

**Department of Veterans Affairs  
Advisory Committee on Women Veterans  
June 16-19, 1998  
Minutes**

The June meeting of the Advisory Committee on Women Veterans convened at 8:00 am, on June 16, 1998, in Washington, DC.

**Advisory Members Present**

Dr. Linda Schwartz, Chair  
Dr. Lois Johns, Vice Chair  
Ms. Karen Ray  
Ms. Bertha Cruz Hall  
Ms. Joy Ilem  
Ms. Veronica A'zera  
Ms. Connie Evans  
Ms. Sherry Blede  
Ms. Lory Manning  
COL. Christine Cook  
Mr. Douglas Russell  
BG Clara Adams-Ender (Ret)  
BG Connie Slewitzke (Ret)  
LTC Sandy Lewis (DACOWITS)

**VA Staff Present**

Ms. Joan Furey, Director 00W  
Ms. Kathy Zeiler, Director, WVHP, VHA  
Dr. Susan Mather, ACMD, VHA  
Ms. Maryanne Carson, EA, 00W  
Ms. Lynn Howell, NCS

**Members Absent**

Ms. Jan McSparren

**I. Opening Activities**

The Advisory meeting was called to order at 8:00am by the Chair and round-table introductions were made.

Ms. Furey introduced the Honorable Togo D. West Jr., Secretary, Department of Veterans Affairs. Secretary West welcomed the Committee and provided opening remarks. He focused on his commitment to provide exceptional service to women veterans; the importance of the activities of the Advisory Committee; and the seriousness with which he reviews their recommendations. Secretary West then presented certificates for exceptional service to Brigadier Generals Connie Slewitzke and Clara Adams-Ender, whose terms expired. Certificates of appointments were presented to: Veronica Azera, National Legislative Director, AMVETS; Sherry E. Blede, National Legislative Committee, VFW; Bertha Cruz Hall, Texas Veterans Commission; Joy J. Ilem, National Appeals Board, DAV; Captain Lory Manning, US Naval Reserve, Director, Women Military Project, Women's Research & Education Institute; and CSM Douglas Russell, USA, Ret.

Ms. Furey reviewed the agenda with the Committee and highlighted the following:

1. The Committee will receive briefings from the key organizations within VA
2. In response to the Committee's request at the last meeting the following individuals will also provide briefings
  - Mr. H. David Burge, Director, National Center for Veterans Statistics. Mr. Burge will discuss the year 2000 survey of veterans. Each member received a copy of the 1995 survey for review prior to this meeting. Please be sure to address any concerns or recommendations regarding the past survey so we can improve upon the survey in 2000. Issues of particular concern to women should be emphasized.
  - Mr. Everett Chasen, Director News Service Office of Public Affairs, will discuss their role in outreach to veterans. Mr. Chasen met with General Slewitske and her subcommittee on outreach earlier this year.
  - Dr. Rebecca Klemm, from the Klemm Analysis Group will give an overview of their research project on assessing the health status of women veterans of the Persian Gulf War. Klemm Analysis Group has been contracted by VA to do this study.
  - Dr. Katherine Skinner from VA's Health Research and Education Division in Bedford, Massachusetts is the primary investigator of VA's National Study on the Health Status of Women Veterans. She will present the preliminary findings of that study.

## **II. Briefings and Presentations**

### **1. Dr. Thomas Garthwaite, Deputy Under Secretary for Health**

Dr. Garthwaite commented on VHA's commitment to improving services for all veterans and improving VA's ability to measure the outcomes of its services. In the area of women's health, he highlighted the following accomplishments:

- Improved privacy in VA facilities
- Established of Women's Clinics
- Met the preventive health measures outlined in HHS's "Healthy People 2000 initiative" (e.g. cholesterol screening, smoking cessation education, gender specific cancer screening)
- Developed VA physician fellowships in women's health
- Future of Reproductive Health Care and Infertility Treatment in VA
- Mental Health Services for Women Veterans

The following issues were discussed in the question and answer period:

- **What is the impact of the highway appropriations bill on healthcare benefits for veterans?** The highway appropriations bill does not directly affect the current healthcare available for veterans. The controversial issue surrounding the tobacco bill relates to whether or not the government should provide compensation to veterans who develop smoking-related illnesses. In fact, we now treat and will continue to treat individuals for smoking related illnesses. Treatment is a separate issue from compensation.
- **Is my understanding correct that any veteran who has a 50% or higher service-connected disability is automatically enrolled in VA's healthcare system.** This is correct. Veterans in other eligibility categories will be provided care based on their priority categories. VA determines if it has the resources to treat them each year.
- **Will the monies obtained through third party billing be returned to the treating facility?** The money obtained through Medical Care Cost Recovery will be returned to the Network. The Network will distribute the funds to the medical centers in its service delivery area.
- **How can you assure equitable distribution of resources. Couldn't hospitals successful in attracting veterans and recovering costs from third party reimbursement see a portion of those funds sent to hospitals less successful in doing this.** Yes, this is a possibility, but the VISN Director must submit a plan of how he plans to distribute the money to assure his VISN meets national goals and it is reviewed for overall soundness. If there are specific problems in specific areas we can address them on an individual basis.
- **Additional questions centered on requests for clarification on enrollment, co-pay determinations, access to Tri Care and Medicare subvention.** Clarification on these issues were provided and can be found in the transcribed proceedings of this meeting.

## 2. Ms. Nora Egan, Deputy Under Secretary for Benefits Veterans

Ms. Egan provided the Committee with a general overview of the changes underway in Veterans Benefits Administration. The following items were highlighted:

- Instituted Formal Evaluation of VBA Mission, Core Values, Organizational Structure( creation of nine Service Delivery Networks), Employee Education
- Implementation of Environmental Scans: Assessing the perception of VBA's services from its stakeholders, e.g., veterans, veteran service organizations, Senators and Congressman, Office of Management and Budget.

- Identification of Key Issues: quality of claim development; timeliness in claims processing; high percentage of remands from Board of Veterans Issues; underachieving information technology; poor communication with stakeholders
- Increased focus on vocational rehabilitation efforts to improve employment rates of veterans enrolled in program
- Review of long-term goals/strategic plan
- Introduction of “Balanced Scorecard” management process which measures five areas of productivity: 1) timeliness, 2) quality, 3) customer, satisfaction, 4) cost per claim and, 5) employee development

The following issues were addressed during the question and answer period.

- **What provisions does VA make for assuring that separating service members who are being discharged from military hospitals receive information about VA benefits, as they are often unable to attend Transition Assistance Briefings?** VBA is trying to improve its outreach initiatives to separating service members and improve coordination and collaboration between DOD and VA. Additionally, VBA has a few pilot programs underway where VA staff is assigned to discharge centers to do C&P exams and follow-up. We are working toward improving our communication with the service members at these sites to assure they are familiar with VA benefits at the time of discharge.
- **Could you address the issue of the low utilization of the Montgomery GI bill( MGIB)?** VBA is very concerned about the low utilization of the MGIB and we are trying to determine the best way to assess what the problem is so we might work toward increasing utilization of the program.
- **There is ongoing frustration among many women veterans that they are unable to gain comprehensive information about VA or VA benefits at any one particular site. Could you expand on your comments about the increased training initiatives between VBA and VHA?** Both VBA and VHA are aware of the difficulties you are referring to and are trying to work together, both locally and nationally to improve both training and communication of VA staff on various benefit issues, information and processing. **(Interjection by Dr. Mather follows)** Some of this has been done already. In women’s health for example we have had joint training on sexual trauma, and are developing one on gynecological disorders. Additionally we just completed such a program on undiagnosed illnesses in Persian Gulf veterans. So we are beginning to improve in this area.

### **3. Dr. Alphonso Batres, Director Readjustment Counseling Service**

Dr. Batres provided the Committee with an overview of RCS services and activities and provided information on the number of women seen in the program in FY’97. Highlights of presentation were:

- Viewing of a videotape describing Readjustment Counseling Service
- RCS saw 8,345 women in the vet center program in FY '97.
- The number of female staff employed by RCS has increased by 15% in the last 3 years.
- RCS, in collaboration with local VHA medical centers, has tele-medicine sites located in 20 vet centers across the country. Located in remote areas, these sites provide veterans with access to medical care, health screening and education via satellite. Four of these sites are located on Native American Reservations. We are also planning on developing sites in some of our large urban areas to see if that will assist some of our other under-served veterans in accessing and improving their health.

The following issues were addressed in the question and answer period:

- **What Native American Reservations are the Tele-medicine Centers on?**  
They are located on the Navajo/Hopi Reservation in Arizona; in Martin, South Dakota; between the Sioux reservations at Rosebud; Pine Ridge; and in Telya, Oklahoma, a large Cherokee community.

#### **4. Vincent Barilie, Deputy Director, National Cemetery Administration**

Mr. Barilie provided an overview of NCS. Highlights of his slide presentation included:

- The National Cemetery Administration is composed of 115 cemeteries; employs approximately 1300 staff; and has a budget of \$171,000,000. Area offices are located in Philadelphia, PA; Atlanta, GA; and Denver, CO.
- Arlington National Cemetery is not operated by VA, it is administered by the Department of the Army.
- VA National Cemeteries are classified into three categories:
  - 1) Open – full range of burial services are available
  - 2) Cremation – burial services are available for cremated remains only. Full casket sites are not available
  - 3) Closed – burial services are available for the interment of a family member in the same grave site, whether it be full casket or cremated remains.
- VA directed 70,000 burials in FY '97. The National Cemetery in Calverton, New York was our busiest cemetery with over 7,300 burials.
- Between now and the year 2006 ,we project 20,000 veterans will pass away, resulting in the number of annual interments increasing to over 100,000 (including veteran and spouse).
- Other services provided by NCS include the provision of headstone/marker for the deceased, and the Presidential Memorial Certificate Program.
- Two new cemeteries have been opened since 1992: San Joaquin Valley and Tacoma, Washington. Four new cemeteries are scheduled to open in 1999: Saratoga, NY; Cleveland, Ohio; Chicago, Ill; and Dallas/Fort Worth, TX.

- NCS works with State governments in developing and funding State veterans' cemeteries through a State veterans cemetery, State grant program.
- Approximately 45% of burials in National Cemeteries receive military honors. About half of these are done by military units and half by veteran service organizations.

The following issues were addressed in the question and answer period:

- **What provisions are made for addressing problems of maintenance and upkeep of State-run veterans' cemeteries?** VA's works very closely with the States to assure these cemeteries operate properly. In some cases we have sent one of our cemetery directors to the State to work with their staff. The States do have a problem regarding their plot allowance of \$150, which is woefully low. Presently, VA has a legislative proposal in Congress to increase the Federal share of the funding from 50% to 100%, as well as provide the State with initial start-up equipment. This would help them defray the up-front costs. There are no provisions for VA to take over these cemeteries because they are the responsibility of the individual States.
- **Is VA supporting legislation to provide VA burial benefits to members of the National Guard?** I am unable to comment on that at the moment, We have just become aware of that legislative initiative and must study it further.
- **There has been a lot of talk about the difficulties in providing military honors to deceased veterans, particularly among the active duty forces. Is there someone who is going to assume responsibility for organizing these efforts with the VSOs and military?** The 1998 Defense Authorization Bill authorized the military to provide funeral honors, however it did not provide funds to support them. This is one of our biggest challenges. We are hoping to have an executive roundtable in the fall with representatives from the involved organizations to try to develop a plan to provide the honors.

##### 5. **Mr. H. David Burge, Director, Center for Veterans Analysis & Statistics**

Mr. Burge discussed the Department's plans for the Year 2000 survey of veterans. Committee members received a copy of the 1995 survey in their pre-meeting packets. Highlights of Mr. Burge's presentation included:

- Ms. Susan Krumhaus, Project Director of the 2000 survey was introduced
- Overview of Survey: Purpose, Methodology, Sample size, Example of information obtained (Handout)
- Opportunity for input into design and questions
- Review of Demographic data on the women veteran population, present and projected: (Handout)

The following issues were discussed during the question and answer period:

- **Are you considering over-sampling the number of women surveyed in order to assure you have a sample size large enough to provide accurate data?** Yes, we are considering the possibility of over-sampling in some populations.
- **Are you going to collect data on homeless veterans?** It is very difficult to survey homeless veterans, as they have no fixed address or phone number. It may be possible to develop some form of supplement to be used in places that provide homeless services, but that will have to be reviewed by the survey team.

#### **6. Mr. Everett Chasen, Director News Service Public Affairs**

Mr. Chasen gave an overview of the News Service under the Office of Public Affairs, which basically takes reporter's and national news media's calls into Central Office, field facilities, hospitals, regional offices or cemeteries. Last year an estimated 2,778 calls were received. He also gave an overview of Public Affairs role in outreach. Public Affairs is organized into three different services:

- **Field Operation Service:** coordinates public affairs aspects of field service sites for Secretary and Deputy Secretary; respond to field facility requests for information and issues related to the Department; promote VA research through a national storage program based in New York and interact with reporters that cover medial issues; provide guidance and support to field facilities during crisis; and provide training for facility public affairs officers (PAO).
- **Internal Communications and Special Projects:** distribute monthly news letters which include the *Vanguard* and *Federal Handbook for Veterans and Dependents* and hometown news release which sends news to participants hometown papers; television and radio public service announcements including the VA Report, which is a televised 12-minute update from film clips from TV stations; special message videos where the Secretary addresses everyone; and VA pamphlets. Special projects include special events such as Veterans Day; special games including wheelchair games, winter sports, clinics and creative arts, and Golden Age games.
- **News Service:** arranges briefings, news conferences and interviews; prepare field guidance when there is a breaking story; provides the Secretary and senior management advice and counsel on controversial issues relating to the Department; prepares daily clip of newspaper summaries.

Current outreach efforts are focusing on Gulf War veterans. Our goal is to assure they are familiar with how to access the network of information we have developed; assure they understand that they receive priority care at VA facilities and understand the compensation process, as well as communicate goals; accomplishments and activities of VA Gulf research.

#### **7. Dr. Rebecca Klemm, Klemm Analysis Group**

The Klemm Analysis group has received a number of contracts from VA to study the health status of veterans. This group supervised the Women Vietnam Veterans Reproductive Outcome Study and is currently involved in a number of studies relating to Persian Gulf Veterans. Dr. Klemm provided an overview of the research currently being done on women veterans.

- Health Outcomes among Women Vietnam Veterans: epidemiological investigation of the reproductive outcomes and development of some cancers in women Vietnam Veterans. Involves three stages: 1) telephone interview, 2) mail survey, 3) review of medical records. Currently in final stages and final report is due in VACO in September 1998.
- Health outcomes among Persian Gulf Veterans: Similar in scope to Vietnam veteran study. A study of the health status of women veterans based on both self-report and a review of health records. It will also incorporate comparisons with women who served in other parts of the world. We will be trying to identify linkages to various physical and psychological exposures also. It is a very large study that will include women in all branches of the service. 10,000 who served in the Persian Gulf and 10,000 who served elsewhere.
- Funded, follow-up study with Georgetown where women will have clinical follow-up on illnesses such as fibromyalgia, chronic fatigue, etc. We hope to be able to then compare the participants' self-report, and diagnosed illness with their exposure to various environmental and psychological stresses.
- Army Chemical Corp veterans health study: Study of the health status of veterans who served in the Army Chemical Corp during the Vietnam era and their children. Currently we have not found any women who served in this Corp during that time. Study is in the pilot stage. Involves 3000 chemical Corp veterans and 3000 non-chemical Corp veterans. Anticipated completion date: summer of 2001.
- Alternative Medical Practices in VA: Investigation of complimentary and alternative medical practices within VA. We will be visiting sites across the country to assist us in identifying and defining alternative medicine and practices to assure we have a broad perspective on what is actually being practiced across the country. It is the first review of this kind of practice in VA and will provide preliminary guidance on what practices should or should not be adapted within VA on a continuing basis.



The following issues were discussed in the question and answer period:

**Clarification: Persian Gulf Study:** The Persian Gulf veterans in the expanded clinical follow-up to be done by Georgetown, will be selected from the pool of veterans in the larger study.

**Comment: Army Chemical Corp Study:** It is important to consider rank and position of individuals in the analysis of findings.

**Comment:** Acknowledgment by Committee of the importance of this work and how we have overlooked studying the impact of these exposures on veterans health for a long time.

#### **8. Mr. Phil Riggin, Deputy Assistant Secretary for Congressional Affairs**

Mr. Riggin provided an overview of the activities of the Office of Congressional Affairs and VA legislative initiatives.

- **Extension of Sexual Trauma Counseling Authority:** VA supports this extension and has initiated a legislative proposal to extend it indefinitely
- **Maternity Care for Women Veterans:** VA General Counsel issued an opinion indicating that the provision of maternity care to women veterans fell within the purview of care that can be provided by Veterans Health Administration. However VA is not authorized to provide care to newborns under present law. VA would need legislative authorization to provide any care to newborns.
- **Medicare subvention:** There are two bills in the Congress right now that would authorize VA to bill Medicare for services provided to Medicare recipients. HR 828 (Stump-Thomas Bill), and S 2054. Both bills face some difficulty in obtaining the approval necessary for enactment. VA strongly supports Medicare subvention legislation and considers in one of our legislative priorities.
- **ISTEA Bill: Inter-Service Transportation Surface Bill.** This is the bill that authorized many transportation projects around the country. It was recently signed by the President. This bill contains language that would prohibit the payment of VA compensation for tobacco related disability. This is a very controversial bill that the Veterans organizations are very concerned about, so you may be hearing more about it in the future.
- **Global Tobacco Settlement Legislation:** This is a measure which would require the tobacco companies to reimburse the Federal Government for certain expenses associated with providing benefits and services to individuals (not just veterans) suffering from tobacco related disabilities, provide funding to support smoking cessation initiatives and foster the establishment of initiatives that would limit teenage smoking. A recent amendment to this bill includes a provision that the Department of Veterans Affairs receive three billion dollars over 5 years, to provide reimbursement for the treatment of veterans with smoking related disorders. This legislation is under review and has not yet been passed.
- **Research funding:** VA's research budget has been increased by 10 million dollars.

The following issues were discussed during the question and answer period.

- **It seems like the laws authorizing VA to provide sexual trauma counseling always have a sunset provision. Why can't the VA receive authorization to provide this treatment without any time limits on it?** I agree with you and this makes sense, I am not sure why the reauthorization was only granted for four years. Discussion from Committee: There is some indication that there was a compromise reached between those congressional members who wanted to eliminate the sunset provision and those members that wanted to eliminate the sexual trauma counseling program. VA does support the sexual trauma counseling program and will work to have reauthorize as necessary.
- **VA General Counsel also rendered an opinion indicating that selected reservists and National Guard members who experience sexual trauma during a period of training are not eligible for VA's sexual trauma counseling program. Is the only way to remedy this through legislation, and what is VA doing in response to this interpretation?** Congressman Gutteriez has incorporated a provision allowing VA to provide this counseling to National Guard and reservists, it is presently being considered by the HVAC.
- **I'd like to revisit the tobacco legislation issue. Am I right that it says that VA will pay compensation to any veteran who develops a tobacco related illness, if they smoked while in service? Would this include illnesses that may or may not be related to tobacco use, for example: heart disease, hypertension.** There has been a lot of discussion around these issues because, as you well know, some of these illnesses develop in non-smokers as well as smokers. The current administration is trying to prohibit the payment of compensation for those disabilities that are strictly related to tobacco use. There is no question that it is a tough issue and will require considerable study if it is enacted.

#### **9. Dr. Katherine Skinner, Health Services and Research Division, Bedford, MA**

Dr. Skinner discussed the VA Women's Health Project. The data presented is unpublished data and as such must be seen and preliminary findings are not ready for public dissemination. Our overarching question for this study was: What is the effect of military service on the physical, mental and social functioning of women veterans. Thus, there were four study objectives:

- 1) Examine the health-related quality of life in women veterans who are users of the VA healthcare system.
- 2) Compare the health-related quality of life of women and men users of VA healthcare services.
- 3) Identify patient characteristics related to health-related quality, social demographics, disease status and military experience.
- 4) Relationship of health-related quality of life to the use of VA healthcare services.

The findings of the study are in Appendix A

#### **10. Ms. Helen Cohen, Chief of Staff to the Assistant Secretary for Veteran's Employment and Training, Department of Labor**

Ms. Cohen gave an overview of Veteran's Employment and Training Division of the Department of Labor and discussed recent initiatives they have undertaken to improve employment opportunities for veterans.

- Interagency Task Force on Certification and Licensing of Military Personnel: joint DOL/VA/DOD task force to assist active duty personnel in obtaining certification and licenses necessary for civilian employment while they are still on active duty. It is hoped this will ease their transition to civilian life and reduce periods of unemployment and/or underemployment. Our contractor has determined that there are 67 military occupation specialties which has civilian counterparts that require certification or licensure.
- Establishment of Internet Reference site: This site would allow active duty military personnel to enter their preferred occupation and State of residence after discharge and they would receive information regarding the State requirements for certification or licensure. Additionally it would also provide them information on what additional training they would need (based on their current Military MOS) to qualify for certification/licensure in the state.
- Pilot Project: Skills two 2000: We have collaborated with Microsoft and arranged pilot programs at four active military sites where active duty service member can enroll in a group of courses leading to a Skills certificate from Microsoft. This certifies an individual has a certain level computer skills and increases their chances of employment in high tech industries. The pilot program sites are: Fort Lewis, Norfolk, San Diego and Atlanta Air Force Base (?Warner Robbins) Separating service members will be informed of this program through TAP workshops and those interested will be required to take an aptitude test to determine their appropriateness for the program. Those personnel selected will have their tuition and fees paid by Microsoft.
- Pilot Project-Communication Workers of America & Veterans Research Education Institute: This program is designed similar to Microsoft pilot but involves the skills needed in the telecommunication industry. Job options include everything from cable installers to customer service representatives.
- TAP Program: DOL/VETS is interested in increasing the number of spouses who attend the TAP workshops.
- Priority Employment Service: Working with Office of Federal Compliance Programs to be sure that America's Job Act and America's Talent Bank continue to provide Priority service to veterans as required by law. These are Employment banks, funded by DOL, that are available on the Internet.
- National Veteran Training Institute (NVTI): Established a new curriculum that incorporates diversity training and sensitivity to State veterans employment counselors to counteract complaints of discrimination "job typing" and other complaints from veterans.

**11. Ms. Cornelia H. Moore, Regional Director, Women's Bureau,  
Department of Labor**

Ms. Moore notified the Committee of a DOL Women's Bureau Project entitled Women Veterans Original Arts Poster Contest, designed to increase their awareness of the work of women veterans

**12. Mr. Willie Hensley, Director, Center for Minority Veterans**

The Center for Minority Veterans was established in the same legislation that established the Center for Women Veterans – P.L.103-446. It also established the Advisory Committee on Minority Veterans. Both Center's and Advisory Committee's have similar missions although the constituencies are different. According to the law, minority veterans are defined as African Americans, Hispanics, Asian Americans, Pacific Islanders and Native Americans. Within the Native American category there are three groups of veterans: Alaskan natives, Hawaiian Natives and American Indians. Over the last two years the Center has worked at deterring what major issues these five groups experienced in relation to VA. They are as follows:

- African Americans: 1) Questions regarding possible disparity between African American and non-minority veterans in C&P ratings: We are unable to validate, one way or the other, the reality of this concern so we have established a study that will match VBA files with files from the Department's of the Army, Navy, Air Force and Marines, by race and ethnicity. This will assist us in determining the rates at which veterans are being compensated and allow for some ethnic and racial comparisons. 2) Medical Care: There is question in both the veteran and civilian population regarding differences in medical treatment of minorities and non-minorities, in a variety of illnesses. We have worked with the Office of Research to assure the development of research protocols designed to assess this issue in VA and determine what, if any, variations exist in the treatment of minority and non-minority veterans. 3) Homelessness: minority veterans represent the largest percentage of the homeless veterans.
- Hispanics: 1) Language barrier: Many Hispanic veterans are not fluent in the English language and have difficulty understanding printed material available through VA. Center has worked to increase the number of VA information and outreach publications available in a Spanish language edition. 2) Access to medical care: Hispanic veterans complain about having to travel long distances to access care. The development of community-based outpatient clinics has begun to address this problem and as more clinics are developed we hope to see this issue diminish in importance. 3) Lack of statistical data: Generally speaking, there is a lack of good statistical data on Hispanic veterans which hinders us in identifying and responding to issues in that segment of the veteran population.

- Native Americans: 1) Access to medical care: Reservation-based Native Americans encounter many problems in accessing VA care, including – living in remote, isolated areas, poor or no personal transportation, absence of public transportation. We are hoping to increase some services on the Reservation through sharing agreements with Indian Health Service and/or VA, establishment of Reservation- based vet centers and the introduction of tele-medicine. 2) Post Traumatic Stress Disorder: According to a national study on PTSD in minority populations, Native Americans suffer with a higher rate of PTSD than any other group of veterans we serve. 52 to 57% of Native American’s who served in Vietnam have PTSD compared to 27% of Hispanics, the second highest group. So, we are working on improving outreach to assure these veterans are familiar with, and have access to VA services and benefits designed to assist them. Readjustment Counseling Service, under the direction of Dr. Alfonso Batres is working to establish Vet Centers on the Reservations and has so far established them on the Hopi and Navajo Reservation. Others are planned for Oklahoma, in support of the Cherokee nation and South Dakota, in support of the Sioux. 3) Native American Home Loan Program: Reservation-based Native Americans have encountered difficulty in obtaining VA home loans because Reservation land is considered trust land, belonging to the tribe and not the individual. The NAHLP remedied this by providing VA the authority to make loans to individuals buying homes on trust land. However, there are a number of steps that must be taken by both the veteran and the tribe before the loan has been granted. This has created some difficulties in getting these loans approved. We are working to do more outreach and education to tribal leaders and veterans about the loans and the conditions that must be met for individual’s to qualify for them. 4) homelessness, as with the African Americans, homelessness among this population is a significant concern.
- Cultural Sensitivity: This area is a major issue for all minority veterans and is an area where we are working to improve the sensitivity and understanding of VA staff providing services to these individuals.
- Minority Veteran Vendor Opportunities: The Center hosts vendor seminars around the country to explain to minority veterans the opportunities for contracts for vendors with VA.
- Minority Veteran Coordinators: We have 280 minority coordinators across the country. This program is very similar to the women veterans’ coordinator program which you are all familiar with. The coordinators accept the responsibility of the MVC program along with their other duties. It is a collateral assignment.

The following issues were discussed during the question and answer period.

- **Do you feel there is any value in having a tribal veteran representative to assist veterans within their own tribe?** Yes, we feel the tribal veteran representative is a very valuable program and promotes the use of benefits by Native American veterans. It is especially valuable to those veterans living on the Reservation who are physically removed from the areas where VA services are usually located.
- **The issue of discrepancy in the treatment of minorities and non-minorities has also been identified between men and women, it seems to me we've done enough research and really need to begin to educate people about these issues.** The Department of Health and Human Services has established an Office on Minority Health and they have begun to hold annual conferences and other seminars to do just that. Needless to say however, the research is important as it provides validation for the issue and specifics regarding treatment practices.

### **13. Ms. Kathleen Zeiler, Director, Women Veterans' Health Programs**

Ms. Zeiler gave an overview of the Women Veterans Health Program, highlights of her presentation included:

- **Women Veterans Coordinators' Time Study:** completed and is in Dr. Kizer's Office for review. It's clear that the coordinators are very busy and their clinical loads are increasing, reducing the time available for outreach. We are taking the findings of this under review.
- **Reproductive health:** Women's health has submitted a white paper to Dr. Kizer on Reproductive Health Issues in both men and women. We proposed a generous package of benefits to assist veterans with both infertility treatment, and in the case of women veterans, pregnancy care. This package is under review by the Health Benefits task force. As was mentioned earlier we do have some issues related to newborn care following a successful pregnancy/delivery. It is our recommendation that we provide newborn care for a proscribed period of time, not to exceed 28 days.
- **Women's Comprehensive Health Clinics:** the eight centers that are established to provide, care, consultation, education and research on women's issues are now required to file an annual report with my office.
- **Women Veterans' Health Program Newsletter:** Newsletter designed for women veteran coordinators and healthcare providers, to update them on women's health issues.
- **Federal Practitioner:** published a two-part series of articles and self-study packets on sexual trauma that provide continuing education credit to clinicians who complete the test included in the magazine and return it for scoring.

- Women Veterans Survey: Executive summary distributed: 11% decrease in the number of women inpatients and an 11% increase in the number of women outpatients. We continue to see consistent increase in the number of women seen and the percentage of women receiving gender-specific screening exams, e.g.. mammography/pap smears.
- Heathy Women 2000: this program, established by the Department of Health and Human Services, sets goals for health promotion activities in a number of area. In women's health, VA has met or exceeded the established goals in most of the areas measured, including cervical cancer screening, influenza vaccinations, counseling for tobacco us and physical activity.
- Primary Care Initiatives: 1) A Women's Health Guide; a pocket size reference book that primary care providers can keep with them at all times is under development at this time. 2) establishment of a mental health mini-residency for primary care providers; and breast center development program are scheduled for the fall. Mini-residencies in women's primary care continue.
- Education: Two satellite TV programs on sexual trauma counseling, one for mental health providers and one for primary care providers.

The Question and answer period focused on the impact of community-based clinics on women's health and VA 's responsibility and role in assuring contract providers were educated about women veterans health issues.

#### **14. Mr. Gunner Kent, Veterans Service Organizations Liaison**

Mr. Kent gave an overview of his role as VSO liaison which included:

- Primary advisor to the Secretary on the Veterans Service Organizations
- 44 recognized veterans groups: these are groups either charged by Congress or recognized by the VA to handle VA claims
- 8 "special interest group" organizations, e.g., Retired Officers Association
- Numerous smaller organizations: e.g., WAVES

Mr. Kent identified the following issues as concerns of VSO's

- Reorganization of VHA
- Transportation Bill and impact on veterans with tobacco related disabilities
- Coordination of Groups in the common interest.

#### **15. Mr. R. Kent Simonis, Director Health Administration**

Mr. Simonis provided an overview of Eligibility Reform and it's impact on VA healthcare. The following points were emphasized during the presentation:

- New system emphasizes preventive medicine and outpatient care as compared to the old system that emphasized inpatient care.
- Relaxes regulations around the issuance of prosthetic devices. Eligibility for the provision of sensory aids (eyeglasses/hearing aids) will be more restrictive
- Inclusion of maternity benefits

- Exclusions: cosmetic surgery and other procedures listed in the National Health Benefits act
- Rules governing the provision of non-VA care have not changed. Non-VA care is provided under different statutory authority and is not included in the eligibility reform legislation.
- Rolling Enrollment: allows veterans to apply for VA care at any time during the year. No restriction on when someone can apply for VA care. However, the priority categories VA will treat will be determined each year. So enrollment, per se, does not guarantee you will be eligible for care indefinitely.
- Automatic Enrollment (eligibility): The following veterans are formally enrolled in VA and do not have to enroll again to receive benefits: 1) veterans who have a service-connected disability rated 50% or greater, 2) veterans being treated for a service-connected disability only, and 3) veterans who are separated within one year of active military service for a disability.
- Initial Registration/Only Registration: Individual will not have to enroll again if they relocate. We will have a master record that will give us the right information for the right patient, when and where we need it. Patients will have the opportunity to update their records every year, so we can be sure they are accurate and current.
- Eligibility for care is consistent: Regardless of where you access care you will be eligible for the same service. Care will not vary from State to State or from one geographical area to another.

The following issues were discussed during the question and answer period.

- **Will the care I receive change from one VA to another, in other words, if I am accepted for care at a VA hospital in Florida and move to Montana, will my enrollment change?** No. The decision on which category of veteran will be eligible to receive VA care will be a national one and will be effective nationwide for one year. So, if in October of 1998, VA decides to treat all veterans through priority Category 7, we will care for all patients in Categories 1-7 who access our services, until September 30, 1999. At which time we will treat all patients in the categories selected for enrollment in FY 1999. The categories we select to treat will be determined by the resources available for each year through Congressional Appropriations and Medical Care Cost Recovery Revenues.
- **What are the priority groups?** They are as follows:
  - Priority 1: veterans who are 50% service-connected or greater
  - Priority 2: veterans who are 30% or 40% service-connected
  - Priority 3: veterans who are 10% or 20% service-connected
  - Priority 4: NSC veterans who are POW's, or in receipt of VA pension
  - Priority 5: NSC veterans with low incomes
  - Priority 6: NSC veterans who have been exposed to chemical or Radiation or other environmental hazards while on active

duty



Priority 7: Any veteran not included in one of the 6 prior groups.

- **Are individuals eligible for Tricare ,eligible for VA care also?** Not necessarily. Tricare is a DoD healthcare program for military retiree's and dependents. Although some VA's have sharing agreements with DoD that make them designated Tricare providers, not all are. So, an individual who is eligible for Tricare may also be eligible for VA care, if the fall into one of the 7 priority categories. Thus, they must be a veteran. But then they will access care through VA and not through Tricare.
- **Can you enroll online?** Unfortunately, not yet, but we do hope to have that capability in the future.
- **How far in advance will an individual know which category will be accepted for care?** Currently we must make that decision by August 1 for the October 1<sup>st</sup> fiscal year. We are hoping eventually to be able to provide this information one year in advance, so we would publish our enrollment priorities by October 1<sup>st</sup> of the preceding year. Giving veterans one year to determine what to do if their enrollment priority changes.

#### 16. **Lynda Petty, Veterans Benefits Administration**

Ms. Petty provided a specific update on women's issues in VBA. These included:

- Overview of VBA
- Regional WVC Coordinator: We now have a regional coordinator for women's programs in each of our 4 area offices. These individuals oversee issues in the 58 regional offices and assist the local WVC's in addressing issues. They also provide me with assistance in obtaining and disseminating information needed at the National, Regional or local level.
- VBA Intranet: Establishing an internal web page for VBA coordinators where they can readily obtain information on programs, services and benefits
- Establish performance standards for WVC's. As the WVC responsibility is a collateral duty no performance standards have been established. I am hoping to change that in the near future.
- Training: We need to improve our training for the WVC's , although we did have a joint training with VHA in San Antonio and some regional conferences. We also had two satellite TV conferences on sexual trauma and the compensation and pension process. All of which were well received.
- Compensation & Pension Women's Advisory Group: Established in 1995. Has been very productive over the last few years. Among their accomplishments are: Developed policies and procedures on the rating decision process in sexual trauma; reviewed rating schedule for gynecological disorders; developed and implemented education and training on developing claims for sexual trauma; reviewed PTSD ratings for sexual trauma; recommended changes to assure correspondence is gender sensitive.

The question and answer session included the following discussion:

- **In spite of the work being done, we continue to see claims being denied by Rating Boards or BVA. Often the C&P exam is not sufficient to support the claim. Is anything being done to address this?** Yes, we have instituted training on these issues and are looking at how mental disorders in general are being evaluated: Including whether women with PTSD are being given other diagnosis. But one of the difficulties we encounter with PTSD due to sexual trauma, is that the diagnosis of PTSD alone is not enough to grant service-connection. There must also be credible evidence linking the stressor to military service. Unfortunately, this documentation is often difficult to find. The markers are simply that: If you have enough of them, you may be able to demonstrate there's a "preponderance of evidence" to support the veterans' claim. Unfortunately, this is more the exception than the rule. We still have many women without any real supporting evidence and it is unlikely they will be able to receive a SC rating.
- **Can you discuss disability ratings and percentages granted?** The rating schedule is very large and very complex. Once it is determined that a veteran has a disabling condition that is service-connected, the rating specialist must review the rating schedule for that particular illness and determine, according to the established guidelines, what rate he should be giving. The rates range from 0%-100%. (This was followed by a lengthy discussion on how ratings are determined.)

#### 17. **Kenneth Clark, Chief Network Officer**

Mr. Clark provided an overview of the Network Strategic Plan Summary 1998-2002 and addressed the following issues:

- **Definition of Network:** A geographical area incorporating a number of VA facilities that are tied to one corporate office. There are 22 Networks in VA healthcare system.
- VA has moved from a model of inpatient specialty care to more of a managed care model: primary care provided in an outpatient setting.
- 50% of future residencies funded by VA will be in primary care
- **Principles of VHA's Transformation/Reorganization**
  - All healthcare is local: Assess the needs of the community and develop a way to respond to them. This can best be done in small geographical networks.
  - Decentralize decision-making: increase accountability and flexibility of provider
  - Increase quality and efficiency: reduce cost
- **Results:** 1) Closed 43% of our beds, 2) decreased inpatient admission 24%, 3) 6.6 million increase in ambulatory care visits, 4) decreased by 25,000 the number of FTEE (-13%) 5) increased outpatient procedures from 30% of our total procedures to 70%. Patients are spending less

and less time in the hospital, decreasing their chances of hospital acquired infections and other problems. 6) treated 10% more patients between 1994 and 1997.

- Medical Care Cost Recovery: estimate VA will collect \$600 million nationwide in FY 1998 through this program
- Customer Service Standards/Customer satisfaction: established benchmarks to evaluate patient satisfaction based on private sector surveys. Have trained 85% of our staff in this area. Goals:
  - Reduce waiting times
  - Reduce variations in quality
  - Improve access and convenience
  - Attract and retain quality staff
  - Develop Innovative programming
  - Establish preventive medicine indexes
- Comparing VA practices with private and public sector: establish benchmarks for chronic disease management and preventive care. Incorporating "Healthy People 2000" goals into VA care.

The question and answer period covered the following areas:

- **What is the conflict between VA and HCFA over Medicare subvention?**  
HCFA's basic objection to providing Medicare benefits to individuals treated in VA hospitals is that they are both Federal benefits and one agency should not be billing another agency for care they are giving under a separate entitlement.
- **If a VA hospital has a sharing agreement to provide services to non-veterans will that affect their ability to provide care to veterans because of resource constraints?** That issue has arisen in the few places where we have sharing agreements to provide care to non-veterans prisoners. Because this has been such an unpopular decision, the Secretary has decided we will no longer do that. However, veterans will receive care based on the eligibility category they fall into, regardless of what other services VA provides.
- **How do you assure that in your quest for efficiency and cost effectiveness, you are not diminishing services that the veteran values?**  
We realize this is a question that is going to be raised we are incorporating studies that will help us to determine how effective our changes are in regard to the veterans health status. For example, as we decrease our inpatient stays on psychiatry and improve our outpatient care, we will measure our success by following our patient readmission rates, to assure they are benefiting from their care, and not just going through a swinging door of recidivism. We will be working to develop quality indicators for all our programs so we have confidence that we are indeed providing the quality of care we would like to give.

- **What is done to assure staff are trained in responding sensitively to the needs of veterans, including minorities and women?** The networks and facilities are responsible for addressing the issues of sensitivity training for their staff. As I mentioned earlier, we have had training in customer satisfaction and we do try to work closely with our people to assure they are responsive to the community they serve.
- **What are your goals for increasing the number of veterans served by VA, and do you have a specific emphasis on increasing the number of women veterans you serve?** At this point, although we have incorporated this into our overall strategic plan, we have left the actual numbers up to the individual VISN's to determine.
- **What percentage of the community-based clinics are contract clinics?** About 50% of the CBOC's are contract clinics.
- **What consideration is being given to allowing individual medical centers the right to retain control over their own budgets and revenue streams, rather than allowing the VISN complete control over the funds?** The best way for me to answer that is to say that, if we are going to run a decentralized system we need to monitor the overall outcomes and not meddle in day-to-day decisions. We are very sensitive to the issue of fiscal responsibility and expect the network director to be held accountable.

### III. Old Business

**Topic:** Electronic ticketing

**Discussion:** travel options

**Action:** Members will be notified by phone with followup letter of meeting dates as soon as date is established

### IV. New Business

**Topic:** Proposal to Secretary to allocate more funding for Committee work

**Discussion:** Funding must be justified, but cannot be used to support a summit. Committee asked for money for site visits and focus groups to look at different settings and rural areas throughout the United States. Since budget is already in place, it was agreed to focus on the year 2000.

**Action:** A copy of 1997/1998 Access to Care Report will be given to the Committee so a plan can be developed from it to present to the Secretary to justify the funding request.

**Topic:** Subcommittee working group reports

**Discussion:** Subcommittee met separately, chairs are responsible for minutes

**Action:** None

**Topic:** The 1998 Report of the Advisory Committee

**Discussion:** A subcommittee consisting of Dr. Schwartz, Dr. Johns, COL. Cook and Mrs. Ray was formed to develop an initial draft of the 1998 report. The draft should be distributed prior to the September 1998, so that Committee members can review and comment on it at that time.

**Action:** None

**Topic:** Upcoming site visit

**Discussion:** Proposed that everyone not visit the same places as a group, but break into teams. Instead of having open hearings have small focus groups and listen to related situations.

**Action:** It was decided that since this was the first site visit for the new members, the Committee would stay together as a group. Focus groups would not benefit the veterans and the Committee's time would not be maximized. It was agreed to hold a town meeting for the women veteran community on Saturday morning.

**Topic:** Location of site visit

**Discussion:** Places of consideration were New York, Chicago and Philadelphia

**Action:** Chicago was selected

## **I. Miscellaneous**

- a. A special presentation was made to the Chair, Linda Schwartz, for the successful completion of her doctorate degree from the Yale University School of Public Health;
- b. Members attended a Senate reception;
- c. Members visited the Women's Memorial hosted by General Wilma Vaught

The meeting was adjourned at 4:00pm.

Respectfully submitted,

Joan A. Furey