model and “Best Practice” that can be duplicated by other VAMC’s across the Nation.

**DC VAMC Quality Care – Cultural Competency, Anselm Beach, Chief, Office of Diversity and Inclusion**

- Cultural competence: the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms and values the cultural differences and similarities and the worth of individuals, families and communities and protects and preserves the dignity of each.
  - Everyone has a culture.
  - Some cultures have very distinct gender roles
  - Cultural bias can influence diagnosis, treatment adherence and care seeking.
- Diversity is the inclusion of things, people, and places that are different and unique to include race, socio-economic backgrounds, religions, culture and heritage:
  - According to DoD data, women make up about 20 percent of today's military.
  - According to the Census Bureau, the U.S. population is becoming increasingly diverse.
- The conclusion is that the VA health care system will see more women and a Veterans population that is becoming increasingly diverse.

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- The need for diversity in health care providers:
  - Health care services that are respectful of and responsive to the health beliefs, gender, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.
- Health care providers need to become culturally competent:
  - Cultural competency is one the main ingredients in closing the disparities gap in health care. It is the way patients and providers can come together and talk about health concerns without cultural differences hindering the conversation.
  - Cultural competency – A standard for quality of care:
  - Integral part of the patient-centered care model.
  - Health care industry standard that promotes:
    - Communication.
    - Patient Safety.
    - Patient & Family Involvement in Care.
    - Cultural Competency Assessment.
    - Completed and submitted to VHA.
    - Assessing gaps and developing action plans to address gaps:
      - Language and Interpretative Services
      - Employee Education
  - Launching Cultural Competency awareness and training:
    - Grand Rounds Series.

**DC VAMC Outreach – Ladies Night, Diane Phillips, RN, Planetree Coordinator**

- Booths such as VBA Housing Loans, PTSD and Military Sexual Trauma information.
- Mini manicures, chair massage and acupuncture.
- Welcoming garden with floral arrangements, faux trees, and balloons.
- Marine string quartet playing a continuous selection of music.
- Wonderful buffet of chicken satay, cold shrimp, hummus, and Perrier.
- Tours were provided to the women's health clinic.
- Women were introduced and enrolled for VA Health care and MyHealthVet.
- Door prizes and gift bags were given out.
- A peaceful labyrinth was placed in the upstairs auditorium and women Veterans were taken through inpatient units to use it.
- Over 150 women Veterans from the Maryland, DC, and Virginia catchment area enjoyed Ladies' Night.
- Planetree components:

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- Human interaction: human beings caring for other human beings, creating a healing environment for patients, families, and staff members.
- Family, friends, and social support: contributes to the quality of the hospital experience by promoting caring connections between the patients and their support systems.
- Information and education: patients, families, and community members are provided with increased access to meaningful information.
- Nutritional and nurturing aspects of food: choice and personalized service, in combination with sound nutrition practices, add pleasure, comfort, and familiarity.
- Architectural and interior design: the Planetree design considers the patients' wellbeing. The hospital is welcoming and accessible, providing clearly marked signs for direction, comfortable and familiar rooms, and designs that engage the senses and break down barriers.
- Arts and entertainment: music, artwork, theater, crafts, and clowns offer engagement and enjoyment to enhance the clinical environment.
- Spirituality: Planetree recognizes the vital role of spirituality in healing the whole person. From chaplains to meditation programs, hospitals can provide opportunities for reflection and support of spiritual needs.
- Human touch: touch reduces anxiety, pain, and stress, benefiting patients, families, and staff members.
- Complementary therapies: expand the choices offered to patients. Aroma and pet therapy, acupuncture, and Reiki are offered in addition to clinical modalities of care.
- Healthy communities: expand the boundaries of health care: working with schools, senior centers, churches, and other community partners, organizations are redefining healthcare to include the health and wellness of the larger community.

**DC VAMC Construction – Women’s Pavilion, Odeal Scott-Bedford, Chief, Facilities Management Services**

- Women’s Pavilion investment: \$3 million.
- Project Status: design complete.
- Construction start and duration: March 2011 – December 2011

Function	Existing	Planned
Exams Rooms	4	8
Mammography	Off Site	Yes

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Waiting	Yes	Yes
Classrooms	No	Yes
Private Consultation	No	Yes
Mental Health	No	Yes
Meditation Room	No	Yes

- Women's Pavilion will have a lounge area, children's play area, tea bar (refreshment bar), reception area.
- It will also have classrooms for patient education issues and a mediation room.
- Working with Women's Health on locating rooms that are comfortable.
- Converting patient rooms to private rooms, with toilets and bathing facilities.

**Outbriefing with DC VAMC Leadership Team.**

**Wrap-up/Meeting Adjourned**



Shirley A. Quarles, Ed.D., R.N., F.A.A.N.  
Chair, Advisory Committee on Women Veterans



Irene Trowell-Harris, Ed.D., R.N.  
Designated Federal Officer

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