LEGISLATIVE TASK FORCE

ON WOMEN VETERANS' HEALTH CARE

FINAL REPORT OCTOBER 2010

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EXECUTIVE SUMMARY

In December 2008, the Governor's Task Force on Veterans' Services submitted its final report to Governor Ted Kulongoski. The report made 39 recommendations, one of which was the creation of a new task force on women veterans' health care. The Governor's Task Force had sought input from veterans throughout Oregon, holding public town hall meetings in 24 cities. One of the last town hall meetings was in Salem where exactly one veteran attended. She was a woman veteran and a victim of Military Sexual Trauma (MST). Up until that night, there were very few comments made about women veterans and their unique and challenging needs. In fact, the Task Force realized in hindsight that very few women veterans were attending any of the town hall meetings. Based upon the information the Task Force learned from that one woman veteran in Salem and subsequent research by the Task Force, it became painfully obvious that there was much more work to do on women veterans' issues in Oregon.

As part of the Task Force's legislative agenda, House Bill 2718 was introduced during the 2009 Legislative Session, asking the Legislature to create a Task Force on Women Veterans' Health Care. HB 2718 passed unanimously and gave the new Task Force the mission of studying the health care needs of women veterans, including but not limited to mental health, in-patient treatment, appropriate women veterans' health care within state and federal systems, as well as identifying gaps in services key to successfully treating women veterans and their gender-specific health care needs. The Task Force would then submit its recommendations to the Legislature by October 1, 2010.

The eight-member Task Force consisted of:

State Senator Laurie Monnes-Anderson
State Representative Jean Cowan
Nanci Visser, LtCol, USMCR (Ret.)
Marcia Hall, PhD – Women Veterans Program Manager, Roseburg VA Health Care System
Sonja Fry, LCSW – Military Sexual Trauma Counselor, VARHS, CBOC Eugene
Val Conley – State Women Veterans Coordinator, Oregon Department of Veterans Affairs
Amy Fauver – Oregon Department of Human Services
BG Mike Caldwell – Oregon Military Department

Other stakeholders were invited to participate, including:

Fritz Graham, Senator Ron Wyden's Office
Ben Hier, Senator Jeff Merkley's Office
Elanna Schlichting, Congressman Earl Blumenauer's Office
JD Baucom, Congressman Kurt Schrader's Office

Frank Van Cleave, Congressman Peter DeFazio's Office
Aja Maloney-Capps, Congressman David Wu's Office
John Howard, Congressman Greg Walden's Office
Frederick White, Executive Assistant to the Director, Portland VA Medical Center
Nancy Sloan, DNP, Women Veterans Program Manager, Portland VA Medical Center
Doina Jeffrey, Women Veterans Program Manager, VA Southern Oregon Rehabilitation Center and Clinics
Jack Heims, Portland VA Medical Center (Ret)
Élan Lambert, Oregon Partners in Crisis and U.S. Navy veteran
LTC Evelyn Brady, Oregon National Guard
Gigi Harris, PhD, Portland State University
Morgan Cowling, Association of Oregon Counties
Mandy Martin, Military One Source, Operation Iraqi Freedom veteran
Mark Meidema, Department of Administrative Service Budget and Management
Jessica Van Diepen, Oregon Association of Community Mental Health Programs
Jane Stein, U.S. Navy veteran
Katie Huffman, U.S. Army veteran

After an organizational meeting in October 2009, the Task Force began monthly meetings in November 2009 with presentations from Dr. Hall regarding VA Services for Women Veterans in Oregon, and a briefing in December 2009 by Sonja Fry on Military Sexual Trauma. Task Force members visited the VA's Southern Oregon Rehabilitation Center and Clinics in White City, the Roseburg VA Health Care System, and the Portland VA Medical Center where they were briefed on specific women veterans' programs and plans for future accommodation. The Task Force had the opportunity to meet and speak with women veterans who were receiving care in the residential treatment programs at White City; to meet with approximately 30 women who use the VA Roseburg Healthcare System and with members of the American Women Veterans Association; and to attend a women veterans' forum at the Portland VA Medical center where more than 150 women veterans voiced their concerns and needs to the PVAMC leadership. Task Force members also attended the 2010 Oregon Women Veterans Conference where they spoke one-on-one with many of the diverse group of more than 300 women veterans who participated in the conference.

Having met with experts, spoken with women veterans, reviewed research on women veterans, and studied a multitude of issues, the Task Force identified 17 Findings from which the Task Force is making 12 Recommendations.

The following are the Task Force Findings:

FINDINGS

- There are an insufficient number of women's health-care providers within the VA System to meet the needs of women veterans.
    - There is inadequate MST and PTSD training for providers outside of the VA System.
- There is a need for safe, gender-specific, in-patient acute, specialized, and residential treatment beds for women veterans in Oregon.
    - Within the VA, there are currently no women's specialized in-patient treatment beds for PTSD and/or MST in VISN 20; only 10 residential beds in Oregon at White City for women veterans; only "mixed use – male-female" acute psychiatric beds at Portland; and 3 designated, but not exclusive female-use beds at Roseburg.
- Women veterans have complex health-care needs and will require increased resources to ensure equitable care.
- Numerous barriers to health care exist for women veterans in Oregon which include:
    - Rural and remote access difficulties.
    - Women veterans often feel stigmatized and will not use VA services.
    - VA Community Care is insufficient (Fee Basis system) and often confounding for women veterans.
    - Lack of childcare for outpatient appointments and in-patient care.
    - DAV Transportation to tertiary facility (Portland) is uniquely difficult for traumatized women who must sit in enclosed vehicles for hours with several male veterans.
- Domestic violence and MST are epidemic among women veterans, are under reported, under treated, and require a concerted systemic response.
- Cultural competence with women veterans is lacking across organizations that serve women veterans.
- There is a need for designated Veteran Service Officer staff in each county in Oregon specifically trained to meet the needs of women veterans.
- Oregon has no military infrastructure and surrounding culture to support veterans.
- There is no 24/7 hotline in Oregon specifically for women veterans.
- There are no protected, designated resources for women veterans within the VA, ODVA, CVSO, and other service organizations.
- Women veterans often feel stigmatized by MST and disabled labels.
- State and federal agencies would benefit by educating all employees on women veterans' unique issues.
- Professionals in the health and social service fields would benefit from education on MST and women veterans.
- Women veterans, especially older veterans, are often not aware of their rights, benefits, and resources.
- VA has extensive expertise on women veterans' unique health and mental health care needs that could benefit civilian health care providers if exported through continuing education programs.
- Rural resources, Tribal health, and faith-based partnerships to support women veterans have not been adequately explored or developed.
- A number of women veterans use TRICARE as their health-care insurance. TRICARE providers can be difficult to locate, and reimbursement rates to these providers is below Medicare rates, further complicating access. TRICARE reimbursements may be further reduced by as much as 21 percent, which may cause a critical shortage of TRICARE providers for women veterans

The following are the Task Force Recommendations:

RECOMMENDATIONS

1. Create dedicated, specialized in-patient treatment beds for women veterans suffering from PTSD, MST, and/or Substance Abuse in VISN 20.

2. Increase dedicated acute psychiatric beds and residential beds for women veterans in VISN 20.

3. Obtain and staff a mobile health-care unit for women veterans to be used in rural and remote Oregon and Southwest Washington.

4. Allow victims of MST to seek mental health counseling and care with the provider of their choice at VA expense.

5. Increase the number of qualified providers who provide gender-specific care within the Veterans Health Administration (VHA) system.

6. Require every Vet Center, Community Based Outpatient Clinic (CBOC), and VA Hospital to have a sufficient number of proficient, interested, and engaged MST counselors to meet the increasing needs of women veterans.

7. Encourage the VHA to export knowledge and expertise on women veterans' health care to private and public sectors through continuing and professional education classes.

8. Require the VHA to fully fund women veterans' health care initiatives and mandates, including gender-specific mental health services and recruitment of women's health primary care providers. Recognize that explicit resources are required to transform the VA to meet women veterans' service needs as defined in VA policy.

9. Require continuing education in MST for all licensed medical providers, counselors, and social workers and encourage all medical and social service curricula to include instruction on MST.

10. Create a social networking and public awareness campaign on women veterans' health care to reach women veterans of all eras in all parts of Oregon.

11. Create a 1-800 MST Hotline and women veterans' "warm line."

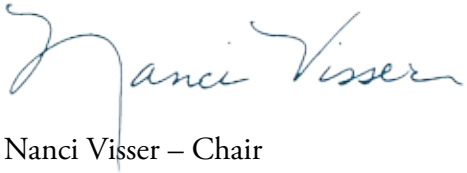
12. Work with the Oregon Congressional Delegation to support stable or increased TRICARE reimbursement rate.

This Task Force could not have done the work it did without the dedication of the members and participants who gave selflessly of their time and expertise without compensation. Of special importance were the contributions made by current and former Veterans Health Administration employees. During the course of the Task Force, all meetings were open, members and participants could attend most meetings via teleconference, and the minutes of all meetings were published on the ODVA web site. Everyone was encouraged to speak openly and candidly about the needs of women veterans in Oregon. Without candor, the Task Force would not have been able to accurately identify where the system works, what service gaps exist, and where the system could use more focus.

The Task Force gathered substantial information and diverse perspectives from individual women veterans, women veterans groups, and service providers including the VA, ODVA, Vet Centers, and Veterans Service Organizations. It was challenging to develop an accurate picture of the status of women veterans' health care in Oregon as it is a dynamic process involving multiple stakeholders with diverse perspectives. During the course of this Task Force, challenges involving information gathering arose between Task Force efforts, membership, and involved organizations. [i] Still, the Task Force persevered to provide a report that can guide future efforts to increase public awareness of the unique needs of women veterans; increase the capacity to provide women veterans' health-care services in Oregon; increase the quality and quantity of care; and decrease barriers that exist to accessing care.

The Task Force took on the great responsibility of clearly identifying women veterans' health-care issues that had long been overlooked with a sincere belief that this work would help not only the women veterans of Oregon, but also those of future generations. All members who served on the Task Force hope that the Findings and Recommendations within this report will act as a resource and guide for positive change as the number of women who have served in the Armed Services and who deserve quality health care continues to grow.

As Chair, I respectfully submit this Final Report to the Oregon Legislature.



Nanci Visser – Chair

(ENDNOTES)

i Inherent in collaborative processes is the potential for divergent views and opinions. While this is healthy within a Task Force and provides for lively discussion and debate, it can be unhelpful and even harmful when it comes from outside the Task Force. It should be axiomatic that duly appointed members of a Legislative Task Force who have their employers' permission to serve should be able to carry out the mission of the Task Force free from worry about the impact on their employment. However, during the course of this Task Force, two VA employees who were members of the Task Force decided to resign their positions due to such a situation. Fortunately, both continued to contribute as private citizens with knowledge of women veterans' health-care issues. The Task Force Chair tried but was unable to find a mechanism to address the conflict in such a way as to resolve the issue. Based on this experience, for future Task Force development, the Legislature may want to consider establishing a mechanism for identifying, preventing, and resolving potential conflicts that may arise between the work of the Task Force and those organizations providing members to the Task Force. Identification of such a process could serve future Task Forces by establishing a structure to protect both the information-gathering process and the Task Force members, themselves.

BACKGROUND AND OVERVIEW OF WOMEN VETERANS' HEALTH CARE

There are approximately 341,000 veterans in Oregon of which 25,103 are women (7.4 percent). At present only 29 percent (7,361) of these women veterans use VA services. With the wars in Iraq and Afghanistan, more women veterans are returning home to Oregon with unique and sometimes challenging medical needs.

Traditionally, the United States Department of Veterans Affairs (VA) has been a male-centric system serving a predominately male population. However, the VA's world has changed with the current conflicts. During Vietnam, 7,500 women served in country, mostly as nurses. In Iraq and Afghanistan, more than 250,000 women have served – many in direct combat as military police, combat medics, helicopter pilots, and truck drivers – without the government's official acknowledgement that they are combat veterans. Women veterans in these wars are coming home with Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), amputations, orthopedic issues, and other injuries that in previous conflicts were reserved only for male combatants.

UNIQUE NEEDS AND CHALLENGES OF WOMEN VETERANS' HEALTH CARE

According to Patricia Hayes, Director of the VA Strategic Healthcare Group on Women Veterans, the VA historically, "has not been responsive to the needs of women veterans."[1] In the past, women were such a small minority within the system that they did not represent a critical mass to effect change. Further, the structures, processes, and personnel of the VA were established to serve a male population of veterans. In addition, the very culture of the military and subsequently the VA has reflected attitudes toward women that have ranged from invisibility to overt hostility. Beyond these factors, "Women don't really know about VA services," according to Hayes.[2] Women veterans themselves have spoken out describing their treatment within the VA. Iraq war veteran Kayla Williams reported, "One of my close friends was told by a VA doctor that she could not possibly have PTSD for just this reason: He did not believe that she as a woman could have been in combat."[3]

But it is the government itself that has provided much information and insight into the treatment and health care of women veterans within the VA. In July 2009, the Government Accounting Office (GAO) released its *VA Health Care – Preliminary Findings on VA's Provision of Health Care Services to Women Veterans*. The report, which was submitted to the U.S. Senate Committee on Veterans' Affairs, highlighted challenges the VA faces to accommodate women veterans.

According to the Report, as of 2008 there were 1.8 million women veterans in America, which was 7.7 percent of the veteran population. Yet only 281,000 of these women veterans used VA health care, an increase of 12 percent from 2006. Interestingly, VA estimates the total veteran population will decline by 37 percent between 2008 and 2033; however, the woman veteran population is expected to *increase* by more than 17 percent during that same period. The report identifies that women veterans face different health care concerns than those of male veterans.

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1 VA Admits its Failure to Give Female Veterans Proper Care, Carrie Wells McClatchy Newspapers July 14, 2009
2 Ibid
3 Ibid

The health care services needed by women veterans are significantly different from those required by their male counterparts. Women veterans are younger, in the aggregate, than their male counterparts. Based on analysis conducted by the VA in 2007, the estimated median age of women veterans was 47, whereas the estimated median age of male veterans was 61. Women veterans seeking care at VA medical facilities need access to a full range of physical healthcare services, including basic gender-specific services – such as breast examinations, cervical cancer screening, and menopause management – and specialized gender-specific services such as obstetric care (which includes prenatal, labor and delivery, and postpartum care) and treatment of reproductive cancers. Women veterans also need access to a range of mental healthcare services, such as care for depression.

In addition, women veterans of OEF/OIF (Afghanistan and Iraq) present new challenges for VA's health care system. Almost all of these women are under the age of 40 – 58 percent are between the ages of 20 and 29. VA data shows that almost 20 percent of women veterans of OEF/OIF have been diagnosed with Post Traumatic Stress Disorder (PTSD). Additionally, an alarming number of them have experienced sexual trauma in the military (19 percent). As a result, many women veterans of OEF/OIF have complex physical and mental health care needs.[4]

The GAO based its report on visiting nine different VA medical facilities in various locations. Their findings include:

- Eight of the VA Medical Centers visited offered mixed-gender inpatient or residential mental health services, and only two offered residential treatment programs specifically designed for women
- Five of eight Vet Centers offered women-only groups, and six had counselors with training and experience in treating military sexual trauma
- None of the VA Medical Centers or CBOCs were fully compliant with VA policy requirements related to privacy for women veterans
- None of the VA Medical Centers or CBOCs ensured adequate visual and auditory privacy at check-in. In most settings, check-in desks or windows were located in mixed-gender waiting rooms or high-traffic public corridors
- Only one of the nine VA Medical Centers and two of the CBOCs were fully compliant with VA's policy requiring exam tables to face away from the door
- Only two of the nine VA Medical Centers and one of the eight CBOCs were fully compliant with VA's requirement that exam rooms where gynecological exams are conducted have immediately adjacent restrooms
- At four of the nine VA Medical Centers, proximity of private restrooms to women's rooms on inpatient and resident units was a concern
- VA facilities are having difficulty hiring qualified health-care providers who are versed in women veterans' health care[5]

STRENGTHS, BARRIERS, AND CURRENT CAPACITIES OF WOMEN VETERANS' HEALTH CARE IN OREGON

The Task Force reviewed and discussed the GAO findings and determined that while Oregon's VA health-care system faced similar challenges, some of the challenges have begun to be addressed. For example, the Portland VA Medical Center opened a dedicated women veterans' health-care clinic in September 2010 that

4 GAO Testimony Before the Senate Committee on Veterans' Affairs – VA Health Care Preliminary Findings on VA's Provision of Health Care Services to Women Veterans.

5 Ibid

meets and/or exceeds VA requirements and policies for women veterans. The Roseburg VA Health Care System also has dedicated women veterans' health care. In the last two years, Roseburg has moved from only 29 percent of women receiving comprehensive primary care services to now more than 85 percent receiving this care. Although VA facilities can use different delivery models, all now seek to provide comprehensive primary care at each site. The Southern Oregon Rehabilitation Center and Clinics in White City not only provides comprehensive primary care services but also has a dedicated woman veteran residential treatment area and recently sought funding to expand its woman veteran program. Unfortunately, its most recent grant request was turned down. All three Oregon VA facilities have a full-time Women Veterans Program Manager (WVPM) mandated in 2008. However, not all facilities have filled the positions vacated by the appointed WVPM, and this has resulted in gaps in clinical care for women veterans.

To set the foundation for the Task Force in November 2009, Dr. Hall provided a PowerPoint presentation outlining VA Services for Women Veterans in Oregon. Highlights of her presentation include the following facts:

- While traditionally women veterans under utilize VA health care, 47.3 percent of OEF/OIF women veterans have enrolled in VA health care
- Women veterans often feel "invisible" or like they are not really veterans, and that 'invisibility' is a barrier to care
- Of the homeless OEF/OIF veterans, 11 percent are women of whom 40 percent say they experienced Military Sexual Trauma (MST)
- Only 7,361 of the 25,103 Oregon women veterans use VA health care
- There are an insufficient number of clinicians in the VA with specific training and experience in women's health and mental health issues
- VA conducts universal screening for MST, and all Oregon facilities have more than a 90- percent screening rate for MST
- VA MST screening is essential; however, finding sufficient MST counselors to meet needs identified through the universal screening remains a challenge
- Lack of available child care services has emerged as a barrier that prevents women veterans from receiving service[6]

Oregon is unique in that it does not have active-duty military bases that serve as focal points for veterans' services. The lack of a military base infrastructure can substantially reduce resources for veterans and limit community awareness and support for veterans' issues. On the other hand, Oregon's VA system is rather robust with a full-service VA Medical Center in Portland, a hospital in Roseburg, and the Southern Oregon Rehabilitation Center and Clinics in White City, just outside of Medford. The Boise VA Medical Center and the Walla Walla VA Medical Center also provide service for Oregon veterans in the eastern part of the state. There are 13 CBOCs with primary care and mental health services (Bend, Brookings, Eugene, Hillsboro, Klamath Falls, La Grande, Newport, North Bend, Ontario, Portland, Salem, Warrenton, and West Linn), two Outpatient Clinics with more limited services (Burns and The Dalles), the Vancouver campus, and five Vet Centers specializing in combat trauma mental health that also provide MST counseling (Bend, Eugene, Grants Pass, Portland, and Salem). Every OEF/OIF veteran receives five years of free VA health care, and veterans of all eras can enroll in VA health care, but the services they receive will be based on several factors, including service-connected disabilities, receipt of VA pension, income, and the award of a Purple Heart or POW status. Task Force members agreed that access to VA health care can be complicated and pointed out that not every veteran qualifies; however, for those who do access and receive VA health care, there is general consensus that the care is among the best offered in the country.

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6 Marcia Hall, PhD – VA Services for Women Veterans in Oregon PowerPoint Presentation November 17, 2009

According to Dr. Hall, the following services are offered to women veterans within the VA system:

- Primary Care
- Mental Health
    - PTSD Counseling
    - MST Counseling
    - In-Patient Psychiatric Treatment
    - Substance Abuse Treatment (In-Patient and Residential mixed-gender only available in Oregon)
    - Psychological Evaluation
    - TBI Evaluation and Treatment
- Family Planning
- Pregnancy Care – VA Maternity Benefits
- OB/GYN
    - Tubal Ligations/Surgical Sterilizations
    - Infertility Evaluation
    - Cervical Cancer Screening
- Mammography/Breast self-care
- Osteoporosis Evaluation and Treatment
- Nutrition and Weight Management
- Healthy Living Guidance specific to women veterans
- Menopause Management
- Incontinence Treatment
- HIV/STD Testing[7]

While, on paper, services to women look impressive, the current landscape for women veterans' health care in Oregon is more complicated. Across the nation and here in Oregon, the VA is currently undergoing a time of rapid change in building and transitioning care for women veterans. VA is working to implement new internal policy mandating gender-specific and appropriate care for women veterans, but to date has not attracted enough qualified clinicians to provide this care and, in some cases, is not meeting its own policy requirements.

Further complicating delivery of women veterans' health care is the fact that there are no protected resources for women veterans. Although VA policy requires VA facilities to implement new women's health-care initiatives and mandates designated (protected) funding and resources to achieve these policies, transitions and growth in women veterans care have not been forthcoming. Rather, women veterans' care funding comes out of the same budget sources as male veterans'. Because women's care has substantial ground to gain to attain a baseline with male veteran care, this funding structure is restrictive.

CHALLENGES AND OPPORTUNITIES IN MENTAL HEALTH SERVICES FOR WOMEN VETERANS

The VA recognizes that many women veterans have mental health needs; and while some, but not all, VA facilities have counselors serving women veterans, the VA cannot currently meet the demand as evidenced

7 Marcia Hall, PhD – VA Services for Women Veterans in Oregon PowerPoint Presentation November 17, 2009

by caseloads exceeding 100 veterans per counselor (a caseload generally acknowledged as twice what is manageable and safe). At present, the VA has no identified plan to contract mental health services in the community as one means to provide more timely and appropriate mental health care. And at facilities that do use Fee Services for MST care, there is no established training on 'best practices' and critical components of care, and no guidelines or clinical oversight for community providers of that care.

Newer women veterans are accessing VA health care at an unprecedented rate with estimates that women veterans utilizing the VA will double between 2009 and 2014. However, barriers to appropriate care still exist, including complex enrollment requirements, challenging rural access, stigmatization, fear of receiving mental health care in a male-centric culture, and not being considered a "real" veteran by the providers delivering care. Women OEF/OIF veterans are screening positive for MST at alarming rates (19 percent) while, as noted above, the VA does not have enough qualified and trained counselors to meet the demand statewide. In addition, there are no dedicated, in-patient, specialized treatment beds in Oregon or the Northwest Region for women veterans with PTSD, MST, or Substance Abuse. This lack of treatment beds has been recognized as a key gap in services and potentially leaves women veterans without needed mental health care. Extensive and expansive new policies, dramatic increases in women veterans needing health-care services, coupled with the fact that the VA has not explicitly resourced its woman veteran programs in Oregon, creates somewhat of a paper tiger. As one Task Force member put it, "If the VA would actually implement all its policies, we wouldn't need a task force."

It is clear the VA as an organization as well as the many dedicated professionals at the federal level and in Oregon are working to meet the needs of women veterans. However, it is also clear there is significant work to be done before Oregon has a working system that provides appropriate, gender-specific care to all of its women veterans.

MILITARY SEXUAL TRAUMA – INCREASING CAPACITY FOR CARE

"Evidence suggests that the problems and the after affects of MST continue to be leading health consequences of military service for women" [8]

The Task Force spent a great deal of energy learning about MST. According to Sonja Fry, LCSW, 22 percent of women veterans have experienced MST, and 55 percent have experienced severe sexual harassment.[9] These figures result in mental health issues, including Post Traumatic Stress Disorder, Depression, Anxiety, Suicidal Ideation, and Suicide. Not only does MST cause psychological damage, but it also has significant medical consequences, including:

- Sleep Disturbances
- Diabetes
- Chronic Pain
- Gastrointestinal Disorders
- Gynecological Problems
- Heart Disease
- Asthma and other Respiratory Problems
- Cancer (Breast and Cervical)

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8 Carol Turner, past Director VA Women's Healthcare Teleconference July 2003

9 Sonja Fry, LCSW Military Sexual Trauma PowerPoint Presentation December 9, 2009

- Dissociation/Memory Loss
- Non-Specific Immune System Disorders
- Substance Abuse
- Suicide[10]

Responding to MST is a complicated health-care problem made more difficult to treat because women abused in the military often are not comfortable using the VA – and organizations associated with the military – for their mental and physical health needs. The VA provides free counseling to any veteran (male or female) who self-identifies as having been sexually traumatized in the military; however, self-identification to an organization such as the VA can be traumatic in itself.

The issue of MST is quite complex. According to Carole L. Turner, former VA director of women's health care, "Sexual violence that occurs in the military environment, especially during times of war…often means that the victims are relying on their perpetrators (or associates of the perpetrator) to provide for basic needs, including medical and psychological care…and for their survival." [11]

Vital to understanding MST is understanding the central role of unit cohesion in the military. Dr. Hall notes that "Unit Cohesion" is central to the military experience and unfortunately can become a compounding and destructive factor complicating recovery from sexual violence in the military. The implied or stated threat of destroying unit cohesion functions to keep women silent even long after they leave the military.[12]

The Task Force was most concerned about the ability of veterans to access appropriate MST counseling throughout the VA system in Oregon. According to Fry, her caseload at the Eugene CBOC is more than 116 patients of which 80 percent are female, and 20 percent are male. The Task Force asked the Women Veterans Program Managers and other VA mental health providers if that was a reasonable caseload. All agreed that it was not, stating that high caseloads impact both the patient's ability to seek appointments in a timely manner and the counselor's ability to provide quality care. Task Force members determined through these conversations with professionals that a proper caseload would be no more than 60 MST clients per counselor. Ultimately, high caseloads will impact an organization's ability to recruit and retain professional staff. In turn, recruitment and retention will impact the quality and availability of care.

In discussions and inquiry, the Task Force also determined that if all Oregon women veterans who had experienced MST (one in five) were to access VA for services, the VA would not have the capacity to treat them given its already bloated caseloads. And, at the time of this report, White City and Roseburg lacked counseling services for MST. Given that one Task Force recommendation is to expand outreach services to women veterans, such outreach would logically increase demand for services at a time when the system is already stretched past capacity. Beyond these concerns, the Task Force believes that the VA may not always be the most appropriate or desirable place for a victim of MST to seek treatment, especially during the transition when the VA is working to become more sensitive to women veterans' needs, but has not yet achieved that goal. The Task Force strongly believes that veterans who have experienced MST should have the option to seek counseling from the provider of their choice at VA's expense.

The Task Force is also concerned about the proficiency level of providers within the VA system to deliver appropriate MST counseling. To remedy this, the Task Force is recommending that the VA put in place policies that require every VA facility to have a sufficient number of trained gender-specific MST counselors available to meet the needs of their client base.

10 Marcia Hall, PhD – VA Services for Women Veterans in Oregon PowerPoint Presentation November 17, 2009

11 Ibid

12 Ibid

According to both Dr. Hall and Fry, it is important that all VA providers receive specific training in MST to understand the connection between the emotional and physical symptomology and to become skilled at recognizing the red flags that may indicate a patient has experienced MST.

Lastly, because of the prevalence of MST, the Task Force recommends that the VA export its knowledge on MST, PTSD, and other topics to the civilian medical and counseling communities and provide continuing education to these providers in these areas.

IN-PATIENT TREATMENT BEDS

The Governor's Task Force on Veterans' Services began to explore the need for dedicated woman veteran, in-patient treatment beds. Within the VA system, there are three general types of psychiatric beds:

- **In-patient Acute Psychiatric Beds** are for treatment that is short-term (days to weeks) and involves intensive intervention for veterans at high risk for suicide or other acute psychiatric needs.

- **Residential Treatment Beds** are for long-term (months to years) counseling for issues such as alcoholism and other addictions.

- **Specialized In-Patient Treatment Beds** are for extended in-patient care (1-3 months) for a specific treatment issue such as PTSD, MST, Substance Abuse, or a combination of these mental health issues.

At one point, the previous task force was examining the possibility of repurposing the Eastern Oregon Training Center in Pendleton for use as a women veterans' specialized in-patient facility to treat PTSD, MST, and/or Substance Abuse. However, in working with the Portland VA Medical Center and receiving input from the VISN 20 Women's Mental Health Committee, the task force determined the concept to be unworkable due to several factors, including the Training Center's location across the street from a prison and down the hill from a mental facility. The VA did not feel that it was an appropriate setting for women veterans suffering from MST and PTSD, the main conditions to be treated at the facility, so the plan was abandoned.

The current Task Force understood there is a lack of psychiatric beds for women veterans in Oregon and set out to determine the current status and capacity of all types of psychiatric beds for women veterans available throughout the state and the NW region. The Task Force learned that in the VA in Oregon the current system of psychiatric bed care is as follows:

In-Patient Acute Psychiatric Beds are available at Portland, but these beds are not designated specifically for women. Rather, available beds are considered 'dual use' or 'swing' beds that can be used by both male and female veterans. The Director of the Roseburg VA Health Care System, Susan Yeager, reported in September 2010 that her facility has a designated women veterans' area, but the beds still could be used for male veterans. "We have a designated three bed dorm for women with Acute Psychiatric illness complete with separate bathroom and a lock on the door. We are buying two additional beds to place in the men's dorm to obviate the need to use the woman's dorm in the event we have no woman and a male needs an inpatient psychiatric bed."[13]

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13 Susan Yeager email dated September 13, 2010

- **Residential Treatment Beds** for the long-term care of women are now available at White City. These 10 residential beds are designated solely for women veterans. The environment has been developed with women veterans' special needs and requirements in mind. A woman veteran resident testified publicly that the availability of these beds has "saved my life."

- **Specialized In-Patient Treatment Beds** for PTSD, MST, and Substance Abuse designated for women do not exist in Oregon or in the NW region. The lack of any specialized in–patient treatment beds for women veterans in the NW was a priority concern of the past Governor's Task Force and remains a top priority for the current Task Force.

Environments that provide safety and address the unique and specific needs of women veterans are required by VA policy 1330.01 to exist in all levels of psychiatric care at all facilities.[14] The importance of safe environments for women veterans who are particularly vulnerable while receiving psychiatric care cannot be underestimated. A woman veteran who had been in an in-patient treatment program stated, "Part of my recovery depended on the knowledge that I was in a safe environment. A woman who has MST may fear men coming into her room; this very fear can cause additional and unnecessary anxiety in an environment that should be a place to heal and receive help."[15] The Task Force supports ongoing and continuous efforts in all facilities – VA and community based – to ensure that all women veterans receiving psychiatric care do so in a safe and therapeutic environment. The current system does support care for some women veterans some of the time, but only works if there are available beds either in a VA facility or in the community - both of which are not currently guaranteed.

CHILDCARE AND PAYMENT FOR PSYCHIATRIC CARE

Two other factors must be taken into consideration when approaching the need for all types of in-patient and residential treatment beds: Children and Payment.

In many cases, women veterans have children and are the sole caregivers for those children. Women veterans are often forced to decide between accessing the in-patient treatment they need and taking care of their children. The VA currently is exploring options for accommodating woman veterans with children, which will be a determining factor for care with some women veterans. The issue of child-care is a crosscutting issue for all types of psychiatric in-patient treatment and also argues for availability of care close to the community where the woman veteran resides. Proximity to children and other family members is often a critical component of therapeutic treatment. Thus, the Task Force supports expanding access to appropriate psychiatric care in both VA and community facilities throughout the state and the region.

Determining when the VA will pay for non-VA or community-based care is often a source of confusion and complaint. Should a woman veteran seek an in-patient psychiatric bed at the VA and instead be placed and cared for in a community facility, the VA must ensure that it is paying the bill for the treatment and not leaving the cost with the veteran, because the veteran is using a non-VA provider. Unfortunately, there are several scenarios by which this can occur. Veterans reported to the Task Force that non-payment "happens routinely." When VA does not have available psychiatric beds it *diverts* both male and female medical and mental health patients from its hospitals to community hospitals. Even though the VA has ordered and initiated the divert, the veteran is later billed for his or her community-based hospital stay, because the VA

14 VHA Handbook 1330.01 May 21, 2010

15 Task Force participant during a Task Force meeting

has not paid the bill. This burden of payment must be addressed. If a veteran seeks VA care, is enrolled in VA health care, and is diverted by the VA because the VA has no available beds, the VA should be responsible for that veteran's care and, therefore, has an obligation to pay the bill. Current individual remedies for disputed payments do not address the apparent systemic problem.

Providing acute in-patient beds, residential beds, and specialized in-patient treatment beds for women veterans is the responsibility of the federal VA. It is clear that in the past, the demand for such beds has been relatively low. However, in this new paradigm of thousands of women veterans with MST, PTSD, TBI, and other psychological conditions returning from war zones and seeking treatment, as well as those from past service eras learning of their benefits, the VA must move forward and develop designated women veterans' treatment beds for all levels of care.

The Task Force believes that VISN 20 has a unique opportunity to take the lead in creating regional, woman veteran, specialized in-patient treatment beds where women veterans suffering from PTSD, MST, and/or Substance Abuse can be treated with safety, dignity, and respect.

REACHING WOMEN VETERANS

The Task Force is making a number of recommendations aimed at reaching out to women veterans. During the Task Force's study, it determined women veterans have several unique characteristics that can affect their accessing health-care services including:

- Women veterans often do not identify themselves as 'veterans' and thus do not seek care at VA facilities.
- A number of women veterans do not even know they are veterans.
- Some eras of women veterans were not briefed about their veterans benefits upon discharge from the military.
- Women veterans can feel invisible as they are not readily or consistently recognized as veterans by their male peers, the VA system, and Veterans Service Organizations. Women veterans often are perceived to be wives, daughters, or mothers of veterans, but not the veterans, themselves.
- Due to traumatic experiences, some women veterans will not identify themselves as either 'traumatized' or as 'veterans' let alone both. This results in delay in seeking needed health-care services and can complicate and prolong treatment.
- Women veterans can feel as if their gender was taken from them in the military where they had to do everything as well or better than a male soldier. "We are soldiers first and women second," one Task Force participant affirmed.
- After initial engagement with the VA, some women veterans report they will never again return to the VA because of the way they were treated by staff.
- Women veterans' health issues are more complex, take more time to address, and do not easily fit into the VA health care's 20-minute appointment structure.
- Women veterans of past eras (Cold War, Vietnam, Korea) often are forgotten, as the main focus seems to be on OEF/OIF veterans who are receiving new, specialized, and prioritized attention and resources.
- Domestic violence and MST are epidemic among women veterans of all eras. Given the high rates of death, disability, and injury that result from these crimes, there has been inadequate response both within government and community agencies, and within faith communities. A coordinated systemic response is required.

Because only 7,361 Oregon women veterans out of 25,103 (29 percent) use VA benefits, there are nearly 20,000 women veterans in Oregon who may be eligible for benefits – and more importantly may need these benefits – who are not receiving the benefits they have earned through their military service. The Task Force believes it is a priority to reach these women veterans and, at a minimum, educate them about their benefits and then help them obtain those benefits. As noted earlier, many women veterans, especially older veterans, do not know their rights, benefits, and resources. ODVA, Veterans Service Officers, VHA, and Veterans Service Organizations all have a role to play in reaching out to these veterans.

The Task Force is recommending the Legislature work with the Oregon Congressional Delegation to seek funding for a Women Veterans' Mobile Health Care Unit that would travel rural and remote Oregon providing medical and mental health care to women veterans. The idea is simple: Meet the woman veteran where she is instead of making her travel to where she may not receive the gender-specific or mental health care that is required to treat her. The mobile unit could function as a very visible and accessible entry point for continuing health-care services. The VA is using mobile health-care buses with great success in other states, and is using the mobile Vet Center in Oregon with success as well. A Women Veterans' Mobile Health Care Unit could reach isolated women veterans in Eastern Oregon, Central Oregon, Southeast Oregon, and in coastal areas not serviced by a CBOC and where transportation to and from the area is often an acute concern. Given that Oregon is the 10th largest state by landmass in the nation, a Women Veterans' Mobile Health Care Unit is reasonable and could enhance visibility for women veterans while concurrently fulfilling their immediate health-care needs.

The Task Force also is suggesting more effort be put into partnering with rural resources, including the faith-based community and Tribes, to help support women veterans. For example, many faith-based organizations offer daycare, which could be used when women veterans need to travel to VA appointments and cannot take their children with them. These types of partnerships could help reduce barriers women veterans face in accessing health-care services.

Another outreach recommendation is to create a dedicated MST hotline, as well as a woman veteran "warm line" where women veterans who are not in crisis can call for advice and resources. Currently, there is a veteran suicide hotline and a military and veteran hotline, but nothing dedicated to women veterans or MST. Again, as discussed earlier in this report, women veterans experience a different set of issues than their male counterparts; it is unlikely a woman veteran will readily use a general military/veteran hotline number if she does not even consider herself a veteran and/or her issues are more sensitive and personal. A dedicated MST hotline would allow those veterans quietly suffering to reach out for help in a confidential and secure way. The warm line would provide women veterans a way to seek resources without fear of stigmatization, rejection, or hostility.

A 'win-win' opportunity to reach women veterans is to leverage the existing VA's expertise by having the VA provide continuing education to civilian providers to educate them on women veterans' health care and to partner with them – especially rural health care providers – to deliver quality women veterans' health care. This would require both a rollout plan and resources to support professional staff as trainers.

The Task Force also recommends creating a pro-active social network geared toward outreach to women veterans to draw them closer together in mutually supportive groups. The Task Force discussed current outreach efforts being implemented by the ODVA and realizes that, if successful, bringing more women veterans into the VA system will result in increasing need for capacity in an already burgeoning system. The

overriding principle of ensuring that all women veterans receive the benefits earned through their military service can in turn be used as evidence to drive further increases in needed capacity for VA, TRICARE, and community systems of care. The Task Force further recommends that the ODVA provide dedicated funding for staff, projects, and outreach for women veterans including expanding current support for the bi-annual Women Veterans Conference.

Linking public, private, community, Tribal, and faith-based organizations together in these outreach efforts would provide a range of services targeted specifically for women veterans where they live and allow them to engage the system in a more user-friendly manner.

CONGRESSIONAL ACTION

Congress has taken a keen interest in ensuring the VA meets the evolving needs of women veterans. U.S. Senator Patty Murray introduced the Women Veterans Health Care Improvement Act of 2009 (S. 597), which held the following provisions:

- Provides the VA with authority to care for newborn children of women veterans who are receiving maternity care from the VA.
- Requires that the VA implement a program to train, educate, and certify VA mental health professionals to care for women with sexual trauma using evidence-based treatments.
- Requires the VA to begin a pilot program that provides childcare to women veterans who seek mental health care services at the VA.
- Requires that the VA begin a pilot program that provides readjustment counseling to women veterans in group retreat settings.
- Requires the inclusion of women who are recently separated from service on VA advisory boards.
- Authorizes a study of women who have served in Iraq and Afghanistan to assess the effects of those conflicts on their physical, mental, and reproductive health. This study would be conducted by an independent, non-VA organization and submitted to Congress.
- Requires the Secretary of the VA to conduct a comprehensive assessment of the barriers women currently face in accessing care through the VA. Among the many factors the Secretary is required to consider are the availability of childcare and the personal safety and comfort of women.
- Requires the Secretary of the VA to submit to Congress a report verifying employment of full-time Women Veterans Program Managers at VA medical centers to ensure that the health-care needs of women veterans are met.[16]

In the House, Congresswoman Herseth Sandlin of South Dakota introduced her own Women Veterans Health Care Improvement Act (H.R. 1211) with the following provisions:

- Authorize $4 million for VA to conduct a study on barriers to accessing health care within the VA system for women veterans.

16 Senate Bill 597 US Senate Sponsor: Patty Murray (D-Washington)

- Authorize $5 million for VA to conduct a comprehensive assessment of the women's health-care program at each VA medical center. Further, requires VA to develop a plan to improve such services at each VA medical center. Mandates a report by VA within one year of the enactment of the Act and a GAO report within six months of the completion of VA's report.

- Authorize the VA to provide medical care for newborn children of women veterans receiving maternity care for a period of seven days beginning on the day the child is born.

- Mandate the VA to carry out a program to provide graduate medical education, training, certification, and continuing medical education for mental health professionals at the VA caring for veterans suffering from military sexual trauma and PTSD. Further, requires an annual report detailing the number of providers certified under such program, the number of women provided counseling, and other relevant data.

- Authorize appropriations of $1.5 million for each of FY 2010 and FY 2011 for the VA to conduct a childcare pilot program for patients in at least three VISNs.

- Require the VA to add recently separated women and minority veterans to serve on the Advisory Committee on Women Veterans and the Advisory Committee on Minority Veterans.[17]

Senator Murray's bill is in the Senate Veterans Committee. Congresswoman Sandlin's bill passed the House unanimously and also is in the Senate Veterans Committee. Both bills have bipartisan and veteran support.

The Task Force is encouraged by a number of developments relating to women veterans' health care, including:

- VA internal policy that strongly supports and articulates improvements in health care delivery to women veterans
- The mandate for and establishment of Women Veterans Program Managers in each VA facility
- Availability of comprehensive women's primary care at all Oregon VA facilities
- Congressional interest in improving health-care delivery for women veterans
- Independent studies that establish where VA needs improvement in health-care delivery for women veterans
- Oregon outreach efforts by the VA Women Veterans Program Managers, Vet Centers, and the Oregon Department of Veterans' Affairs

17 House Resolution 1211 US House of Representatives Herseth Sandlin (D-South Dakota)

CONCLUSION

It is clear by these developments that women veterans and their health-care needs are not going unnoticed. There is, however, work to do in all organizations and communities serving women veterans, including the following areas:

- Support and resources to implement VA policy into action
- Dedicated funding to VA women veterans' programs
- Appropriate funding for mental health to meet the demand
- Dedicated in-patient treatment beds specifically for women veterans
- Sufficient gender-specific and appropriate clinicians to meet demand
- Outreach to women veterans who have been marginalized over the years
- Dedicated funding for women veterans' projects in ODVA, including funding for the bi-annual conference
- Dedicated funding for Veterans Service Officerss specializing in women veterans' service claims.
- Building community collaborations with existing non-profits such as women's advocacy services and faith-based organizations
- Exporting VA clinical expertise to community professionals, agencies, and organizations

The Task Force recognizes this report not as the end, but rather the beginning of a strong focus on Oregon's women veterans. The Task Force recommendations are in line with the mission of HB 2718 and aligned with congressional actions aimed at the same mission. The Task Force firmly believes that implementing these 12 recommendations will advance actions that change the lives of women veterans in Oregon by providing them access to the quality health care they earned through their honorable military service.

LEGISLATIVE TASK FORCE
ON WOMEN VETERANS' HEALTH CARE

FINAL REPORT OCTOBER 2010

APPENDIX

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1330.01
Transmittal Sheet
May 21, 2010

HEALTH CARE SERVICES FOR WOMEN VETERANS

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook defines the scope of health care services to women Veterans. It delineates essential components necessary to ensure that all enrolled women Veterans have access to appropriate services, regardless of VHA site of care.

2. SUMMARY OF MAJOR CHANGES. This VHA Handbook incorporates the new standard requirements for the delivery of health care to women Veterans and specifies services that must be provided at each Department of Veterans Affairs (VA) Medical Center and Community-Based Outpatient Clinic (CBOC).

3. RELATED ISSUES. VHA Handbook 1330.02.

4. RESPONSIBLE OFFICE. The Chief Consultant, Women Veterans Health Strategic Health Care Group (13E) is responsible for the contents of this VHA Handbook. Questions may be referred to (202) 461-1070, or Fax at (202) 495-5961.

5. RECISSIONS. VHA Handbook 1330.1, dated July 16, 2004, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled to be recertified on or before the last working day of May 2015.

Robert A. Petzel, M.D.
Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 5/25/2010

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VHA SERVICES FOR WOMEN VETERANS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes the minimum clinical requirements to ensure that all eligible and enrolled women Veterans, irrespective of where they obtain care in VHA, have access to all necessary services as clinically indicated.

2. BACKGROUND

a. While women Veterans constitute a minority of Veterans, they represent a "critical mass" deserving the same level of services provided to male Veterans. The Women Veterans Health Strategic Health Care Group (WVHSHG) works to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment at VHA facilities nationwide. The Department of Veterans Affairs (VA) strives to be a national leader in the provision of health care for women, thereby raising the standard of care for all women.

b. The WVHSHG has adopted the following principles to provide the highest quality care for our women Veterans:

(1) Comprehensive primary care.

(2) Provided by proficient and interested primary care clinicians.

(3) Focused on safety, dignity, and sensitivity to gender-specific needs.

(4) Offering the right care in the right place at the right time.

(5) Using state-of-the-art health care equipment and technology.

3. AUTHORITY

a. Public Law (P. L.) 102-585, Veterans Health Care Act of 1992, Title I, enacted November 4, 1992, authorizes VA to provide gender-specific services, such as Papanicolaou tests (Pap smears), breast examinations, management of menopause, mammography, and general reproductive health care services to eligible women Veterans. In addition, this law authorizes VA to provide women Veterans counseling services needed to treat conditions related to sexual trauma experienced while serving on active duty.

b. P. L. 102-585 also mandates that a VHA official in each region must serve as coordinator of women's services with specific responsibility for assessing the needs of and enhancing services for women Veterans. As a result of the realignment of VHA the position of Regional Women Veterans Coordinator is re-titled Deputy Field Director (DFD), Women Veterans Health Program.

c. P. L. 103-452, the Veterans Health Programs Extension Act of 1994, signed

November 2, 1994, authorizes VA to provide appropriate care and services for conditions related to sexual trauma. The law also made VA's authority to treat sexual trauma gender-neutral.

d. P. L. 104-262, Veterans' Health Care Eligibility Reform Act of 1996, required VA to establish and implement a national enrollment system. Maternity and infertility services, excluding in-vitro fertilization (IVF), are included in VA's Uniform Medical Benefits package.

e. P. L. 106-117, Veterans Millennium Health Care and Benefits Act, signed November 30, 1999, extended VA's authority to provide counseling and treatment for conditions related to sexual trauma.

f. VA's Uniform Medical Benefits package includes pregnancy and delivery services as authorized by law and certain medically necessary infertility services. ***NOTE**: See Title 38 Code of Federal regulations (CFR) Sections 17.38(a)(1)(xiii) and 17.38(b) [care needed to promote, preserve, or restore health]*. Abortions, abortion counseling, and in-vitro fertilization (IVF) are expressly excluded from the medical benefits package. ***NOTE:** See Title38 CFR , Section17.38(c)(1) & (2).*

g. Section 1720D of Title 38, United States Code, as amended by P. L. 108-422, Veterans Health Programs Improvement Act of 2004, grants VA permanent authority to provide counseling and treatment for conditions related to military sexual trauma and extends eligibility to Veterans who experienced sexual trauma while on active duty for training (ADUTRA) status.

h. P. L. 110-387 enhances domiciliary care for women Veterans, and requires that VA Domiciliary programs are adequate, with regard to capacity and safety, to meet the needs of women Veterans.

4. DEFINITIONS

a. **Co-Location:** Primary care and gender specific specialty care in the same physical location in order to optimize care delivery.

b. **Comprehensive Primary Care for Women Veterans**: The provision of complete primary care and care coordination by *one primary care provider at one site*. The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs, including:

(1) C**are for Acute and Chronic Illness:** Routine detection and management of acute and chronic diseases commonly seen in primary care including, but not limited to: acute upper respiratory illness, cardiovascular disorders, screening for cancer of the breast and cervix, osteoporosis, thyroid disease, chronic obstructive pulmonary disease (COPD), etc.

(2) **Gender-Specific Primary Care:** Contraception counseling and care, sexually transmitted infection (STI) treatment, pharmacologic issues related to pregnancy and lactation, management of menopause-related concerns, initial evaluation and treatment of gender-specific conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, urinary incontinence, etc.

(3) **Preventive Services:** Age-appropriate cancer screening, nutrition counseling, weight management and fitness counseling, STI screening and counseling, smoking cessation counseling and treatment, immunizations, etc.

(4) **Mental Health Services:** Assessment and psychosocial treatment as needed for a variety of mental health disorders, which include depression and problem drinking, within the parameters of Mental Health-Primary Care integration.

(5) **Coordination of Care:** Coordinating care and communicating with specialty providers regarding evaluation and treatment plans to ensure care continuity.

NOTE*: It is important to recognize that those women's clinics offering only gender-specific care (Pap clinic or gynecology care alone) do not meet the definition of comprehensive primary care given above). Primary Care may be delivered utilizing a team model, but it is expected that gender-specific primary care is provided by the same clinician that renders other routine Primary Care, preferably without multiple encounters or visits scheduled over different days.*

c. **Designated Women's Health Primary Care Provider (WH PCP):** A primary care provider who is interested and proficient in women's health. A designated WH PCP is preferentially assigned women Veterans within their primary care patient panels.

d. **Exclusive Space:** A separate physical location, for the delivery of primary care to women Veterans, not shared by other services providing care to male veterans.

e. **Facility:** Includes all freestanding medical centers, parent facilities and their divisions, Community-Based Outpatient Clinics (CBOCs), and independent clinics.

f. **Separate Shared Space:** A separate physical location for the delivery of primary care to women Veterans. This location may be used by other services on days when women Veterans are not being seen.

g. **Military Sexual Trauma (MST) (defined according to Title 38 U.S. Code 1720D):** "physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while a Veteran was serving on active duty or active duty for training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." The location where the sexual trauma occurred, the genders of the people involved, and their relationship to each other do not matter.

5. SCOPE

Each VHA facility must ensure that eligible women Veterans have access to comprehensive medical care, including care for gender-specific conditions and mental health conditions, that is comparable to care provided for male Veterans.

a. All enrolled women Veterans need to receive comprehensive primary care from a designated WH PCP who is interested and proficient in the delivery of comprehensive primary care to women, irrespective of where they are seen (freestanding medical centers, primary facilities, community-based outpatient clinics (CBOCs), and independent clinics).

b. Each medical facility must have a designated full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health issues that improves the overall quality of care provided to women Veterans.

c. Privacy must be provided to women Veterans in all health care settings.

(1) A review to evaluate structural, environmental, and psychosocial patient safety and privacy must be conducted on an annual basis and incorporated into routine environment of care rounds. ***NOTE:*** *It is recommended that at a minimum, rounds include Facilities Management/Engineering, the Associate Director or designee, and the Women Veteran Program Manager.*

(2) Each VHA facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for women Veterans. ***NOTE****: See Appendix A for a checklist for minimum standards for environmental privacy and security.*

d. A female chaperone **must** be in the examination room during examinations, procedures, or treatments involving the breast and genitalia, regardless of the gender of the provider. In addition to breast examinations and pelvic examinations, and Pap smears, this may include procedures such as Urodynamic testing or treatments such as Pelvic Floor Physical Therapy.

(1) The following staff may function as female chaperones (health technicians, nurse's aides, Licensed Practical Nurses) for all gender specific examinations (breast, genitalia and rectal). Female chaperones need to be provided irrespective of whether the examination is being performed by a male or a female provider.

NOTE: *Female Volunteers may be used as chaperones when a specific position description outlining the duties and expectations has been written in collaboration with the Chief, Voluntary Services, the position description has been approved, and staff have been educated on the role limitations of the Volunteer chaperone (VHA Handbook 1620.1). Female Volunteer chaperones will have had prior experience working in a clinical health care environment (such as an RN, LPN or health technician).*

(2) A chaperone must be present at all gender specific exams, procedures, or treatments and when requested by a female Veteran for any visit. Chaperones help with the set up for Pap smears and Pelvic examinations; assist the Veteran with dressing and undressing, and provide gowns and other dressing apparel to the Veteran. If chaperones are utilized, duties should *not* be of a nature that would require credentialing/privileging.

6. RESPONSIBILITIES OF THE CHIEF CONSULTANT, WVHSHG

The Chief Consultant WVHSHG is responsible for the management, administration, technical aspects, program planning, policies, evaluations, integration and implementation of the national Program's activities. These programs include activities related to clinical services evaluation and coordination of women Veterans health care, women Veterans' health policy, epidemiology and research. It also includes other women Veterans' health issues as defined by VA on an evolving and as-needed basis.

a. The Chief Consultant, in collaboration with Patient Care Services, develops and implements national directives, program initiatives, and VHA guidance related to women's health issues.

b. The Chief Consultant initiates, promotes, and leads effective collaborations with Veterans Integrated Service Network (VISN) and facility Directors to integrate the delivery of comprehensive health care services to women Veterans across the national health care system and continuously evaluates and improves the delivery of health care to women Veterans.

7. RESPONSIBILITIES OF THE VISN DIRECTOR

Each VISN Director is responsible for:

a. Ensuring that a Lead Women Veterans Program Manager (WVPM) is designated to serve as the VISN representative on women Veteran's issues and as a member of the WVHSHG Field Advisory Group.

(1) The VISN Lead WVPM needs to have direct access to top management in the VISN and serve on appropriate administrative and clinical boards or committees.

(2) It is highly recommended that the Lead WVPM also have VISN level funding and staff support for data analysis and project implementation, as well as money for travel to meetings with the facility-level WVPMs in the VISN.

b. Ensuring that a planning and implementation team for comprehensive primary care for women Veterans has been established at every facility and that the requirements in this handbook are carried out.

c. Ensuring that all staff members assume the responsibility of caring for women Veterans.

NOTE: *VHA Handbook 1330.02, Appendices A and B describe work performed at the Network level.*

8. RESPONSIBILITIES OF THE FACILITY DIRECTOR

Each Facility Director is responsible for:

a. Ensuring that all staff members assume the responsibility of caring for women Veterans.

b. Ensuring that a multi-disciplinary planning and implementation team for comprehensive primary care for women Veterans has been established.

c. Appointing a clinical health care professional as full-time WVPM who is sensitive to the needs of women in VA health care facilities.

(1) VHA Handbook 1330.02 details the duties and responsibilities of health care professionals who perform the duties of the WVPM and provides in-depth detail for position descriptions and functional statements for the WVPM role.

(2) As of December 1, 2008, each facility must have a designated full-time WVPM.

(a) The position is mandated to be a full time administrative position with minimal allotment of clinical time (1/8 FTEE) to maintain clinical competency.

(b) The WVPM must be a health care professional such as a Registered Nurse (RN); Social Worker or Psychologist; Doctor of Medicine (MD/DO); Nurse Practitioner (NP); Physician Assistant (PA); Pharmacist; or other allied health care professional.

d. Ensuring that the WVPM has direct access to top management in the facility and serves on appropriate administrative and clinical boards and/or committees.

e. Ensuring that the name, location, and business telephone number of the WVPM is posted and appropriately publicized in each facility (e.g., on the facility website and accessible through the facility locator web tool).

f. Ensuring that when a new full-time WVPM is appointed, the name, title, commercial telephone number, and e-mail address is submitted to the appropriate Deputy Field Director (DFD) and to the VISN Director within 10 working days. The DFD then notifies the VHA WVHSHG which maintains a listing of current WVPMs.

g. Ensuring the appointment of a Women's Health Medical Director or a Women's Health Champion.

h. Ensuring that an individual is designated at each facility to enter data from women Veterans' health care services provided by the facility into existing software packages or other formal mechanisms. ***NOTE****: This individual must be a clerical support staff member and not the clinical professional providing the care.*

i. Ensuring support for data analysis and project implementation and sufficient resources to support quality and follow-up care.

j. Ensuring that each Community-Based Outpatient Clinic (CBOC) has a Women's Health Liaison who collaborates with the WVPM at the parent facility.

9. RESPONSIBILITIES OF CLINICAL EXECUTIVE LEADERSHIP

Facility Clinical Executive Leadership is responsible for:

a. Ensuring that clinical leadership, in Primary Care, Mental Health, and Specialty/Acute Care, plan and implement equitable, high quality, comprehensive healthcare services for women Veterans, including gender specific services, in a secure and sensitive environment in all areas of the facility.

b. Ensuring excellent and equitable achievement on all clinical gender neutral and gender specific performance measures in the facility and CBOCs.

c. Participating in a multidisciplinary planning and implementation team for comprehensive care of women Veterans.

d. Working closely with the WVPM and Women's Health Medical Director/Clinical Champion.

e. Holding Primary Care leadership accountable for identifying designated interested and proficient women's health primary care providers at each facility and CBOC.

f. Ensuring the medical staff members providing women's comprehensive primary care are appropriately proficient, credentialed and privileged.

10. RESPONSIBILITIES OF PRIMARY CARE LEADERSHIP

Primary Care Leadership is responsible for:

a. Excellent and equitable achievement on all primary care gender neutral and gender specific performance measures in the facility and CBOCs.

b. Participating in a multidisciplinary planning and implementation team for comprehensive care of women Veterans.

c. Working closely with the WVPM and Women's Health Medical Director/Clinical Champion.

d. Ensuring that designated, interested and proficient comprehensive women's primary care providers are appointed at each facility and CBOC.

11. RESPONSIBILITIES OF THE WOMEN VETERANS PROGRAM MANAGER (WVPM)

The WVPM is responsible for:

a. Executing comprehensive planning for women's health issues that improves the overall quality of care provided to women Veterans and achieves program goals and outcomes.

b. Collaborating with and coordinate planning efforts with the WVHSHG.

c. Attending national conference calls held monthly to learn about ongoing initiatives to improve women Veteran's care.

d. Assessing the need for and implementation of services for women Veterans and providing oversight to ensure identified needs are met.

e. Collaborating with primary care providers to ensure that the needs of women Veterans are met in a comprehensive manner.

f. Working in coordination with diagnostic services to develop, implement and maintain a formal tracking mechanism to assure proper and timely notification of gender-specific diagnostic studies.

g. Participating in the regular review of the physical environment, including formal review of all plans for renovation and construction, to identify potential privacy and safety deficiencies and facilitate availability and accessibility of appropriate equipment for the medical care of women.

h. Partnering with the local Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Coordinators to ensure that OEF and OIF women Veterans have access to and receive priority, quality, comprehensive primary and gender-specific health care and services.

i. Partnering with leaders from all other applicable programs such as the Military Sexual Trauma (MST) Coordinator, Homeless Coordinator and the Minority Veterans Coordinator at the facility.

j. Working with acquisitions and contracting to have input on contracts that impact the delivery of services to women Veterans (e.g., contracts for radiology and mammography, maternity and infertility, gynecology, , grant and per diem, and CBOCs) .

k. Working with CBOC liaisons to facilitate patient-related issues.

l. Assuring that local policies and procedures guarantee proper and timely notification of gender-specific diagnostic study results.

m. Conducting outreach activities such as: mailings, public speaking, public service announcements (PSAs), health fairs, recognition ceremonies, brochures, workshops, newsletters, newspaper articles, website maintenance, educational seminars, focus groups, and town hall meetings or forums where women Veterans have the opportunity to provide input and feedback to program staff and facility management.

n. Organizing "Inreach" activities (internal marketing to Veterans already using the system and to facility staff). This may include educational seminars, in-service programs and workshops, new employee orientation activities, and customer feedback mechanisms.

12. RESPONSIBILITIES OF THE WOMEN'S HEALTH MEDICAL DIRECTOR OR CLINICAL CHAMPION

The Women's Health Medical Director or Clinical Champion is responsible for:

a. Working closely with the WVPM, forming the foundation of the women's healthcare team.

b. Serving as a clinical leader for women's health.

c. Working in collaboration with Primary Care Leadership and participates in all Primary Care Leadership meetings at the facility level.

d. Establishing priorities and direction for implementing quality improvement and is held responsible for excellent achievement on quality measures that apply to women's health.

e. Developing or supervising clinical education programs for women's health providers and trainees.

f. Participating in groups created for Women's Health Medical Directors.

13. RESPONSIBILITIES OF THE WOMEN VETERANS HEALTH COMMITTEE (WVHC)

a. Each VHA facility must have a WVHC to assist the WVPM in carrying out duties and responsibilities of that position, and to provide recommendations to leadership for improving services and programs for women Veterans.

b. The WVPM should chair the WVHC, but at a minimum must be a member of the committee.

c. Membership on the committee may include, but is not limited to: representatives from clinical services such as primary care, specialty care (gynecology, radiology, oncology surgery), nursing services, pathology and laboratory services, pharmacy, extended care, prosthetics, domiciliary care, chaplain, social services, behavioral and mental health services, public and consumer affairs, OEF and OIF Team, Minority Veteran Coordinator, Patient Representative, member from management team office (Director or Chief of Staff), Readjustment Counseling Service (RCS), Veterans Benefits Administration (VBA), homeless programs. ***NOTE:*** *In compliance with the Federal Advisory Committee Act, 5 U.S.C. App., women Veteran consumers, representatives of Veteran Service Organizations (VSOs), and other non-Federal employees may only serve as consultants to the WVHC. Consultants do not regularly attend WVHC meetings and do not participate in any collective fact finding, dispensing of advice, or decision making. Consultants provide only individual advice and factual information as requested by the WVHC.*

d. Minutes of the committee must be distributed to committee members with reporting requirements to include routing to the Clinical Executive Leadership and the medical facility Director.

e The WVHC needs to meet, at a minimum, quarterly. ***NOTE:*** *Monthly or bi-monthly meetings are more conducive to achieving productivity and outcomes.*

14. COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS

VHA policy maintains that the full scope of primary care is provided to all eligible Veterans seeking on-going health care. Therefore, regardless of the number of women Veterans utilizing a particular facility, all sites that offer primary care services must offer comprehensive primary care to women Veterans. The WVHSHG works in close collaboration with Primary Care, Mental Health, and Specialty and Acute Care to ensure: equal access to high quality health care services in all sectors for women Veterans; care is provided in a sensitive environment, and all necessary gender specific services must available at every facility and CBOC.

a. **Patient Centered Medical Home (PCMH) Standards.** Comprehensive primary care is fully consistent with the principles of the PCMH. The PCMH standards of patient centeredness, access, continuity, and coordination of care in the setting of team based care must be applied in delivering primary care for women Veterans.

b. **Assignment to a Designated WH PCP.** Each woman Veteran enrolled for primary health care must be assigned to a WH PCP who assumes responsibility for providing, coordinating and ensuring continuity of care.

(1). All enrolled women Veterans must receive comprehensive primary care from a designated Women's Health Primary Care Provider (WH PCP) who is interested and proficient in the delivery of comprehensive primary care to women, irrespective of where they are seen (freestanding medical centers, primary facilities, (CBOCs), and independent clinics). ***NOTE:*** *An interested provider is one who is knowledgeable, concerned, engaged, and willing to participate in the primary care of women.*

(2) Women Veterans who are already assigned to a Primary Care Provider (PCP) who is not a designated WH PCP, must be offered the opportunity for reassignment to a designated WH PCP.

(3) To ensure that women Veterans receive equal opportunity to change PCPs, requests for PCP reassignment from women Veterans will be honored and processed according to facility standard procedure, even if the request is for a non-WH PCP.

(4) In all cases, arrangements must be made to provide this gender-specific care within the Primary Care setting.

(5) Designated WH PCPs must be preferentially assigned women Veterans within their primary care patient panels. ***NOTE:*** *This model allows these providers to maintain their clinical skills in delivering comprehensive primary care to female Veterans.*

(6) Each facility must ensure that an appropriate number of designated WH PCPs is available at every site to ensure that all VHA access goals are met for women Veterans.

c. **Mental Health Services.** A required component of comprehensive primary care involves receipt of basic mental health services in the same physical location as primary care, thus integrating services and improving the quality of care delivered to women Veterans. Patients requiring more intensive comprehensive and specialized mental health services will be referred to Mental Health Clinics.

(d) **Choice of Provider.** Facilities need to give women Veterans the option to designate their preference for a female or male provider. When a woman Veteran requests a female or male provider, accommodation must be made. Fee basis can be used if necessary to ensure the request but time/access measures should be suspended.

15. WOMEN'S HEALTH PRIMARY CARE PROVIDER PROFICIENCY

Proficiency in the core concepts of primary care women's health is required to provide comprehensive primary care for women. Essential components include, but are not limited to: pelvic/breast exams; contraception counseling and management; management of osteoporosis, menopause, pelvic pain, abnormal uterine bleeding, and sexually transmitted diseases; in addition to screening for breast and cervical cancer or, a history of sexual trauma. ***NOTE:*** *See Appendix B for a detailed list of provider competency standards which include primary care competency with gender specific manifestations and basic gender specific competencies.*

a. The designated WH PCP must be fully proficient in providing the complete range of primary care.

(1) Retraining of interested primary care providers may be required, as will recruitment of new primary care providers who are able to provide comprehensive primary care for both men and women.

(2). To maintain proficiency in women's health, each site must ensure that the patient panel of every designated WH PCP is comprised of at least 10% female patients. Each designated WH PCP will spend at least one-half day every week practicing or precepting in a women's health practice.

(3) For VHA facilities where women's health is integrated into primary care, a designated WH PCP must have a number of female patients assigned to them to ensure a practice experience equivalent to those participating in a women's clinic one-half day every week. This number needs to be 120 patients under the current PCMM guidelines. If insufficient numbers of female patients are available to maintain a panel inclusive of 10% women, an alternative plan to ensure ongoing proficiency must be implemented at a local level and may include:

(a) A provider being precepted at a VA women's clinic on a regularly scheduled basis, or

(b) Working with a contractor to hone practice skills.

(4) Each facility must participate in and support an ongoing staff and provider education plan to promote, improve, and maintain skills and proficiency in women's health to all interested primary care providers. All primary care providers must be encouraged to provide women's

health services. ***NOTE:*** *Incentives, such as inclusion of WH services in the provider performance pay, need to be strongly considered at a facility level.*

16. DELIVERY OF COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS: CLINIC MODELS

All women Veterans must be assigned to receive comprehensive primary care conveniently located to their place of residence. A facility may choose one or more of the following Comprehensive Primary Care Clinic Models to best meet the needs of women Veterans and to achieve the standards for Comprehensive Primary Care for Women Veterans.

a. **Model 1. General Primary Care Clinics.** Comprehensive primary care for the women Veteran is delivered by a designated WH PCP who is interested and proficient in women's health. Women Veterans are incorporated into the WH PCP panel and seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the general gender-neutral Primary Care Clinic in accordance with the Primary Care-Mental Health Integration. Efficient referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance (less than 50 miles).

b. **Model 2. Separate but Shared Space.** Comprehensive primary care services for women Veterans are offered by designated WH PCP(s) in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.

c. **Model 3. Women's Health Center (WHC).** VHA facilities with larger women Veterans populations are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high quality comprehensive care to women Veterans.

(1) WHC offers comprehensive primary care services by a designated WH PCP(s) in an exclusive separate space. Whenever possible, a WHC needs to have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity and physical comfort.

(2) Specialty gynecological care, mental health and social work services must be co-located in this space.

(3) Other sub-specialty services such as breast care, endocrinology, rheumatology, neurology, cardiology, nutrition, etc., may also be provided in the same physical location.

(4) Women Veterans receiving comprehensive primary care through general primary care clinics in sites with WHC need to be referred to the WHC for gynecological care, mental health treatment, and other sub-specialty care.

NOTE: *Specialty gynecology clinics may not be utilized for routine breast and cervical cancer screening.*

17. SPECIAL CONSIDERATIONS IN THE DELIVERY OF COMPREHENSIVE PRIMARY CARE

a. **Appointment Times**

(1) Adequate appointment lengths for both new and follow-up visits are necessary to provide comprehensive primary care to women Veterans. It is recommended that appointment lengths for primary care visits be sufficient to allow time for gender-specific care during the primary care encounter.

(2) Appointment duration recommendations for all practice settings:

(a) New women's health appointment & Annual	60 min
(b) Routine follow-up appointment	30 min
(c) Urgent appointment	30 min

b. **Panel Sizes**. Strong consideration should be given to adjusting panel sizes downward to accommodate the unique needs of women Veterans in the primary care setting.

(1) Providers who have women Veterans in their panel will have their maximum panel size reduced proportionate to the number of women Veterans that they serve.

(2) The modeled panel size will be reduced by the number of unique patients equal to 20% of the total number of women Veterans in the mixed gender panel. This reduction will be similar for a physician or a nurse practitioner or physician assistant (mid-level provider).

c. **CBOCs**

(1) All female patients seen at CBOCs must receive the same high quality comprehensive primary care that is received by female patients at the parent facility.

(2) CBOCs and independent clinics must designate a Women's Health clinical liaison to coordinate women's issues with the parent facility.

(3) The proficiency standards as stated above in Paragraph 15 shall apply to all WH providers providing services at the CBOCs.

d. **Mobile Clinics.** Mobile Clinics that offer primary care services must assure equitable access to comprehensive primary care services for both men and women. This includes the provision of gender-specific primary care to women Veterans.

18. PREVENTIVE CARE FOR WOMEN VETERANS

Preventive care for women Veterans must include age-appropriate screening for colon, breast and cervical cancer. Preventive services must also include: nutrition counseling; weight

management and fitness counseling; sexually transmitted infection screening and counseling; smoking cessation counseling and treatment; counseling to reduce alcohol use; and immunizations, etc. Special consideration needs to be given to breast and cervical cancer screening.

a. **Breast Cancer Screening.** Breast cancer screening includes mammography, with or without clinical breast examination.

(1) **Mammography Program Standards.** ***NOTE:*** *Refer to 38 U.S.C. 7319(b) and VHA Mammography Handbook 1104.1 for full details regarding Mammography Program Standards. See FDA Mammography Standards Guidance at www.fda.gov\Radiation-EmittingProducts\MammographyQualityStandardsActandProgram\Guidance\PolicyGuidanceHelpSystem\ucm135583.htm* .

(a) Every mammography program must develop and document procedures for preparing a written report of the results of each mammography examination performed under its certificate, consistent with 21 CFR 900.12(c) and its subsections.

(b) When mammography services are obtained through contractual arrangements or sharing agreements, the referring VHA facility must ensure, prior to services being rendered, that the provider is certified by the Food and Drug Administration (FDA), or a State that has been approved by FDA under 21 C.F.R. 900.21 to certify mammography facilities.

(c) A written Standard Operating Procedure (SOP) sufficient to meet the requirements of 21 CFR 900.12(g) is required to ascertain which patients have breast implants, and to provide proper care for patients with breast implants prior to mammography.

(2) **Mammography Orders and Access**

(a) All screening and diagnostic mammograms must be initiated via an order placed into the VistA Radiology package. This order must be entered regardless of where the Veteran will obtain the mammogram. Fee basis or contract agreements must be electronically entered as a CPRS radiology order. All breast imaging and mammography results must be linked to the appropriate radiology mammogram or breast study order.

(b) Mammograms must be accessible within a reasonable (less than 50 miles) distance. If the Veteran lives more than a reasonable distance from a facility with a mammography suite, the study should be provided off-site at the closet facility thru fee-basis, sharing agreement, or other contractual arrangements to the extent the Veteran is eligible.

(3) **Mammography Report Tracking.** The in-house VA Mammography Program is required to establish and maintain a mammography medical outcomes audit process in accordance with the provisions found in 21 C.F.R. 900.12(f).

(a) Each VHA facility will establish and document a process for tracking results from procedures performed off-site, ensuring that required data is captured and entered into the Computerized Patient Record System (CPRS) Radiology Package. In addition, there must be a

process established at each facility that ensures timely tracking and follow up of all abnormal mammogram results.

(b) All mammography reports, regardless of where they are performed, must be entered in the Radiology Reports section of Veterans Integrated System Technology Architecture (VistA.) If the study was interpreted elsewhere, for example through Fee Basis, the hardcopy report must be scanned into VistA and electronically filed using the Outside Reports option of the Radiology Package. This 'electronic filing' attests:

1. To the correct entry of the report into the VistA Radiology Package,

2. That the report is for the patient for whom the procedure was ordered, and

3 That the report is electronically released for access, review and action by the patient's health care providers. The Final Assessment Category needs to be entered as a diagnostic code and will reflect the assessment category wording approved by FDA.

(4) **Patient Notification of Mammography Results**

(a) Each certified VA Mammography Program and off-site non-VHA mammography provider is required to establish a documented procedure to provide a lay summary of the written mammography report to the patient within 30 days from the date of the procedure. The documentation of letters, reports, and/or verbal communication with the patient in the patient's medical record must be in accordance with VA or Mammography Quality Standards Act (MQSA) standards and guidelines (ref: 21 C.F.R 900.12(c), et.seq.).

(b) When the mammography report assessment is "Suspicious" or, "Highly Suggestive of Malignancy," the lay summary results and recommended course of action should be communicated to the patient as soon as possible but no later than 5 business days after the mammogram. One way to achieve this is through documented direct verbal communication. However, prompt verbal communication does not obviate the need to also provide written communication to the patient within 30 calendar days of the date of the mammogram.

(5) **Ordering Provider Notification of Mammography Results**

***NOTE**: Separate VHA policies may set standards regarding communication of results for specific tests. When separate VHA policies exist that set standards for communication of specific test results, the shorter standard (of the separate policy or the 14-day standard of this policy) takes precedence. Communication must be documented in the medical record. The VHA ordering practitioner is expected to also communicate and document a follow up diagnostic or treatment plan. The fact that an outside Radiologist may discuss findings with the Veteran patient does not remove the obligation of the VHA ordering practitioner to discuss the findings and a follow-up plan with the patient.*

(a) Facilities are strongly encouraged to negotiate report turnaround times consistent with VHA policy in their mammography contracts. Current VHA turnaround timeliness is within 48 hours of the imaging study performance. In any case, the off-site (non-VHA) mammography

facility must supply mammography reports to the referring VA facility within 30 days of the date of the procedure. Electronic entry of the mammography report into the Radiology Package is sufficient notification to the ordering provider. Responsibilities for VHA on-site provider notifications may be found in VHA Handbook 1104.1.

(b) The off-site contracted mammography facility's interpreting physician must ensure the referring VHA practitioner or surrogate is contacted for results of "Suspicious" or, "Highly Suggestive of Malignancy," as soon as possible but no later than 3 business days after the mammogram procedure. Responsibilities for VHA on-site provider notifications may be found in VHA Handbook 1104.1.

(6) **Documentation of Breast Imaging Findings in CPRS**

The VHA ordering practitioner communicates the results of Breast Imaging Reporting and Data System (BI-RADS) Codecategories 0, 3, 4, 5 findings to the patient within 14 calendar days from the date on which the results are available to the ordering practitioner. Significant abnormalities may require review and communication in shorter timeframes and 14-days represents the outer acceptable limit. For abnormalities that require immediate attention, the 14-day limit is irrelevant, as the communication needs to occur in the timeframe that minimizes risk to the patient.

b. **Cervical Cancer Screening**

(1) Cervical cancer screening includes a speculum examination and cervical pathology evaluation performed by the primary care provider in accordance with VHA guidelines. The results of normal (NEM-No Evidence of Malignancy) cervical pathology must be reported to the ordering provider within 30 calendar days of the pathology report being issued. The interpreting physician must ensure the ordering provider is contacted with abnormal results within 5 business days.

(2) The cervical pathology report of Normal (NEM-No Evidence of Malignancy) results must be communicated to the patient in terms easily understood by a layperson within 14 days from the date of the pathology report becoming available. Documentation of a letter and/or verbal communication with the patient must be entered into CPRS. If using the United States (U.S.) Postal Service, confirmation of the receipt of these results is not required. For any abnormal cervical pathology report, the results must be communicated within 5 business days of the report being issued.

c. **Tracking and Timeliness**

The Quality Management team for each VHA facility, in collaboration with the Women Veterans Program Manager, Radiology Service, Pathology Service, and Primary Care Service will oversee the tracking and timeliness of follow-up of findings from breast and cervical cancer screening.

19. GENDER-SPECIFIC SPECIALTY CARE FOR WOMEN VETERANS

Gender-specific specialty services must include:

a. **Gynecological Care**

(1) A gynecologist will be available to both inpatients and outpatients for evaluation and treatment of:

(a) Gynecological conditions such as abnormal cervical pathology, uterine fibroids, endometriosis, polycystic ovarian syndrome, abnormal uterine bleeding, pelvic pain, and gynecological malignancies.

(b) Contraceptive needs such as implantable contraceptives, IUDs or surgical sterilization.

(c) Infertility (see inclusions and exclusions below).

(2) For VHA facilities that offer emergency care, a gynecologist needs to be available for consultation either on-site or via telephone.

***NOTE**: A female chaperone **must** be in the examination room during examinations or procedures involving the breast and genitalia, regardless of the gender of the provider (see Subpargraph 5d).*

(3) The patient needs to be evaluated within 30 days for a routine referral and within 7 days for an urgent condition. VHA facilities with a separate WH Center must co-locate gynecological services for women Veterans to the WH Center.

(4) The co-payment fee for routine Gynecology visits was changed from a specialty visit to basic co-pay effective FY 2008.

(5) Abortion and abortion counseling are excluded from the medical benefits package [38 CFR § 17.38(c)(1)]. With the decision to exclude abortions from the medical benefits package, VA also made a policy decision to no longer perform therapeutic abortions. RU 486 (mifepristone) is an abortifactant not available through VA pharmacies.

(6) Levonorgestrel (Plan B) Emergency Contraception is not an abortifactant and is available in VA pharmacies. A process must be implemented at the local or VISN level to ensure availability of emergency contraception to patients in a timely manner (same day).

***NOTE:** The VHA goal is that gender-specific specialty services need to be provided in-house to the greatest extent possible. If gender-specific specialty services are not available in-house, such services must be provided through fee-basis, contractual or sharing agreements, academic affiliates, or other VA facilities within a reasonable traveling distance (less than 50 miles).*

NOTE: *When a women Veteran requests a female or male gynecologist, accommodation must be made. In order to satisfy the patient request, referral to Network sites or use of fee basis may be utilized.*

b. **Maternity Care**

(1) VHA is authorized to provide comprehensive pre-natal, intra-partum and post-partum care to eligible women Veterans. Maternity benefits begin with the confirmation of pregnancy, preferably in the first trimester, and continue through the final post-partum visit, usually at 6-8 weeks after the delivery, when the Veteran is medically released from obstetric care.

(2) Each VHA facility must have a policy to identify the process for assessing pregnant women; identifying care that could be provided by VHA in conjunction with the Obstetrician (e.g., mental health, provision of medications, maintenance of chronic conditions, etc); identifying mechanisms for co-management of care, identification of risk factors, and change to high risk pregnancy status.

(3) VHA facilities may use the enhanced sharing authority (Title 38 United States Code (U.S.C.) 8153) to contract for services including pre-natal, intra-partum and post-partum care of the mother. If contracting for services is required, competitive bid is the first option to be considered. VHA facilities may negotiate non-competitive contracts with VHA affiliates or with practice groups associated with the affiliate when the services of affiliate faculty members are required to perform services under the contract. ***NOTE:*** *See VA Handbook 1663.*

(4) High-risk pregnancies and outpatient services may require individualized referrals using fee-basis, contractual or sharing agreements to the extent the Veteran is eligible.

(5) To furnish women Veterans with needed outpatient services on a fee basis, the Veteran must meet the eligibility criteria of Title 38 CFR Section 1703.

(6) Fee basis care is routinely used to provide maternity care within a reasonable distance of a Veterans' home, even when a contract is otherwise available. Maternity care must be provided within 50 miles or one hour of the Veterans' home.

(7) In the case that a pregnant Veteran needs immediate hospitalization prior to the establishment of a contract, fee basis can be used for this under the authority of Title 38 U.S.C. §1703(a)(4) and 38 CFR §17.52(4).

(8) The co-payment fee for Obstetric visits was changed from a specialty visit to basic co-pay effective FY 2008. Fee basis rules apply to co-payment rates for both individual visits and bundled billing of routine obstetric care. Additionally, the patient has no payment responsibility to the provider of non-VHA maternity benefits care for services that have been authorized in advance by VHA. Regulations prohibit "balance billing" of the difference between the providers' billed charges and VHA allowable payment for the services.

NOTE: *VHA should utilize the updated Management of Uncomplicated Pregnancy in the Primary Care Setting released in 2009 by the VA/DoD Evidence Based Clinical Practice Guideline Working Group as a reference to manage maternity care.*

(9) Maternity care needs to include appropriate (community standard) education and tools such as:

(a) Genetic consultation with a physician when clinically indicated,

(b) Childbirth preparation,

(c) Parenting education,

(d) Breastfeeding support and lactation classes, and

(e) Breast pumps.

NOTE: *Breast pumps and related supplies, when clinically indicated, can be obtained through a Prosthetics Consult at least two weeks in advance of the women Veteran's estimated date of confinement (EDC).*

(11) VHA is not authorized to pay for newborn services. It is essential that the Veteran be advised to make alternative arrangements for newborn care coverage prior to delivery. WVPMs are available to assist with information on Medicaid, State Child Health Insurance Programs, and other sources of newborn health insurance coverage.

c. **Infertility**

(1) Because medical remedies for infertility exist, medically necessary infertility services may be provided. Limited infertility services, such as assessment of reproductive capacity and treatment or correction of some obvious abnormalities, such as endometriosis or varicocele, are available at VHA facilities. Surgical reversal of tubal ligation is a covered benefit for treatment of infertility.

(2) VHA is not authorized to provide advanced reproductive in-vitro fertilization technologies.

(3) Infertility services, excluding in vitro fertilization, can be provided locally or through network referrals and negotiated comprehensive contract packages with consultants, contractual or sharing agreements, or through fee basis to the extent the Veteran is eligible. The package can be tailored to meet individual facility needs based on local expertise and resources. A very close relationship with the reproductive endocrinologist needs to be established to ensure that diagnostic results and efforts are not duplicated.

d. **Breast and Reproductive Oncology**

(1) Reproductive and breast oncology, and associated endocrinology, referrals need to be addressed through Network referrals, sharing agreements, academic affiliates, fee-basis, or in-house when available.

(2) Genetic testing is authorized when needed to make diagnostic, management, and secondary prevention decisions.

e. **Mental Health**

(1) Mental health services must be provided to women Veterans according to VHA Handbook 1160.01.

(2) VHA facilities that have a separate WHC should co-locate mental health services for women Veterans to the WHC. ***NOTE:*** *The privacy of the WHC space makes it an ideal location for such services.* If a WHC is not available, such as in CBOCs, it is strongly recommended that mental health services be provided in the same area that comprehensive primary care is offered.

(3) VHA facilities are strongly encouraged to provide Veterans being treated for conditions related to MST (women and men) the option of being assigned a same-sex mental health provider, or opposite-sex provider if the trauma involved a same-sex perpetrator.

(4) VHA facilities are strongly encouraged to make gender separate therapy groups available where needed. Staff must take full responsibility to address gender issues, such as safety and security, within mixed gender groups.

(5) The care environment is an integral component of the design of the outpatient mental health, in-patient psychiatry and residential milieu. The WVPM must participate in routine environmental rounds with special emphasis on improving privacy and security.

(6) Mental health program staff needs to collaborate with the WVPM in the design and implementation of VA residential and transitional housing programs as they relate to the privacy and security of women Veterans.

(7) Evidence based practices need to be provided in individual and group counseling.

f. **Care for Conditions Related to Military Sexual Trauma (MST)**

(1) All primary care providers must screen all women patients for military sexual trauma and appropriately refer for counseling and treatment as clinically indicated. Mental health services for conditions related to MST must be available at all VHA facilities. Referral to the local Vet Center may be an appropriate alternative.

(2) Full requirements for mental health services for conditions related to MST are found in VHA Handbook 1160.01. All VHA facilities must use the CPRS Clinical Reminder for MST to document screening and the encounter form checkbox for MST to indicate MST-related care, as

delineated in VHA Handbook 1160.01. ***NOTE:*** *This helps to ensure the accuracy of the facility's MST-related screening and treatment data and allows monitoring of MST-related care on a national level.*

NOTE: VHA acknowledges the gender-neutrality of sexual trauma experiences, and requires that all male veterans with a history of military sexual trauma have access to comparable standards of sexual trauma counseling programs and services.

20. URGENT/EMERGENT CARE

a. It is required that all VHA facilities have a mechanism in place whereby urgent and emergent care needs of women Veterans are met in an appropriate, timely manner with the highest quality of care during normal hours as well as during evenings, weekends and holidays.

b. All VHA facilities offering urgent care treatment for women Veterans during business and expanded business hours (i.e., same-day clinic appointments, urgent care appointments) are required to have the necessary equipment to treat female patients (tables, lights, Sexually Transmitted Infections (STI) kits, urine pregnancy tests, speculums, medications, etc) and to have appropriate supplies to make accurate and efficient diagnosis of vaginal and sexually transmitted infections at the point of care. This includes microscopes, slides, Potassium Hydroxide (KOH) solution, litmus paper, etc.

c. Point of care testing (CLIA waivers) should be considered as needed. ***NOTE:*** *Point of care testing may be accomplished online through www.medtraining.com*. VHA facility laboratories must assign a point of contact to track provider's completion of annual online training.

d. It is required that urine pregnancy tests be available at all sites (including CBOCs and mobile clinics). Additionally, every VHA facility laboratory must have the ability to perform a quantitative beta Human Chorionic Gonadotropin (HCG) level on a blood sample. Urine pregnancy and wet preps need to be processed within 15 minutes of delivery to the lab.

e. VHA facilities must ensure that all staff who provide urgent care treatment to Veterans receive regular training in women's health to maintain proficiency in topics such as, but not limited to: documenting a menstrual and obstetric history; evaluation of acute abdominal pain; vaginal bleeding in early pregnancy; and gender-based differences in the presentation of myocardial infarction and other disease processes.

f. VHA facilities must ensure that the 24 hour a day, 7 days a week (24/7) telephone triage system is staffed by professionals trained in and aware of the health care needs of female patients. The triage system needs to ensure that procedures are in place so that women Veterans are triaged and cared for according to the urgency of their condition.

g. VHA facilities with an Emergency Department that provides urgent and emergent care for Veterans after business hours must properly equip the Emergency Department to provide urgent and emergency care for women Veterans. Requirements include equipment and staff to treat female patients during normal business hours, as well as nights, weekends, and holidays. If

urgent care treatment is not available for certain conditions such as sexual assault evaluation, vaginal bleeding, or acute abdominal pain in a pregnant patient, or a pregnant patient in labor, these sites must have arrangements in place with a local or regional community facility that is able to provide the requisite care. VHA will transfer patients to such facilities safely and in accordance with VHA policy.

21. ADDITIONAL SERVICES FOR WOMEN VETERANS

a. **Prosthetics Services**

WVPMs need to work closely with the Prosthetics Service and Supply, Purchase and Distribution Department to ensure that supplies specific to women's health are properly stocked, easily requested, and provided in a timely manner (e.g., intra-uterine devices (IUDs), breast pumps, compression stockings, etc.).

b. **Tele-Health Programs**

(1) Women Veterans have specific health care needs that must be considered as Tele-health programs expand; services must be tailored to meet their needs.

(2) Consideration must be given to include women Veterans as part of these programs. Targeted goals need to be set to increase the enrollment of women Veterans in VHA proportional to the population of women Veterans.

(3) The Tele-health Program must develop specific training modules to update clinical providers in health care issues specific to women.

c. **Poly-Trauma Centers**

(1) It is necessary to ensure that services are tailored to the unique needs of women Veterans including ordering and stocking equipment and supplies that are the correct designs, sizes and fit for women Veterans.

(2) Staff needs to be trained to understand the unique needs of women and maintain privacy and security for women Veterans.

(3) Gender-specific specialty care in gynecology, uro-gynecology, mental health, oncology, neurology, etc., must be available within the polytrauma center or within the medical facility for women Veterans.

(4) Women Veterans must be assured basic and routine care in addition to the highly specialized care that they receive at Poly-trauma Centers.

d. **Physical Medicine and Rehabilitation**

It is necessary to ensure that services are tailored to the unique needs of women Veterans including ordering and stocking equipment and supplies that are the correct size and fit for women Veterans.

e. **Care for Women Veterans with Spinal Cord Injury/Disorders (SCI/D)**

(1) Women veterans with SCI/D must be followed as outlined in VHA Handbook 1176.1, Spinal Cord Injury and Disorders System of Care. Care may be provided within a women's health clinic or an SCI Clinic. The designated SCI primary care providers must provide or arrange for timely women's health care and gender specific screenings during the Veteran's annual evaluation. ***NOTE:*** *Veterans with SCI/D have difficulty accessing health care services due to mobility, transfers, and positioning, and often travel long distances for their health care.*

(2) When the SCI primary care provider or Veteran chooses to have these screenings done in a women's health clinic or by a WH PCP, pre-arrangements for this care during the annual evaluation (or when issues arise) must be made, or arrangements with Women's Health to provide the services within the SCI/D examination rooms, or through fee basis to an appropriately trained provider with accessible health care office space and equipment will be made.

f. **Pharmacy Services**

(1) It is strongly recommended that Women's Health Program officials (WVPM's, WH Medical directors, WH champions) assure that the unique medication needs of women Veterans are clearly communicated at the local, VISN and National levels.

(2) A process needs to be in place at the local or VISN level, to include CBOCs, to ensure availability of levonorgestrel (Plan B) emergency contraception to patients the same day of their appointment.

(3) All VHA facilities must have a mechanism to monitor the prescription of high risk **teratogenic** medications (FDA class D or X) which could be prescribed to women with the potential to become pregnant. Women need to be counseled on the risks and benefits of such prescriptions and documentation of patient counseling must be recorded in CPRS.

22. DATA COLLECTION

a. As part of VHA's program to assess and improve the quality of health care, a systematic data collection process must be initiated to collect information related to women Veterans' health care services. Identification of sources (data bases) to retrieve reliable data is essential. In addition to data about key performance measures and standards, new clinical guidelines, flowcharts, and other performance improvement tools are needed to standardize and improve outcomes of care.

b. Performance improvement activities need to include areas such as:

(1) Understanding and designing interventions to address the differences in quality measures for women Veterans compared to male Veterans.

(2) Screening and follow-up for military sexual trauma.

(3) Appropriate follow-up of abnormal mammograms and abnormal cervical cytology reports as well as timeliness to initiate treatment for breast and cervical cancer.

(4) Customer satisfaction initiatives and outcomes.

(5) Tracking of access and no-show rates as facilities implement comprehensive primary care for women Veterans.

23. GUIDELINES FOR WOMEN VETERANS' HISTORY & PHYSICAL EXAMINATION

a. The primary care provider must document a detailed history of the woman Veteran including; current and past medical and surgical history; a gynecologic and obstetric history; history of allergies; family history of disease; a psycho-social history including military service; and an occupational history.

b. Military service history must include: the branch and length of military service; location and period of deployment(s); type of work done for the military; possible exposures; and injuries or trauma experienced.

c. The initial intake history must include screening for military sexual trauma and must be done prior to the physical examination while the patient is fully dressed.

d. When clinically indicated, the primary care provider must also perform a complete physical examination that includes the head and neck, cardiovascular, respiratory, abdominal, musculoskeletal, and neurological systems. A complete primary care examination for women also includes a breast and genital examination.

e. If a patient is due for a cervical cancer screening examination and this is not included as a part of a complete physical examination, the reason(s) for deferring the examinations must be clearly documented in the medical record.

NOTE: *A female chaperone* ***must*** *be in the examination room during examinations or procedures involving the breast and genitalia, regardless of the gender of the provider. (See Subparagraph 5d).*

f. Patient dignity and privacy must be maintained at all times during the course of a physical examination. Privacy curtains must shield the actual examination area. Placement of the examination table needs to minimize inadvertent exposure of the patient during a physical examination i.e. the foot of the table must be facing away from the door. Examination room doors must have locks. Gowns, sheets, and other appropriate apparel must be available to protect

the patient's dignity and avoid embarrassment. The patient must never be asked to disrobe in the provider's immediate presence.

g. Appropriate draping techniques must be used during the breast and pelvic examination or during examinations or procedures when these areas are exposed (e.g., EKG, chest auscultation).

h. The provider must explain the necessity of a complete physical examination or the components being performed during the examination and the purpose of disrobing in order to minimize the patient's anxiety and possible misunderstandings.

i. Following a physical examination, the provider must discuss any positive findings with the patient and provide the opportunity for questions. The patient must be fully dressed during this discussion.

j. VHA has experienced increased use of camera and computer-based video technology for tele-health, resident training, security observation, etc. When establishing and reviewing these services, attention must be given to the privacy needs of Veterans. Veterans must be informed that cameras are in use before entering an active camera area. Consideration must be given to balancing the clinical activity with maintaining privacy and dignity. Active cameras must not be utilized while a Veteran is dressing or undressing for examinations, bathing, toileting, or engaging in similar activities. Installed cameras must be covered or shielded when not in use, even when turned off.

k. When medical students, Nurse Practitioner students, or Physician Assistant students participate in the provision of comprehensive primary care or gender-specific specialty care to women Veterans, they must be appropriately supervised as defined by relevant handbooks.

24. THE HEALTH CARE ENVIRONMENT

a. The health care environment directly and indirectly affects the quality of care provided to women Veterans. It affects their comfort and sense of security, as well as their perceptions of care received. Measures must be taken to maintain and adjust care environments to support their dignity, privacy, and security.

b. The privacy and security needs of women Veterans must be addressed when planning new construction, remodeling older facilities, or improving patient care programming. Annual reviews of the health care environment must occur in all VHA facilities to ensure that the environment promotes dignity, privacy, safety and security. The WVPM and appropriate members of the facility must participate in these reviews on a routine basis.

c. Each VHA facility must engage in an on-going, continual process to assess and correct physical deficiencies and/or environmental barriers to care for women Veterans. ***NOTE:*** *See appendix A for a checklist for minimum standards for environmental privacy and security.*

d. Other elements within the environment that are of special concern to women Veterans and require the input of the WVPM including, but are not limited to:

(1) Inpatient admissions and patient flow.

(2) Accommodations, with special emphasis on privacy in all examination rooms, sleeping areas, restrooms, bathing/shower facilities, and other areas such as physical medicine and rehabilitation therapy rooms when needed, cardiac stress test areas, etc. Women Veterans must have women only restrooms and bathing/shower facilities.

(3) Availability of personal hygiene products, female pajamas and robes, and hair care services and products.

(4) Diaper changing stations need to be available in designated male and female restrooms.

(5) Residential, domiciliary and long-term care facilities.

(6) Recreational and social programs including pool areas, gyms, and recreation halls.

(7) Separate rooms with appropriately locking doors (allowing staff to have key or code access in the case of emergency) are required for toilets, baths and showers.

e. Educational programs addressing attitudes and sensitivity toward women Veterans are essential components of orientation and in-service education of employees and trainees. Education needs to focus on, but not be limited to; sensitivity regarding women's military experiences; caregiver and parenting roles; intimate partner violence; sexual trauma; and sexual orientation.

f. **Ambulatory Care Dignity, Respect and Security**

(1) Veterans must be provided adequate visual and auditory privacy at check-in. Patient names are not posted or called out loudly in hallways or clinic areas.

(2) Veterans must be provided adequate visual and auditory privacy in the interview area.

(3) Patient-identified information must not be visible in the hall including charts where names are visible. Every effort should be made to restrict unnecessary access to hallways by patients and staff who do not work in that clinic area.

(4) The examination rooms must be located in a space where they do not open into a public waiting room or a high-traffic public corridor. Appropriate locks (either electronic or manual) for examination room doors are required (allowing staff to have key or code access in the case of emergency). When doors are closed, all healthcare personnel must knock, WAIT, and enter only after invited in.

(5) Privacy curtains must be present and functional in examination rooms. Privacy curtains must encompass adequate space for the healthcare provider to perform the examination unencumbered by the curtain. A changing area must be provided behind a privacy curtain.

(6) Examination tables must be placed with the foot facing away from the door. If this is not possible, tables must be fully shielded by privacy curtains.

(7) Patients who are undressed or wearing examination gowns must have proximity to women's restrooms that can be accessed without going through public hallways or waiting rooms.

(8) If toilet facilities cannot be located in close proximity to the examination room, the woman must be discreetly offered the use of a toilet facility before she disrobes for the exam.

(9) Sanitary napkin and tampon dispensers and disposal bins must be available in women's public restrooms. Tampons and sanitary pads should also be available in examination rooms where pelvic examinationss are performed and in bathrooms within close proximity.

g. **Inpatient Care Dignity, Respect and Security**

(1) When clinically unrelated to an acute hospitalization, a screening pelvic and breast examination may be deferred. Upon discharge from the acute hospitalization, a follow-up appointment needs to be arranged to complete these examinations if clinically indicated.

(2) If a pelvic or breast examination is necessary during an inpatient admission, adherence to all privacy and security standards is required as delineated in the physical examination guidelines for women Veterans. Patient dignity and privacy must be maintained at all times.

(3) VHA facilities must ensure that sufficient inpatient medical and surgical rooms are available to accommodate female patients with plans for increases as the population of women Veterans expands. Capacity for women Veterans must be, at a minimum, equivalent to the current proportion of the women Veteran utilization rates or the specific VISN utilization rate for that site, whichever is greater. Plans for new inpatient medical/surgical space must project a 15% minimum utilization rate for women Veterans.

(4) The number of inpatient rooms assigned for females needs to be at a minimum equivalent to the current proportion of the women Veterans enrolled at the facility or the specific VISN utilization rate for that site, whichever is greater.

(5) Privacy curtains must be placed in all inpatient rooms, with the exception of Psychiatry and Mental Health units.

(6) Female patients must have access to private and secure women's bathroom facilities (toilet and shower) in close proximity to their room. A private and secure bathroom must have an appropriate locking mechanism (allowing staff to have key or code access in the case of emergency) while also allowing the patient to signal for the hospital staff if they are in distress. ***NOTE:*** *It is not sufficient to have a group shower room with a sign on the door when it is utilized by women.*

(7) Female pajamas and robes must be stocked and provided on all inpatient units.

(8) Nursing intake and assessment forms need to be modified to capture gender-specific data such as last menstrual period and current pregnancy or breastfeeding status.

h. **Mental Health Residential Rehabilitation Treatment Program (MH RRTP) Dignity, Respect, and Security**

(1) Residential and domiciliary facilities must ensure safe and secure sleeping arrangements for women Veterans including but not limited to door locks, access bar codes, or controlled access ID card scanners. All locking arrangements must be in compliance with National Fire Protection Association (NFPA) 101, Life Safety Code.

(2) All inpatient and residential care facilities must include separate and secure sleeping arrangements (unit or wing) for women Veterans.

(3) Mixed gender units must ensure safe, private, and secure sleeping and bathroom arrangements for women Veterans including, but not limited to, proximity to staff, door locks and gender-specific personal care and hygiene products.

(4) The Annual Safety and Security Assessment must be conducted jointly with the facilities Management/Engineering, the Associate Director or designee, and the WVPM. The WVPM must also participate in regular environmental rounds with special emphasis on improving privacy and security.

VETERANS HEALTH ENVIRONMENTAL PRIVACY AND SECURITY

AMBULATORY CARE SETTINGS

The Veterans Health Administration (VHA) is dedicated to ensuring the dignity, privacy, sense of security, and safety of every Veteran in all care settings. A review of structural, environmental, and psychosocial patient security and privacy issues will be conducted in VHA ambulatory care settings on an annual basis by the Women Veterans Program Manager and incorporated into monthly environment of care rounds. Each facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for all Veterans, particularly women Veterans. This Checklist is to be utilized as a guide for assessing minimum standards during environmental rounds.

Public Areas:

Yes	No	N/A	
			Check-in clerk station has auditory privacy.
			Interview area has auditory privacy.
			Clinic waiting area has auditory privacy.
			Patient names are not posted.
			A “family” or “unisex” restroom is available where a patient or visitor can be assisted.
			Sanitary napkin and tampon dispensers and disposal bins in women’s public restroom
			Baby Changing Tables in women’s and men’s public restrooms
Notes:			

Examination, Procedure, and Testing Areas:

Yes	No	N/A	
			Patient names are not called out loudly.
			Access to hallways by patients/staff who do not work in that clinic area is restricted.
			Patient-identifiable information is not visible in hallways (chart notes/patient names).

			When doors are closed, staff knock and WAIT until they are invited to enter.
			Rooms do not open into a public waiting room or a high-traffic corridor.
			Room doors have locks, either electronic or manual.
Notes:			

Yes	No	N/A	
			Gowned patients can access sex-specific restrooms without entering public areas.
			Privacy curtains are present in all examination rooms □yes □no Privacy curtains allow adequate space for providers to perform physical exams. □yes □no Privacy curtains are located so patients can undress behind them.
			Examination tables are placed with the foot facing away from the door.
			Examination tables are shielded from view when the door is opened.
			If not… □yes □no Examination tables are fully shielded by privacy curtains.
			Cameras are not exposed when not in use (removed or mounted in locked cabinet).
			Trash collection/routine maintenance is scheduled when patients are not present.
			Draping techniques are used to shield intimate body parts during exams/procedures.
			Procedure and testing areas have auditory privacy.
			Special consideration is given to privacy and dignity in areas that involve exposure: □yes □no □N/A Colonoscopy. □yes □no □N/A Gynecology, urology, and proctology. □yes □no □N/A Cardiac treadmill testing. □yes □no □N/A EKG testing. □yes □no □N/A Radiology dressing areas. □yes □no □N/A Ultrasound, trans-vaginal ultrasound testing.
Notes:			

INPATIENT, RESIDENTIAL, DOMICILIARY AND HOPTEL FACILITIES

The health care environment directly and indirectly affects the quality of care provided to Veterans. It affects their comfort and sense of security, as well as their perceptions of care received.

The Veterans Health Administration (VHA) is dedicated to ensuring the dignity, privacy, sense of security, and safety of every Veteran in all care settings. A review of structural, environmental, and psychosocial patient security and privacy issues in VHA inpatient care settings will be conducted on an annual basis by the Women Veterans Program Manager and incorporated into monthly environment of care rounds. Each facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for all Veterans, particularly women Veterans. This Checklist is to be utilized as a guide for assessing minimum standards during environmental rounds.

Inpatient Facilities:

Yes	No	N/A	
			Patient-identifiable information is not visible in hallways (chart notes/patient names).
			Patient records are not left unattended.
			When doors are closed, staff knock and WAIT until invited to enter.
			Privacy curtains are present in all rooms (mental health units are exempt).
			Rooms are assigned to same-sex patients (except in facilities where spouses share rooms).
			Women patients have access to women-only toilet and shower facilities in close proximity to the patient's room.
			Male and female patient pajamas, gowns, robes, etc. are stocked in all sizes.
			If not… □yes □no An equitable system is in place to obtain appropriate clothing.
Notes:			

Residential and Hoptel Facilities:

Yes	No	N/A	
			Client records are not left unattended.
			Female bathroom doors are lockable if accessible from unit hallways or other public spaces.
			Female bedrooms will be located in a separate and secured area of the unit or located near main staff offices or nursing station
			Appropriate private space is available for female Veterans to visit with children.
			When doors are closed, staff knock and WAIT until invited to enter.
			Rooms are assigned to same-sex clients (except in facilities where spouses share rooms).
			Women have safe and secure sleeping arrangements: □yes □no □N/A Door locks □yes □no □N/A Access bar codes □yes □no □N/A Controlled access ID card scanners
Notes:			

WOMEN'S HEALTH PROVIDER COMPETENCY STANDARDS

Primary Care Competencies with Gender-Specific Manifestations:
Care practiced should be evidenced-based and adhere to current standards of care.

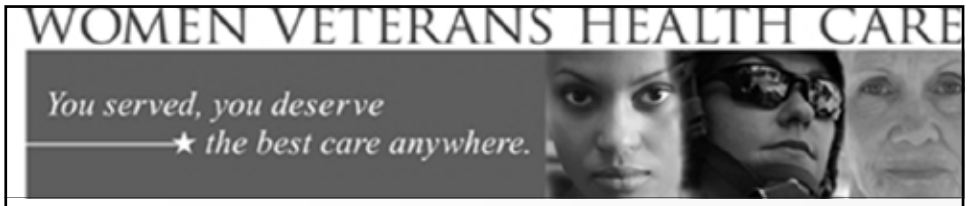
Nutrition Counseling
Obesity &Weight Management Counseling
Exercise & Fitness Counseling
Smoking Cessation Counseling & Nicotine Replacement
Screening for Alcohol and Substance Use/Abuse
Screening for Depression
Screening for PTSD
Post-Deployment Readjustment Issues
Endocrine disorders including:
-Thyroid disorders
-Diabetes
Genitourinary tract disorders including:
-Cystitis
-Urinary Tract Infection
-Pyelonephritis
-Urinary incontinence
Respiratory Illnesses including:
-COPD
-Bronchitis/common cold/acute upper respiratory illness
Hyperlipidemia (due to gender quality disparities)
Screening for Military Sexual Trauma
Diagnosis and prevention of Osteoporosis/Osteopenia
Cardiovascular Disorders
-Chest pain
-Hypertension
Fibromyalgia
Connective Tissue Disease
Headaches
Hirsutism
Acne
Anemia
Gastrointestinal disorders including:
-Irritable Bowel Syndrome
-Diarrhea/Constipation
-Gastroenteritis
Assess risks for cancers (e.g. lung, breast, ovary, colon and skin)

"Basic"/"Minimal" Women's Health Competencies:
Assess and manage reproductive concerns including:
-Contraception counseling
-Emergency contraception
-Sexually transmitted disease screening, counseling and treatment

-Basic diagnostic evaluation and tests for infertility
Cervical Cancer Screening
Assessment of abnormal cervical pathology
Breast Cancer Screening
Evaluation and management of Breast Symptoms (Mass, Fibrocystic Breast Disease, Mastalgia, Nipple Discharge, Mastitis, Galactorrhea, Mastodynia)
Evaluation and management of Acute and Chronic Pelvic Pain
Evaluation & Treatment of Vaginitis
Evaluation of Abnormal Uterine Bleeding
Amenorrhea/Menstrual Disorders
Menopause Symptom Management
Crisis Intervention; Evaluate pyshosocial well being and risks including issues regarding abuse
Violence in women & Intimate Partner Violence Screening
-Personal and physical abuse
-Verbal/Psychological abuse
Diagnosis of pregnancy and initial screening tests
Recognition and management of Postpartum Depression and Postpartum Blues
Pharmacology in Pregnancy & Lactation
Preconception Counseling
-medical assessment
-vaccination evaluation
-genetic history
-supplement recommendations
-awareness of terotogenic medications
Recognize presentation of Ectopic Pregnancy

Procedures:
"Basic"/"Minimal"
Breast Exam
Pelvic Examination
Rectal Exam
Pap Smear
Wet Mount
Removal of Foreign Body from Vagina

Interpreting Test Results:
" Basic"/"Minimal"
Bone densitometry
Colposcopy & Biopsy
Cervical Cytology Report
Endometrial Biopsy
CT of Abdomen & Pelvis
Pelvic Ultrasound
Pregnancy Test
Mammography
Infertility workup
Basic Urodynamic Testing



VA Services for Women Veterans in Oregon

Marcia Hall PhD

Women Veterans Program Manager
Roseburg VA Healthcare System

November 17, 2009

Objectives of Presentation

1. Identify the demographic and clinical characteristics of women Veterans using the VA Healthcare Services in Oregon.
2. Describe How Women Veterans 'Access' care and what care is available in Oregon.
3. Describe some current barriers for women Veterans accessing VA services.
4. Define VA priority initiatives to improve Women Veterans Health services based on VA Women's Health Research.

The New Face Of Our Women Veterans

New Considerations and Emerging Trends….
In Times of War the 'Aftermath' is in our Communities:
Veterans are Our Communities

- The Northwest Region has more returning veterans than other regions of the country.
- The majority of veterans are returning to rural communities.
- Many returning veterans, have Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), have Family Conflicts and too many are homeless.
- They are returning profoundly changed by their experiences of war and multiple deployments.

Embedded In this "Bigger Picture" of Returning Troops… Are Women Veterans.

- **Women Veterans serve honorably: "We are Soldiers First and Women Second."**
- **Women Veterans have experienced, survived and carry both common and unique burdens from their service to our country.**
- **Too often, women veterans are *invisible*, and this *invisibility* is, in and of itself, a barrier to healthcare services.**
- **Women veterans face specific issues of violence (military sexual trauma and domestic violence) which are frequently hidden and stigmatized.**
- **Of homeless veterans from the Iraq and Afghanistan wars 11% are women.**
- **Roughly 40% of the homeless female Veterans of recent wars have said they were sexually assaulted while serving.**

Women Veterans: Background

- There are 1.7 Million Women Veterans in the U.S. . Women Veterans are my 93 year old mother and your 19 year old niece.
- 200,000 women have served in the current wars in Iraq and Afghanistan.
- Women Comprise 14% of 230,000 Active Duty and 19.6 % of Reserve Troops serving oversees. They remain a 'Minority Population' in the military and in the VA.

Combat Roles?

All our troops in Iraq and Afghanistan are in Combat

Sgt. Lynn Kinney, Maj. Megan McClung and Staff Sgt. Amy Forsythe stand together on Camp Fallujah, Iraq, April 2006. All worked together at the Public Affairs Office for the 1st Marine Expeditionary Force serving in Al Anbar Province. McClung was killed in action Dec 6, 2006 by an IED while escorting media in Ramadi, Iraq.

Women will Double in the next 5 Years

The mass influx of women veterans that the VA faces would be a challenge for any health care system. It is particularly challenging for a system that has a history of caring for a predominantly male population. As recently as 1971, women constituted less than 1 percent of the U.S. military.

Female Enrolllees FY 2007 = 255, 324

Projected female enrollees 2008 = 481,054

Projected female enrollees 2010 = 533,208

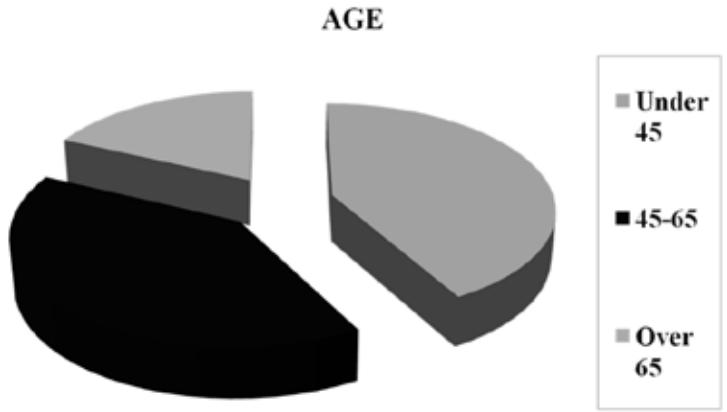
Projected female enrollees 2013 = 589,383

Utilization by Women Veterans

- Traditionally, women Veterans have under-utilized VA health care – many also receive VA and health care outside VA.
- Utilization data indicate current models of care delivery present barriers to women Veterans using VA.
- However, there is high utilization by women who served in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF):
  - Over **114,949** female OEF/OIF Veterans since 2002
  - 47.3% of women enroll; of these, 45% have used from 2-10 visits

9 9

VA Women Users: Age



Women Veterans Seeking Care:

How it Works

- First, women Veterans Enroll and Eligibility is determined. Care will vary dependent on eligibility status. *See pg. 81 of Gov. Task Force Report for Eligibility Categories 1-8.*
- ****Eligibility is a key point of miss-understanding among Veterans, Civilians, and between VA community partners.*
- Veteran will request care at specific VA Facility – usually closest to their home.
- Veteran is assigned a Primary Care Provider who will coordinate and deliver necessary care. The current goal is a first new pt. appt. within 30 days.

Eligibility in Brief:

Requirements as Barriers for Women's Healthcare

- Time in service (a significant issue in MST cases).
- Service Connected Disability - r/t active duty. For women there tends to be less support (isolation), less precedence, and research identified gender biases i.e. PTSD).
- MST – Eligibility for services r/t MST aftermath. Current challenges with how MST is determined, and the extent of services covered remains controversial.

***** ***Not all women Veterans are eligible for care and some are eligible for 'only designated services'.***

VA Facilities and Services in Oregon The Big Picture:

- Portland: Main Hospital and 4 CBOCs - clinics: Bend, Salem, E.PDX and Vancouver.
  The highest level of care and services in State exist at PVAMC.
- Roseburg: Main Hospital, 2 CBOC and 2 outpatient clinics: Eugene, N. Bend, Brookings and Crescent City.
  The intermediate level of care and some specialized services.
- White City: Main Domiciliary, 1 CBOC; Klamath Falls.
  Domiciliary with out-patient care only.

Levels of Care - Distance from Care - Eligibility for Care -

- Not all VA facilities have the same level of care or services – transportation is a barrier…childcare is a barrier.
- Some Veterans live considerable distance from point of care – innovative technologies such as tele-medicine may help bridge the gap but not eliminate it.
- Not all Women Veterans are eligible for care.

Women Veterans in Oregon:

Demographics

- 25,000 Women Veterans in Oregon
- 17,673 do not receive healthcare from the VA.

2009	Portland VA	Roseburg VA	White City VA	Total Females In Oregon using VA
Female Users	4927	1511	823	7,361

Current Challenges Identified VA Women's Health Research:

- 1. Under-serving Women Veterans: Gender disparities in relative utilization of VA services (M = 22% F= 15%). In Oregon women Veteran utilization is 29%.
  (i.e. The % of men versus the % of women who use the VA)

- 2. Increased need for service delivery: Women veterans using VA services are projected to double in the next 5 years with declining male veteran numbers. The case for "insufficient numbers" of women has now become obsolete.

- 3. Demographic shifts and impacts on age-related concerns. Women veterans are significantly younger than male counterpart (M-61 F-48) with almost all new women using the VA now are under 40.

- 4. Gender Disparities in quality care. Despite improvements for women, there exists a significant difference in outpatient quality measures. From Diabetes management to colo-rectal screening, to influenza vaccination…we need to close the gap.

- 5. Fragmentation of health care delivery (how we deliver care) for women veterans. 67% of VA sites provide primary care in a "multi-visit, multi-provider model": primary care at one visit and gender-specific primary care at another. This *has been* the predominant model of women's care, and a model associated with lower quality and outcomes.

- 6. Insufficient numbers of clinicians in VHA with specific training and experience in women's health issues. The historical predominance of male Veterans in the VA has resulted in VA providers will little experience or exposure to women patients. ***Skills, CULTURE, Environment.

- 7. Inconsistent policy for women's health. Policy drives practice and in 2003 policy changed gender related care from "mandated" to "preferred". This change to 'preferred' fragmented care. Gender care has always been recognized as integral part of primary care for male veterans "you would never send a male veteran to a separate doctor for a prostate exam…but that is what has routinely happened for women veterans".

VA Priority and Plan For Women's Health

- To improve quality of healthcare for women veterans a new model of care - comprehensive primary care – is now the priority national effort. The new model will decrease fragmentation of care and increase quality of care outcomes.
- This singular focus has been the priority of funding and unprecedented efforts during the past year to improve women Veteran's health.
- Women Veterans Program Managers have been 'Mandated' for each VA facility 12-1-08.

Healthcare Services

Top 2 Diagnosis for Women Using VA Services

- Posttraumatic Stress Disorder (PTSD)
- Hypertension

Primary Care Services

- Traditionally VA Primary Care Providers have served a predominant male population.
- Providing primary care to women Veterans by skilled providers has been, and continues to be a central focus of improvement.
- ***We need to develop a cadre of professionals who are 'Proficient, Interested, and Engaged' in Womens Health.***

Nancy Sloan DNP Portland VAMC

Gender Specific Services Offered

- Healthy Living Guidance specific to women Veterans
- Nutrition & Weight Management
- Primary Care
- Family Planning/Birth Control
- Pregnancy Care – VA Maternity Benefits
- Tubal ligations/Surgical sterilization
- Infertility Evaluation
- Diagnosis and treatment of gynecologic problems,
- surgical interventions available
- Cervical Cancer Screening (e.g. pap smears, HPV typing)
- Breast self-care
- Mammography
- Menopause Management
- Incontinence treatment
- Osteoporosis Evaluation & Treatment
- HIV/STD Testing

Mental Health Services

- Posttraumatic Stress Counseling
- Military Sexual Trauma Counseling
- Inpatient Psychiatric Treatment
- Substance Abuse residential and outpatient treatment (mixed gender only - no gender specific unit in our region).
- Psychological Evaluation
- Traumatic Brain Injury (TBI) evaluation and treatment.

Military Sexual Trauma (MST):

MST is the umbrella term used to describe physical assault, sexual assault, stalking or harassment that occurs while on active duty. Prevalence estimates of MST harassment are reported as high as 78% in female active duty personnel and rape prevalence range from15% to 26% of women.

(Department of Defense).

MST is the "Sentinel Health Concern" of Women Veterans

Carole L. Turner, Veterans Affairs' National Director Women Veterans Health Program

- Sexual victimization that occurs in the military environment, especially during times of war…often means that victims are relying on their perpetrators (or associates of the perpetrator) to provide for basic needs including medical and psychological care…and for their survival.
- In addition, when sexual trauma occurs within the workplace, this form of victimization disrupts the career goals of many of its victims. When perpetrators are peers, supervisors, commanding officers responsible for making decisions about work-related evaluations and promotions…careers often end.
- *Entrapment, severe and often prolonged physical and emotional trauma, can create an enduring consequence for the individual survivor that eventually emerges in the context of VA Healthcare delivery.*

You cannot talk about MST without talking about "Unit Cohesion".

- The 'unit cohesion' so central to" survival in times of war and an integral part of the 'positive' military experience becomes the compounding destructive factor complicating recovery from sexual violence in the military.
- The implied or stated threat of destroying "unit cohesion" functions to keeps women silent even long after they leave the military.
- What exists as a primary 'resiliency' factor for many soldiers exists for MST survivors as a factor or mechanism of entrapment and terror.

Military Sexual Trauma and Women Veterans:

The VA is the first and only healthcare system which conducts universal screening for sexual violence.

- Portland VA = 856 MST with 5,714 female patient encounters last year.
- Roseburg VA = 319 MST with 2,483 female patient encounters last year
- White City VA = 208 MST with over 1019 female patient encounters last year.

We tend to think of Sexual Trauma as resulting in "Psychiatric Problems" ...both acute and chronic. This is how we as a society have come to comfortably conceptualize the aftermath.

Sexual Trauma Produces a Physiologic – A Biologic Imprint

Biologic Changes may Become Chronic Health Consequences and Exist as an Enduring 'after effect' of Sexual Trauma.

"The Body Keeps Score"

Historically, beyond the immediate physical injuries that can be associated with the sexual assault… little attention has been given to an array of physical maladies and complaints persistent and consistent among survivors.

Sexual Trauma has Medical Consequences:

Increased prevalence of physical symptoms and disease.

- Sleep problems
- Diabetes
- Chronic pain
- Gastrointestinal Disorders
- Gynecological Problems
- Heart Disease
- Sexual problems and intimacy.
- Asthma and other respiratory problems
- Cancer (including breast and cervical)
- Dissociation/memory loss
- Non-specific immune-system disorders
  - (Lupus, Fibromyalgia, Chronic Fatigue Syndrome)
- ***Death , suicide, and homicide, and severe bodily injuries are also medical consequences of MST.

Women Veterans are at Increased Risk of Interpersonal Violence (MST, and Domestic Violence)

- Specific issues of experienced violence are often hidden and stigmatized…but commonly surface as healthcare problems.
- Increased interpersonal violence always associated with war, is frequently obscured…but exists as a predominant, and often intergenerational legacy…in families and specifically through children.

Substance Abuse and Trauma Frequently Co-occur.

The Majority of Substance Abuse Patients have a History of Trauma.

Percentage of ALL Male and Female Outpatients Receiving Mental Health code for Substance Abuse.

		2008	⇧ Women
PORTLAND	F	% 25.0	7%
	M	% 17.1	
ROSEBURG	F	% 26.4	12%
	M	% 14.6	
WHITE CITY	F	% 23.1	3%
	M	% 21.6	

The Greatest Need

Inpatient Treatment for Trauma and Substance Abuse for Our Women Veterans has been Identified as the Number #1 Mental Health Service Need in our Region by VA Women's Mental Health Providers.

Critical Success Factors for the VA Serving Women In Oregon

- Sufficient staff to service health needs of increasing women Veterans: Recruit, Train, and Support healthcare professionals.
- Educate interested Primary Care providers in women's health care.
- Establish designated providers at each site as point person in women's health
- Integrate Women's Health into overall Organizational Planning.
- Support a culture of dignified care for women Veterans.

Cross Cutting Issues: Women Veterans

- VA must increase recognition of women Veterans. Women Veterans report that they feel "invisible" in VA.
- VA must enhance privacy, respect, dignity, and sense of security for all Veterans. Women Veterans in particular express needs for privacy.
- Every level of VA, including program offices, VISN and facility leadership, and staff at every site need to be engaged in the enhancement of services to women Veterans

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Patty Hayes

Our Women Veterans Healthcare Needs

Feedback from Women Veterans on VA Services

Needs of Women Veterans

- Clinics to serve the needs of young, working women.
  - Access, flexible hours, use of technology
  - Address reproductive health issues
- Many have childcare responsibilities and eldercare demands.
- Many are employed, difficult to get time off for appointments.
- Adjustment and depression issues
- Homelessness
- Age-related health effects
  - Cardiac risk, obesity and diabetes, lung cancer, colorectal cancer, breast and cervical cancer screening, osteoporosis screening

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Childcare for Veterans

- Lack of childcare services is a barrier that prevents women from coming to appointments.
- Task force: different types of care needed
  - "Drop-off casual care" for medical outpatient appointments
  - Intermediate care, e.g. attending mental health intensive care
  - Daycare when Veteran is in polytrauma and rehabilitative care
- Due to recent VA General Counsel opinion, VA is examining what options might be feasible under current authority.

Dr. Patty Hayes

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Newborn Care

- VA is not authorized to pay for newborn services.
- Follow-up in VA is often lost when women Veterans rely on newborn care coverage elsewhere (i.e. Medicaid).
- VA has supported legislation for newborn care.
  - Current VHA Legislative proposal for 96 hours of care is under review at Office of Management and Budget.
  - S 252 Proposes 7 days of newborn care.
  - HR 1211 Proposes 7 days of newborn care.

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A Time of Transformational Change in VA Women's Healthcare and A Time of Tremendous Challenge

The Taskforce is an Additional Opportunity to Build and Link Efforts for

Improving Healthcare for Women Veterans

in Oregon

Military Sexual Trauma

Sonja Fry, LCSW
Social Worker
Military Sexual Trauma

Facts:

There are 23 million veterans in the U.S.

8% of those veterans are female.

22% of women veterans have experienced MST.

55% have experienced severe sexual harassment.

Anyone can be sexually assaulted, rape happens across class, race, gender and age lines.
Sexual Assault is a societal problem.

Military Sexual Trauma defined:

"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 PL 102-585, 1992; 108-422, 2004

What is Military Sexual Trauma (MST)

- Sexual Harassment
- Sexual Assault

Sexual Harassment –

- A put-down because of your gender
- Flirting when you've made clear it's not welcome.
- Sexual comments or gestures about your body or lifestyle.
- Pressure for sexual favors.

Sexual Assault – any sort of sexual activity between at least 2 people in which one of the people is involved against his or her will.

- Unwanted touching or grabbing
- Intercourse
- Oral or anal sex
- Penetration with an object

History of Military Sexual Trauma (MST)

The tailhook incident prompted an investigation of sexual assault – senate hearings were conducted. People were charged, nationwide awareness of
-Sexual assault in the military.
More hearings were Conducted and in 1992 P.L. 102-585 – ENACTED.

http://www.pbs.org/wghbh/pages/frontline/shows/navy/tailhook/

History of Military Sexual Trauma (MST)

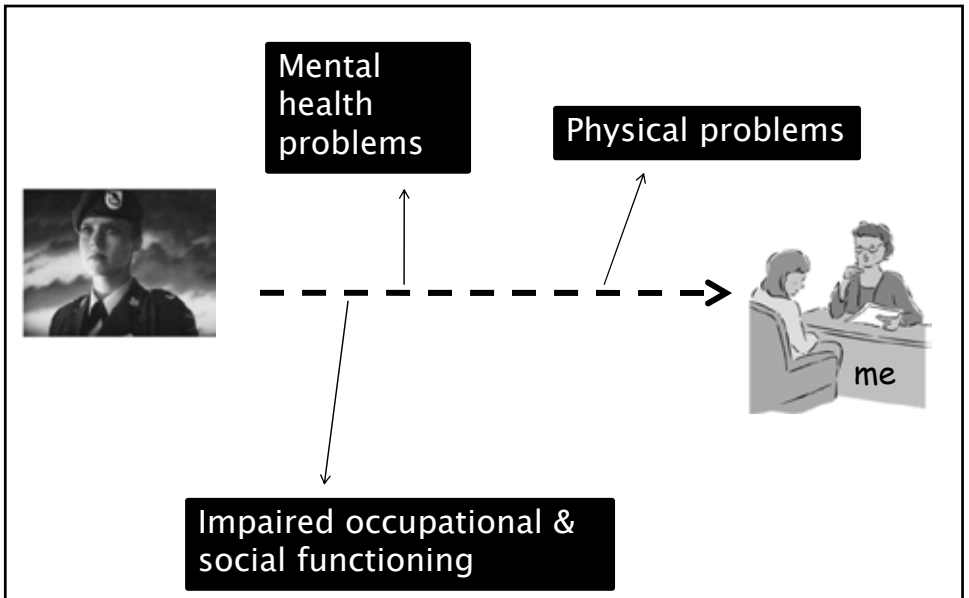
1991 – "Tailhook Incident" - US Navy and Marine Corps Officers had a 3 day Aviator Convention – 83 women and 7 men were assaulted.

Gauntlet – sexual assaults, sexual harassment

1 female came forward originally and made a formal complaint - LT Coughlin.

http://www.pbs.org/wgbh/pages/frontline/shows/navy/tailhook/

5 Public Laws from 1992-2005



Process of care for Women Veterans at Eugene CBOC:

My current caseload – well over 116 patients

- 80% female MST
- 20% male MST

PROCESS FOR CARE W/VA

- Application filled out by veteran
- Approved for care, attend orientation
- Assigned PCP, Clinical Reminder completed.
- PCP generates consult to MST Clin SW
- Clin SW contacts patient for initial.
- Initial MH Assessment/Trt Plan conducted (patient diagnosed – majority PTSD/MDD. Referred to Psychiatrist or Psych NP).
- 45-50 minute 1:1 counseling/groups
- Evidence Based Therapy – CPT and Prolonged Exposure Therapy.

2 Case Presentations

- #1 – Female Veteran
- #2 – Male Veteran

Female Veterans

Female Veteran

- PVT Jane Doe
- Iraq Veteran
- Sexually Assaulted and Harassed
- Court Martial – AWOL and Missing Movement
- Served 23 days in jail
- Honorably Discharged

Male Veteran

- John Doe
- Vietnam Veteran
- Sexually Assaulted
- Court Martial – unfounded
- Honorably Discharged
- 40 years of secrets
- Prostate Cancer

What is the Federal Government doing to ADDRESS THE ISSUE OF MILITARY SEXUAL TRAUMA?

- Sexual Assault Prevention and Response Program

In 2005, Section 577 of the Ronald Reagan National Defense Authorization Act stated that the Department of Defense would be responsible for collecting all data on sexual assault from all the branches of the military and the military service academies.

http://www.sapr.mil/

DoD is the single point of accountability for sexual assault matters.

- Each installation or unit has a SARC - Sexual Assault Response Coordinator (provides oversight and management and tracks the services provided to the victim in each reported assault)
- Each installation or unit has a VA - victim advocate (provide direct assistance to the victim)

Restricted –

The service member chooses not to inform his or her commander and law enforcement of the sexual assault.

Unrestricted –

Service member chooses to inform commander and law enforcement of sexual assault, referred for investigation.

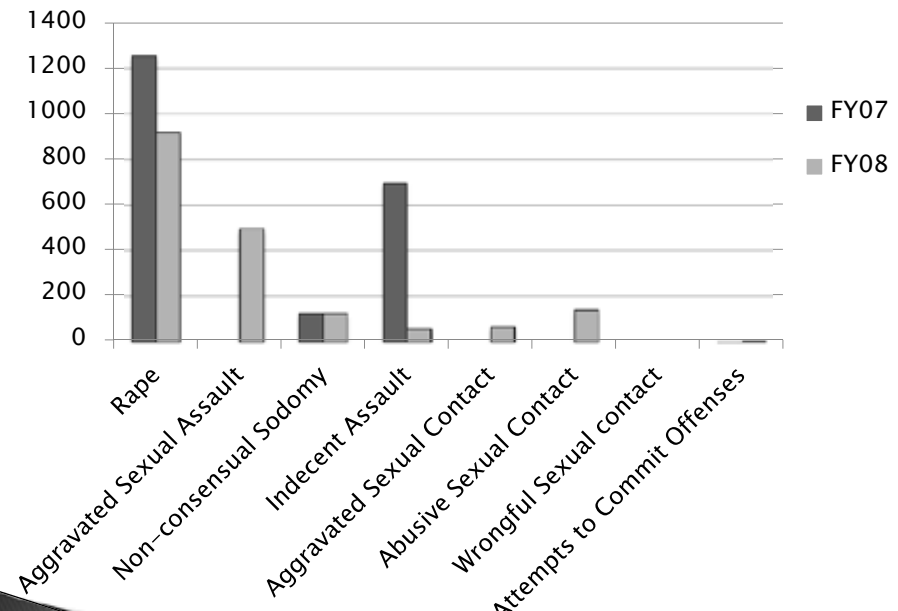
Victims may receive healthcare, counseling and advocacy services under either option.

Statistics – FYO8 DoD Report on Sexual Trauma

- Governed by PL 108-375 - requires annual report on sexual assault in the military.
- FY 2008 (10/01/07 – 9/30/08)
- Posted 3/17/09
- Army, Air Force, Navy, Marines

2688–FY 07(Oct 06–Sep 07)
+220 8% increase
2908–FY08(Oct 07–Sep 08)

reported incidents of sexual assault in the 4 services (Army, Air Force, Navy, Marines)



USCENTCOM

USCENTCOM SARC's and VA's reported:

174 in FY 07/251 in FY 08
sexual assault (26% increase in FY08)

163 happened in Iraq/Afghanistan
65% of USCENTCOM reports

OUTREACH TO MST VETERANS

- Recognize and reach out in April 2010 (2nd year) with a presentation to med/mental health staff at the Eugene CBOC.
- Clothesline Project in April 2010. (2nd year) Interviewed on television and newspaper.
- Started an organization in November 2008 in Eugene, Oregon called "Oregon Women Veterans" (designed to be an organization where women veterans can network and connect w/each other).

Women Veterans Making a Difference
O.W.V.
www.OregonWomenVeterans.com

LÉS
U.S. COAST GUARD
ATTEMPTED RAPE BY MY CO
MY NON-COMBAT
SERVICE-CONNECTED
WOUNDS

SEXUAL
ASSAULT...
Sexual Assault
SCARS
For Life
Sexual Assault
Hurts!

FIRE
Sexual Awareness
Month

In Closing…..

- Military Sexual Trauma continues to be an ongoing problem in all 4 services.
- You can make a difference – “talk about it to everyone”

United States Government Accountability Office

GAO

Testimony

Before the Committee on Veterans' Affairs, U.S. Senate

For Release on Delivery
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VA HEALTH CARE

Preliminary Findings on VA's Provision of Health Care Services to Women Veterans

Statement of Randall B. Williamson
Director, Health Care

GAO
Accountability * Integrity * Reliability

GAO-09-884T

GAO
Accountability·Integrity·Reliability
Highlights

Highlights of GAO-09-884T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

July 14, 2009

VA HEALTH CARE

Preliminary Findings on VA's Provision of Health Care Services to Women Veterans

Why GAO Did This Study

Historically, the vast majority of VA patients have been men, but that is changing. VA provided health care to over 281,000 women veterans in 2008—an increase of about 12 percent since 2006—and the number of women veterans in the United States is projected to increase by 17 percent between 2008 and 2033. Women veterans seeking care at VA medical facilities need access to a full range of health care services, including basic gender-specific services—such as cervical cancer screening—and specialized gender-specific services—such as treatment of reproductive cancers.

This testimony, based on ongoing work, discusses GAO's preliminary findings on (1) the on-site availability of health care services for women veterans at VA facilities, (2) the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, and (3) key challenges that VA facilities are experiencing in providing health care services for women veterans. GAO reviewed applicable VA policies, interviewed officials, and visited 19 medical facilities—9 VA medical centers (VAMC) and 10 community-based outpatient clinics (CBOC)—and 8 Vet Centers. These facilities were chosen based in part on the number of women using services and whether facilities offered specific programs for women. The results from these site visits cannot be generalized to all VA facilities. GAO shared this statement with VA officials, and they generally agreed with the information presented.

View GAO-09-884T or key components.
For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

The VA facilities GAO visited provided basic gender-specific and outpatient mental health services to women veterans on site, and some facilities also provided specialized gender-specific or mental health services specifically designed for women on site. Basic gender-specific services, including pelvic examinations, were available on site at all nine VAMCs and 8 of the 10 CBOCs GAO visited. Almost all of the medical facilities GAO visited offered women veterans access to one or more female providers for their gender-specific care. The availability of specialized gender-specific services for women, including treatments after abnormal cervical cancer screenings and breast cancer, varied by service and facility. All VA medical facilities refer female patients to non-VA providers for obstetric care. Some of the VAMCs GAO visited offered a broad array of other specialized gender-specific services on site, but all contracted or fee-based at least some services. Among CBOCs, the two largest facilities GAO visited offered an array of specialized gender-specific care on site; the other eight referred women to other VA or non-VA facilities for most of these services. Outpatient mental health services for women were widely available at the VAMCs and most Vet Centers GAO visited, but were more limited at some CBOCs. While the two larger CBOCs offered group counseling for women and services specifically for women who have experienced sexual trauma in the military, the smaller CBOCs tended to rely on VAMC staff, often through videoconferencing, to provide mental health services.

The extent to which the VA medical facilities GAO visited were following VA policies that apply to the delivery of health care services for women veterans varied, but none of the facilities had fully implemented these policies. None of the VAMCs and CBOCs GAO visited were fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied. For example, many of the medical facilities GAO visited did not have adequate visual and auditory privacy in their check-in areas. Further, the facilities GAO visited were in various stages of implementing VA's new initiative to provide comprehensive primary care for women veterans, but officials at some VAMCs and CBOCs reported that they were unclear about the specific steps they would need to take to meet the goals of the new policy.

Officials at facilities that GAO visited identified a number of challenges they face in providing health care services to the increasing numbers of women veterans seeking VA health care. One challenge was that space constraints have raised issues affecting the provision of health care services. For example, the number, size, or configuration of exam rooms or bathrooms sometimes made it difficult for facilities to comply with VA requirements related to privacy for women veterans. Officials also reported challenges hiring providers with specific training and experience in women's health care and in mental health care, such as treatment for women veterans with post-traumatic stress disorder or who had experienced military sexual trauma.

United States Government Accountability Office

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee considers issues related to the Department of Veterans Affairs' (VA) delivery of health care services to women veterans. Historically, the vast majority of VA patients have been men, but that is changing. As of October 2008, there were more than 1.8 million women veterans in the United States (representing approximately 7.7 percent of the total veteran population), and more than 102,000 of these women were veterans of the military operations in Afghanistan and Iraq, known as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). According to VA data, in fiscal year 2008, over 281,000 women veterans received health care services from VA—an increase of about 12 percent since 2006. Looking ahead, VA estimates that while the total number of veterans will decline by 37 percent between 2008 and 2033, the number of women veterans will increase by more than 17 percent over the same period.

The health care services needed by women veterans are significantly different from those required by their male counterparts. Women veterans are younger, in the aggregate, than their male counterparts. Based on an analysis conducted by the VA in 2007, the estimated median age of women veterans was 47, whereas the estimated median age of male veterans was 61. Women veterans seeking care at VA medical facilities need access to a full range of physical health care services, including basic gender-specific services—such as breast examinations, cervical cancer screening, and menopause management—and specialized gender-specific services such as obstetric care (which includes prenatal, labor and delivery, and postpartum care) and treatment of reproductive cancers. Women veterans also need access to a range of mental health care services, such as care for depression.

In addition, women veterans of OEF/OIF present new challenges for VA's health care system. Almost all of these women are under the age of 40—58 percent are between the ages of 20 and 29. VA data show that almost 20 percent of women veterans of OEF/OIF have been diagnosed with post-

traumatic stress disorder (PTSD).[1] Additionally, an alarming number of them have experienced sexual trauma while in the military.[2] As a result, many women veterans of OEF/OIF have complex physical and mental health care needs.

Congress and others have raised concerns about how well VA is prepared to meet the physical and mental health care needs of the growing number of women veterans, particularly veterans of OEF/OIF. Traditionally, women veterans have utilized VA's health care services less frequently than their male counterparts. In fiscal year 2007, 15 percent of women veterans used VA's health care services, compared to 22 percent of male veterans. VA believes that part of this difference may be attributable to barriers that the current care models at many VA medical facilities present to women veterans. For example, women veterans have often been required to make multiple visits to a VA facility in order to receive the full spectrum of primary care services, which includes such basic gender-specific care as cervical cancer screenings and breast examinations. Because many of these women work or have child care responsibilities, multiple visits can be problematic, especially when services are not available in the evenings or on weekends.

VA has taken some steps to improve the availability of services for women veterans, including requiring that all VA medical facilities make the Women Veterans Program Manager (WVPM)—an advocate for the needs of women veterans—a full-time position and providing funding for equipment to help VA medical facilities improve health care services for women veterans. Additionally, in November 2008, VA began a systemwide initiative to make comprehensive primary care for women veterans available at every VA medical facility—VA medical centers (VAMC) and community-based outpatient clinics (CBOC). In announcing this initiative,

[1]PTSD may develop following exposure to combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who experience stressful events often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can occur within the first few days after exposure to the stressful event but may also be delayed for months or years. If symptoms continue for more than 30 days and significantly disrupt an individual's daily activities, a diagnosis of PTSD is made.

[2]VA defines military sexual trauma (MST) as "psychological trauma, which in the judgment of a VA mental health professional resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." VA reported that in fiscal year 2008, 21 percent of women screened for MST, screened positive for having experienced MST.

VA established a policy defining comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, gender-specific care, and mental health care—from one primary care provider at one site.

You asked us to examine VA's health care services for women veterans. In my testimony today, I will discuss our preliminary findings, based on visits to selected VA facilities, regarding (1) the on-site availability of health care services at VA facilities for women veterans, (2) the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, and (3) some key challenges that VA facilities are experiencing in providing health care services for women veterans.

To examine the availability of health care services at VA facilities for women veterans and to determine the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, we reviewed applicable VA policies[3] and available VA data, and interviewed officials from VA headquarters, Veterans Integrated Service Networks (VISN),[4] and VA facilities. In addition, we conducted site visits to a judgmental sample of nine VAMCs located in Atlanta and Dublin, Georgia; San Diego and Long Beach, California; Minneapolis and St. Cloud, Minnesota; Sioux Falls, South Dakota; and Temple and Waco, Texas. We also visited 10 VA CBOCs affiliated with these nine VAMCs, and eight Vet Centers, which are counseling centers that help combat veterans readjust from wartime military service to civilian life. We used VA data to select these sites based on several factors, including the number of women veterans using health care services at each VAMC and whether facilities offered specific programs for women veterans, such as outpatient or residential treatment programs for women who have PTSD or have experienced military sexual trauma (MST). See appendix I for additional details on the selection criteria we used and information on the number of women veterans using health care services at each VAMC and CBOC we

[3]The scope of services VA requires to be provided to women veterans, including requirements for ensuring the privacy of women veterans, are outlined in Veterans Health Administration (VHA) Handbook 1330.1, and the requirements for WVPM are outlined in VHA Handbook 1330.02 and in a July 2008 VA directive titled "Women Veteran Program Managers Full-Time FTEE Positions."

[4]The management of VAMCs and CBOCs is decentralized to 21 regional networks referred to as VISNs.

visited. To further examine the availability of services for women veterans, we obtained information from each VAMC and CBOC regarding the organization and availability of primary care services, basic gender-specific services, specialized gender-specific services, and mental health services in outpatient, residential, and inpatient settings; and the availability of specific clinical services such as prenatal care, osteoporosis treatment, mammography, and counseling for MST. When services were not available on site, we determined whether they were available through fee-for-service arrangements (fee basis), contracts, or sharing agreements with non-VA facilities. During our site visits we also toured each facility and documented observations of the physical space in each care setting. We examined how facilities were implementing VA policies pertaining to ensuring the privacy of women veterans in outpatient, residential, and inpatient care settings; and VA's model of comprehensive primary care for women veterans. Finally, to identify key challenges that VA facilities are experiencing in providing health care services for women veterans, we reviewed relevant literature; interviewed VA officials in headquarters, medical facilities, and Vet Centers; interviewed VA experts in the area of women veterans' health; and documented challenges observed during our site visits. The findings of our site visits to VA facilities cannot be generalized to other VA facilities. We shared the information contained in this statement with VA officials, and they generally agreed with the information we presented.

We conducted our performance audit from July 2008 through July 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA Health Care System

VA's integrated health care delivery system is one of the largest in the United States and provides enrolled veterans, including women veterans, with a range of services including primary and preventive health care services, mental health services, inpatient hospital services, long-term

care, and prescription drugs.[5] VA's health care system is organized into 21 VISNs that include VAMCs and CBOCs. VAMCs offer outpatient, residential, and inpatient services. These services range from primary care to complex specialty care, such as cardiac and spinal cord injury care. VAMCs also offer a range of mental health services, including outpatient counseling services, residential programs—which provide intensive treatment and rehabilitation services, with supported housing, for treatment, for example, of PTSD, MST, or substance use disorders—and inpatient psychiatric treatment. CBOCs are an extension of VAMCs and provide outpatient primary care and general mental health services on site. VA also operates 232 Vet Centers, which offer readjustment and family counseling, employment services, bereavement counseling, and a range of social services to assist combat veterans in readjusting from wartime military service to civilian life.[6]

When VA facilities are unable to efficiently provide certain health care services on site, they are authorized to enter into agreements with non-VA providers to ensure veterans have access to medically necessary services.[7] Specifically, VA facilities can make services available through

- referral of patients to other VA facilities or use of telehealth services,[8]
- sharing agreements with university affiliates or Department of Defense medical facilities,
- contracts with providers in the local community, or

[5]See 38 U.S.C. § 1710(a), 38 C.F.R. § 17.38 (2008). Any veteran who has served in a combat theater after November 11, 1998, including OEF/OIF veterans, and who was discharged or released from active service on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active duty service to enroll in VA's health care system and receive VA health care services. See 38 U.S.C. § 1710(e)(1)(D), (e)(3)(C). Veterans who were discharged or released before January 28, 2003, and who did not enroll in VA's health care system are eligible for these VA health care services for 3 years after January 28, 2008.

[6]All veterans who have served in a combat theater, including OEF/OIF veterans, are eligible for Vet Center services. See 38 U.S.C. § 1712A(a).

[7]See 38 U.S.C. § 1703.

[8]Telehealth is the provision of health services from a distance using telecommunications technologies, such as videoconferencing.

- allowing veterans to receive care from providers in the community who will accept VA payment (commonly referred to as fee-basis care).

VA Policies Pertaining to Women's Health

Federal law authorizes VA to provide medically necessary health care services to eligible veterans, including women veterans.[9] Federal law also specifically requires VA to provide mental health screening, counseling, and treatment for eligible veterans who have experienced MST.[10] Although the MST law applies to all veterans, it is of particular relevance to women veterans because among women veterans screened by VA for MST, 21 percent screened positive for experiencing MST. VA provides health care services to veterans through its medical benefits package—health care services required to be provided are broadly stated in a regulation and further specified in VA policies. Through policies, VA requires its health care facilities to make certain services, including gender-specific services and primary care services, available to eligible women veterans.[11] Gender-specific services that are included in the VA medical benefits package[12] include, for example, cervical cancer screening, breast examination, management of menopause, mammography, obstetric care, and infertility evaluation. See table 1 for a list of selected basic and specialized gender-specific services that VA is required to make available and others that VA may make available to women veterans.

[9]38 U.S.C. § 1710.

[10]38 U.S.C. § 1720D.

[11]These services are defined in VHA Handbook 1330.1, *VHA Services for Women Veterans* (revised July 16, 2004) and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008).

[12]See 38 C.F.R. § 17.38 (2008).

Table 1: Selected Clinical Services That VA Is Required to Make Available and Others That VA May Make Available to Women Veterans, by Category

	Services that VA medical facilities may make available to women veterans
Primary care/basic gender-specific services[a]	• Intake and initial assessment, including screening for military sexual trauma (MST)[b] • Routine physical exams • Intimate partner violence screening • Smoking cessation counseling • Smoking cessation treatment • Nutrition counseling • Weight management and fitness • Urgent/emergent gender-related care—normal hours • Urgent/emergent gender-related care—evenings, weekends, and holidays • Pelvic examination[b] • Clinical breast examination[b] • Education on performing breast self-examination[b] • Cervical cancer screening[b] • Menopause management[b] • Uncomplicated vulvovaginitis treatment[b] • Osteoporosis screening[b] • Osteoporosis treatment[b] • Hormone replacement therapy[b] • Prescription of oral contraceptives[b]
Specialized gender-specific services[a]	• Treatment after abnormal cervical cancer screening[b] • Surgical sterilization—evaluation[b] • Surgical sterilization • Sexually transmitted disease (STD) screening • STD counseling • STD treatment • Intrauterine device (IUD) placement • Pregnancy test—urine • Pregnancy test—serum • Prenatal care • Labor and delivery • Postpartum care • Infertility evaluation[b] • Endometriosis treatment • Evaluation of polycystic ovarian syndrome[b] • Treatment of polycystic ovarian syndrome[b]

Services that VA medical facilities may make available to women veterans
• Screening mammography[b]
• Diagnostic mammography
• Surgical treatment of breast cancer[b]
• Surgical treatment of reproductive cancer[b]
• Medical treatment of breast cancer[b]
• Medical treatment of reproductive cancer[b]

Source: GAO review of VA data.

Notes: The data are from a review of VHA Handbook 1330.1 and VA's annual Plan of Care and Clinical Inventory Survey.

[a]The distinction between "basic" and "specialized" gender-specific services is based on the definitions included in VHA Handbook 1330.1 and the 2003 article by Yano and Washington. Elizabeth Yano and Donna Washington, "Availability of Comprehensive Women's Health Care Through Department of Veterans Affairs Medical Center." Published by Donna Washington, et al., in *Women's Health Issues*, v. 13 (2003).

[b]Denotes a service that VA medical facilities are required to make available to women veterans, based on VHA Handbook 1330.1.

In November 2008, VA established a policy that requires all VAMCs and CBOCs to move toward making comprehensive primary care available for women veterans. VA defines comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, basic gender-specific care, and basic mental health care—from one primary care provider at one site. VA did not establish a deadline by which VAMCs and CBOCs must meet this requirement.

VA policies also outline a number of requirements specific to ensuring the privacy of women veterans in all settings of care at VAMCs and CBOCs.[13] These include requirements related to ensuring auditory and visual privacy at check-in and in interview areas; the location of exam rooms, presence of privacy curtains, and the orientation of exam tables; access to private restrooms in outpatient, inpatient, and residential settings of care; and the availability of sanitary products in public restrooms at VA facilities.

1n 1991, VA established the position of Women Veteran Coordinator—now the WVPM—to ensure that each VAMC had an individual responsible for assessing the needs of women veterans and assisting in the planning and delivery of services and programs to meet those needs. Begun as a part-time collateral position, the WVPM is now a full-time position at all

[13]VHA Handbook 1160.01 and VHA Handbook 1330.1.

VAMCs. In July 2008, VA required VAMCs to establish the WVPM as a full-time position (no longer a collateral duty) no later than December 1, 2008. Clinicians in the role of WVPM would be allowed to perform clinical duties to maintain their professional certification, licensure, or privileges, but must limit the time to the minimum required, typically no more than 5 hours per week.

VA Mental Health Services

In September 2008, VA issued the *Uniform Mental Health Services in VA Medical Centers and Clinics*,[14] a policy that specifies the mental health services that must be provided at each VAMC and CBOC.[15] The purpose of this policy is to ensure that all veterans, wherever they obtain care in VA's health care system, have access to needed mental health services. The policy lists the mental health care services that must be delivered on site or made available by each facility. To help ensure that mental health staff can provide these services, VA has developed and rolled out evidence-based[16] psychotherapy training programs for VA staff that treat patients with PTSD, depression, and serious mental illness. VA's training programs cover five evidence-based psychotherapies: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE), which are recommended for PTSD; Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT), which are recommended for depression; and Social Skills Training (SST), which is recommended for serious mental illness. The training programs involve two components: (1) attendance at an in-person, experientially-based, workshop (usually 3-4 days long), and (2) ongoing telephone-based small-group consultation on actual therapy cases with a consultant who is an expert in the psychotherapy.

[14]VHA Handbook 1160.01.

[15]The mental health services that must be provided in CBOCs differ according to the size of the clinics.

[16]Psychotherapies that have consistently been shown in controlled research to be effective for a particular condition or conditions are referred to as "evidence-based."

VA Facilities Provided Basic and Specialized Gender-Specific Services and Mental Health Services to Women Veterans, though Not All Services Were Provided On Site at Each VA Facility

The VA facilities we visited provided basic gender-specific and outpatient mental health services to women veterans on site, and some facilities also provided specialized gender-specific or mental health services specifically designed for women on site. All of the VAMCs we visited offered at least some specialized gender-specific services on site, and six offered a broad array of these services. Among CBOCs, other than the two largest facilities we visited, most offered limited specialized gender-specific care on site. Women needing obstetric care were always referred to non-VA providers. Regarding mental health care, we found that outpatient services for women were widely available at the VAMCs and most Vet Centers we visited, but were more limited at some CBOCs. Eight of the VAMCs we visited offered mixed-gender inpatient or residential mental health services, and two VAMCs offered residential treatment programs specifically designed for women veterans.

Basic Gender-Specific Care Services Were Generally Available On site at VA Medical Facilities

Basic gender-specific care services were available on site at all nine of the VAMCs and 8 of the 10 CBOCs that we visited. (See table 2.) These facilities offered a full array of basic gender-specific services for women—such as pelvic examinations, and osteoporosis treatment—on site. One of the CBOCs we visited did not offer any basic gender-specific services on site and another offered a limited selection of these services. These CBOCs that provided limited basic gender-specific services referred patients to other VA facilities for this care, but had plans underway to offer these services on site once providers received needed training. In general, women veterans had access to female providers for their gender-specific care: of the 19 medical facilities we visited, all but 4 had one or more female providers available to deliver basic gender-specific care.

Table 2: On-site Availability of Selected Basic Gender-Specific Services for Women Veterans at Selected VA Facilities

	VAMC, by number									CBOC, by number									
Service	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Pelvic exam and cervical cancer screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿	⦿[a]	●	●	●
Prescription of oral contraceptives	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿[a]	●	●	●
Osteoporosis treatment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿[a]	●	●	●
Menopause management	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿[a]	●	●	●

Source: GAO.

Key:

● Service available on site

⦿ Refer to another VA facility

Note: We collected this information using a data collection instrument during site visits to VA medical facilities from October 2008 through April 2009. Some VA facilities reported that serious or complicated cases may be referred to other VA medical facilities.

[a]This facility may also fee-base this service to an outside provider on a case-by-case basis.

The facilities we visited delivered basic gender-specific services in a variety of ways. Seven of the nine VAMCs and the two large CBOCs we visited had women's clinics. The physical setup of these clinics ranged from a physically separate dedicated clinical space (at five facilities) to one or more designated women's health providers with designated exam rooms within a mixed-gender primary care clinic. Generally, when women's clinics were available, most female patients received their basic gender-specific care in those clinics. When women's clinics were not available, female patients either received their gender-specific care through their primary care provider or were referred to another VA or non-VA facility for these services.

Basic gender-specific services were typically available between 8:00 a.m. and 4:30 p.m. on weekdays. At one CBOC and one VAMC, however, basic gender-specific care was only available during limited time frames. At the CBOC, a provider from the affiliated VAMC traveled to the CBOC 2 days each month to perform cervical cancer screenings and pelvic examinations for the clinic's female patients. In general, medical facilities did not offer evening or weekend hours for basic gender-specific services.

While All VAMCs Offered at Least Some Specialized Gender-Specific Services On site, CBOCs Typically Referred Patients Needing These Services to Other VA or Non-VA Medical Facilities

The provision of specialized gender-specific services for women, including treatment after abnormal cervical cancer screenings and breast cancer treatment, varied by service and by facility. (See table 3.) All VA medical facilities referred female patients to outside providers for obstetric care. Some of the VAMCs we visited offered a broad array of other specialized gender-specific services on site, but all contracted or fee-based at least some services. In particular, most VAMCs provided screening and diagnostic mammography through contracts with local providers or fee-based these services. In addition, less than half of the VAMCs provided reconstructive surgery after mastectomy on site, although six of the nine VAMCs we visited provided medical treatment for breast cancers and reproductive cancers on site. In general, the CBOCs we visited offered more limited specialized gender-specific services on site. For example, while most CBOCs offered pregnancy testing and sexually transmitted disease (STD) screening, counseling, and treatment, only the largest CBOCs offered IUD placement on site. Most CBOCs referred patients to VA medical facilities—sometimes as far as 130 miles away—for some specialized gender-specific services. Because the travel distance can be a barrier to treatment for some veterans, officials at some CBOCs said that they will fee-base services to local providers on a case-by-case basis. At both VAMCs and CBOCs, specialized gender-specific services were usually offered on site only during certain hours: for example, four medical facilities only offered these services 2 days per week or less.

Table 3: On-site Availability of Selected Specialized Gender-Specific Services for Women Veterans at Selected VA Facilities

	VAMC, by number									CBOC, by number									
Service	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Treatment of sexually transmitted diseases (STD)	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●[a]	⦿	●	●	●
Treatment after abnormal cervical cancer screening	●	●	⦿[b]	●	●	●[c]	●[a]	●[a,c]	●[a]	●	●	⦿	⦿	⦿[c]	⦿	⦿[c]	⦿	⦿	⦿
Intrauterine device (IUD) placement	●	●	⦿[b]	●	●	●	●[a]	●	●	●	●	⦿	⦿	⦿[c]	⦿	⦿[c]	⦿	⦿	⦿
Screening mammography	●	⊙[d]	●	⊙	●	○	⦿	⊙	⊙[d]	⦿	○	⊙	⦿	⊙	⦿	⦿[c]	⊙	⊙	⊙
Obstetric care	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Medical treatment of breast and reproductive cancers	●[c]	●[c,e]	●[c]	●[c]	●	⦿[c]	⦿	●[e]	⦿	[Data about the availability of this service were not collected at CBOCs.]									
Reconstructive surgery after mastectomy	○	●	●[c]	●	●	○	○	⊙	⦿	[Data about the availability of this service were not collected at CBOCs.]									

Source: GAO.

● Service available on site

⦿ Refer to another VA facility

⊙ Refer to a contract provider

○ Refer to a fee-basis provider

Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.

[a]This facility may refer this service to another VAMC.

[b]This facility refers this service to a large CBOC located approximately 13 miles from this facility.

[c]This facility may also fee-base this service to a non-VA provider on a case-by-case basis.

[d]This facility provided screening mammography services through a contract provider. That contract provider has a mobile unit that offers screening mammography services on site at the VAMC a few days a month.

[e]This facility contracts for associated stereotactic biopsies.

Outpatient Mental Health Services Were Widely Available at Most VAMCs and Vet Centers, but More Limited at Smaller CBOCs

A range of outpatient mental health services was readily available at the VAMCs we visited. The types of outpatient mental health services available at most VAMCs included, for example, diagnosis and treatment of depression, substance use disorders, PTSD, and serious mental illness. All of the VAMCs we visited had one or more providers with training in evidence-based therapies for the treatment of PTSD and depression. All but one of the VAMCs we visited offered at least one women-only counseling group. Two VAMCs offered outpatient treatment programs specifically for women who have experienced MST or other traumas. In addition, several VAMCs offered services during evening hours at least 1 day a week. While most outpatient mental health services were available

on site, facilities typically fee-based treatment for a veteran with an active eating disorder to non-VA providers.

Similarly, the eight Vet Centers we visited offered a variety of outpatient mental health services, including counseling services for PTSD and depression, as well as individual or group counseling for victims of sexual trauma. Five of the eight Vet Centers we visited offered women-only groups, and six had counselors with training or experience in treating patients who have suffered sexual trauma. Vet Centers generally offered some counseling services in the evenings.

The outpatient mental health services available in CBOCs were, in some cases, more limited. The two larger CBOCs offered women-only group counseling as well as intensive treatment programs specifically for women who had experienced MST or other traumas, and two other CBOCs offered women-only group counseling. The smaller CBOCs, however, tended to rely on staff from the affiliated VAMC, often through telehealth, to provide mental health services. Five CBOCs provided some mental health services through telehealth or using mental health providers from the VAMC that traveled to the CBOCs on specific days.

While Most VAMCs Offer Mixed-Gender Residential or Inpatient Mental Health Services, Few Have Specialized Programs for Women Veterans

While most VAMCs offer mixed-gender residential mental health treatment programs or inpatient psychiatric services, few have specialized programs for women veterans. Eight of the nine VAMCs we visited served women veterans in mixed-gender inpatient psychiatric units, mixed-gender residential treatment programs, or both. Two VAMCs had residential treatment programs specifically for women who have experienced MST and other traumas. (VA has ten of these programs nationally.) None of the VAMCs had dedicated inpatient psychiatric units for women. VA providers at some facilities expressed concerns about the privacy and safety of women veterans in mixed-gender inpatient and residential environments. For example, in the residential treatment programs, beds for women veterans were separated from other areas of the building by keyless entry systems. However, female residents in some of these programs shared common areas, such as the dinning room, with male residents, and providers expressed concerns that women who were victims of sexual trauma might not feel comfortable in such an environment.

Medical Facilities Had Not Fully Implemented VA Policies Pertaining to the Delivery of Health Care Services for Women Veterans

The extent to which VA medical facilities we visited were following VA policies that apply to the delivery of health care services for women veterans varied, but none of the facilities had fully implemented VA policies pertaining to women veterans' health care. In particular, none of the VAMCs or CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans. In addition, the facilities we visited were in various stages of implementing VA's new initiative on comprehensive primary care: most medical facilities had at least one provider that could deliver comprehensive primary care services to women veterans, although not all of these facilities were routinely assigning women veterans to these providers. Officials at some VA facilities reported that they were unclear about the specific steps they would need to take to meet VA's definition of comprehensive primary care for women veterans.

None of the Facilities Were Fully Compliant with VA Policies Related to Ensuring the Privacy of Women Veterans

None of the VAMCs and CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied. Table 4 summarizes the extent to which the facilities we visited complied with VA policy requirements related to privacy for women veterans.

Table 4: VA Facilities' Compliance with VA Privacy Requirements

	Compliance with requirement																		
	VAMC, by number									CBOC, by number									
Privacy requirement	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Adequate visual and auditory privacy at check-in	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	○	◒	○	◒	○
Adequate visual and auditory privacy in the interview area	●	◒	◒	●	●	◒	●	◒	●	◒	●	●	◒	●	●	●	●	●	●
Exam rooms located so they do not open into a public waiting room or a high-traffic public corridor	●	●	◒	◒	◒	◒	◒	●	◒	●	●	●	●	●	●	●	●	●	●
Privacy curtains present in exam rooms	●	●	●	◒	●	●	●	●	●	●	●	○	●	●	●	●	○	○	●
Exam tables placed with the foot facing away from the door (if not possible, placed so they are fully shielded by privacy curtains)[a]	◒	◒	○	○	◒	○	●	○	◒	○	●	○	○	○	N/A	N/A	○	●	○
Changing area provided behind privacy curtain	●	●	●	◒	●	●	●	●	●	●	●	○	●	●	●	●	○	○	●
Toilet facilities immediately adjacent to examination rooms where gynecological exams and procedures are performed	◒	●	○	●	◒	◒	○	○	◒	○	○	○	○	●	N/A	N/A	○	○	○
Sanitary napkin and/or tampon dispensers and disposal bins in at least one women's public restroom	●[b]	○	○	○	○	○	○	○	●[b]	○	○	○	○	○	○	○	○	○	○
Privacy curtains in inpatient rooms (exception: psychiatry and mental health units)	◒	●	●	●	●	●	N/A	●	○	[This requirement does not apply to CBOCs.]									
Access to a private bathroom facility (with toilet and shower) in close proximity to the patient's room (inpatient and residential units)	●	◒	●	●	●	◒	◒	◒	●	[This requirement does not apply to CBOCs.]									

Source: GAO.

● Facility was compliant with requirement in all clinical settings

◒ Facility was compliant with requirement in at least one—but not all—clinical settings

○ Facility was not compliant with requirement in any clinical settings

N/A We did not tour any clinical settings at this facility where this requirement must be applied

Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.

[a]We did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the doorway.

[b]At this facility, sanitary napkins, tampons, or both were available free of charge in baskets that had been placed in public restrooms.

All facilities were fully compliant with at least some of VA's privacy requirements; however, we documented observations in many clinical settings where facilities were not following one or more requirements. Some common areas of noncompliance included the following:

- **Visual and auditory privacy at check-in**. None of the VAMCs or CBOCs we visited ensured adequate visual and auditory privacy at check-in in all clinical settings that are accessed by women veterans. In most clinical settings, check-in desks or windows were located in a mixed-gender waiting room or on a high-traffic public corridor. In some locations, the check-in area was located far enough away from the waiting room chairs that patients checking in for appointments could not easily be overheard. In a total of 12 outpatient clinical settings at six VAMCs and five CBOCs, however, check-in desks were located in close proximity to chairs where other patients waited for their appointments. At one CBOC, we observed a line forming at the check-in window, with several people waiting directly behind the patient checking in, demonstrating how privacy can be easily violated at check-in.

- **Orientation of exam tables**. In exam rooms where gynecological exams are conducted, only one of the nine VAMCs and two of the eight CBOCs[17] we visited were fully compliant with VA's policy requiring exam tables to face away from the door.[18] In many clinical settings that were not fully compliant at the remaining facilities, we observed that exam tables were oriented with the foot of the table facing the door, and in two CBOCs where exam tables were not properly oriented, there was no privacy curtain to help assure visual privacy during women veterans' exams. At one of these CBOCs, a noncompliant exam room was also located within view of a mixed-gender waiting room. Figure 1 shows the correct and incorrect orientation of exam tables in two gynecological exam rooms at two VA medical facilities.

[17]We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams.

[18]According to VA policy, if it is not possible for exam tables to be placed with the foot facing away from the door, they may be placed so that they are fully shielded by privacy curtains. However, we did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the door.

Figure 1: Correct and Incorrect Placement of Exam Tables in Gynecological Exam Rooms at VA Medical Facilities

Correct placement of exam table.

Incorrect placement of exam table.

Source: GAO.

- **Restrooms adjacent to exam rooms**. Only two of the nine VAMCs and one of the eight CBOCs we visited were fully compliant with VA's requirement that exam rooms where gynecological exams are conducted have immediately adjacent restrooms.[19] In most of the outpatient clinics we toured, a woman veteran would have to walk down the hall to access a restroom, in some cases passing through a high-traffic public corridor or a mixed-gender waiting room.

- **Access to private restrooms in inpatient and residential units**. At four of the nine VAMCs we visited, proximity of private restrooms to women's rooms on inpatient or residential units was a concern. In one

[19]We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams, so this requirement was not applicable at those 2 CBOCs.

mixed-gender inpatient medical/surgical unit, two mixed-gender residential units, and one all-female residential unit, women veterans were not guaranteed access to a private bathing facility and may have had to use a shared or congregate facility. In two of these four settings, access to the shared restroom was not restricted by a lock or a keycard system, raising concerns about the possibility of intrusion by male patients or staff while a woman veteran is showering or using the restroom.

- **Availability of sanitary products in public restrooms**. At seven of the nine VAMCs and all 10 of the CBOCs we visited, we did not find sanitary napkins or tampons available in dispensers in any of the public restrooms.

Medical Facilities Were in Various Stages of Implementing VA's Initiative on Comprehensive Primary Care for Women Veterans, but Officials at Some Facilities Were Unclear about the Steps Needed to Implement VA's New Initiative

VA has not set a deadline by which all VAMCs and CBOCs are required to implement VA's new comprehensive primary care initiative for women veterans, which would allow women veterans to obtain both primary care and basic gender-specific services from one provider at one site. Officials at the VA medical facilities we visited since the comprehensive primary care for women veterans initiative was introduced reported that they were at various stages of implementing the new initiative. Officials at 6 of the 7 VAMCs and 6 of the 8 CBOCs we visited since November 2008—when VA adopted this initiative—reported that they had at least one provider who could deliver comprehensive primary care services to women veterans. However, some of the medical facilities we visited reported that they were not routinely assigning women veterans to comprehensive primary care providers.

Officials at some medical facilities we visited were unclear about the steps needed to implement VA's new policy on comprehensive primary care for women veterans. For example, at one VAMC, primary care was offered in a mixed-gender primary care clinic and basic gender-specific services were offered by a separate appointment in the gynecology clinic, sometimes on the same day. The new comprehensive primary care initiative would require both primary care and basic gender specific services to be available on the same day, during the same appointment. Officials at this facility said that they were in the process of determining whether they can adapt their current model to meet VA's comprehensive primary care standard by placing additional primary care providers in the gynecology clinic so that both primary care services and basic gender-specific services could be offered during the same appointment, in one location. Facility officials were uncertain about whether it would meet VA's comprehensive primary care standard if primary care and basic gender-specific services were still delivered by two different providers.

However, VA's comprehensive primary care policy is clear that the care is to be delivered by the same provider. Another area of uncertainty is the breadth of experience a provider would need to meet VA's comprehensive primary care standard. Officials from VA headquarters have made it clear that it is their expectation that comprehensive primary care providers have a broad understanding of basic women's health issues—including initial evaluation and treatment of pelvic and abdominal pain, menopause management, and the risks associated with prescribing certain drugs to pregnant or lactating women. However, in one location, we found that the only provider who was available to deliver comprehensive primary care may not have had the proficiency to deliver the broad array of services that are included in VA's definition, because the facility serves a very low volume of women veterans and opportunities to practice delivering some basic gender-specific services are limited.

VA Officials Identified Key Challenges Related to Space, Hiring Staff with Specific Experience and Training, and Establishing the WVPM as a Full-time Position

VA officials at medical facilities we visited identified a number of key challenges in providing health care services to women veterans. These challenges include physical space constraints that affect the provision of care, including problems complying with patient privacy requirements, and difficulties hiring providers that have specific experience and training in women's health, as well as hiring mental health providers with expertise in treating veterans with PTSD and who have experienced MST. Officials at some VA medical facilities also reported implementation issues in establishing the WVPM as a full-time position.

VA Facility Officials Identified Space Constraints as a Challenge Affecting the Provision of Health Care Services to Women Veterans

Officials at VA medical facilities we visited reported that space constraints have raised issues affecting the provision of health care services to women veterans. In particular, officials at 7 of 9 VAMCs and 5 of 10 CBOCs we visited said that space issues, such as the number, size, or configuration of exam rooms or bathrooms at their facilities sometimes made it difficult for them to comply with some VA requirements related to privacy for women veterans. At some of the medical facilities we visited, officials raised concerns about busy waiting rooms and the limited space available to provide separate waiting rooms for patients who may not feel comfortable in a mixed-gender waiting room, particularly women veterans who have experienced MST. Officials at one CBOC said they received complaints from women veterans who preferred a separate waiting room. At this

facility, space challenges that affected privacy were among the factors that led to the relocation of mental health services to a separate off-site clinic. VA facility officials told us that some of the patient bedrooms at two VAMC mixed-gender inpatient psychiatric units that were usually designated for female patients were located in space that could not be adequately monitored from the nursing station. VA policy requires that all inpatient care facilities provide separate and secured sleeping accommodations for women and that mixed-gender units must ensure safe and secure sleeping arrangements, including, but not limited to, the ability to monitor the patient bedrooms from the nursing station.

VA facility officials also told us they have struggled with space constraints as they work to comply with VA's new policy on comprehensive primary care for women and the requirements in the September 2008 *Uniform Mental Health Services in VA Medical Centers and Clinics*, as well as the increasing numbers of women veterans requesting these services. For example, officials at a VAMC said that limitations in the number of primary care exam rooms at their facilities made it difficult for providers to deliver comprehensive primary care services in an efficient and timely manner. Providers explained that having only one exam room per primary care provider prevents them from "multitasking," or moving back and forth between exam rooms while patients are changing or completing intake interviews with nursing staff. Similarly, mental health providers at a medical facility said that they often shared offices, which limits the number of counseling appointments they could schedule, and primary care providers sometimes have two patients in a room at the same time separated by a curtain during the intake or screening process. In addition, at one VAMC, officials reported that the facility needed to be two to three times its current size to accommodate increasing patient demand.

VA officials are aware of these challenges and VA is taking steps to address them, such as funding construction projects, moving to larger buildings, and opening additional CBOCs. However, some of these projects will not be finished for a few years. In the interim, officials said, some facilities are leasing additional space or contracting some services to community providers.

VA Facility Officials Identified Difficulties Hiring Primary Care Providers with the Specific Training and Experience Needed to Provide Services to Women Veterans

VA facility officials reported difficulties hiring primary care providers with specific training and experience in women's health. VA's comprehensive primary care initiative requires that women veterans have access to a designated women's health primary care provider that is "proficient, interested, and engaged" in delivering services to women veterans. The new policy requires that this primary care provider fulfill a broad array of health care services including, but not limited to

- detection and management of acute and chronic illness, such as osteoporosis, thyroid disease, and cancer of the breast, cervix, and lung;
- gender-specific primary care such as sexuality, pharmacologic issues related to pregnancy and lactation, and vaginal infections;
- preventive care, such as cancer screening and weight management;
- mental health services such as screening and referrals for MST, as well as evaluation and treatment of uncomplicated mental health disorders and substance use disorders; and
- coordination of specialty care.

Officials at some facilities we visited told us that they would like to hire more providers with the required knowledge and experience in women's health, but struggle to do so. For example, at one VAMC, officials reported that they had difficulty filling three vacancies for primary care providers, which they needed to meet the increasing demand for services and to replace staff who had retired. They said it took them a long time to find providers with the skills required to serve the needs of women veterans. Similarly, at one CBOC, officials reported that it takes them about 8 to 9 months to hire interested primary care physicians. Further, officials at some facilities we visited said that they rely on just one or two providers to deliver comprehensive primary care to women veterans. This is a concern to the officials because, should the provider retire or leave VA, the facility might not be able to replace them relatively quickly in order to continue to provide comprehensive primary care services to women veterans on site.

VA officials have acknowledged some of the challenges involved in training additional primary care providers to meet their vision of delivering comprehensive primary care to women veterans. A November 2008 report on the provision of primary care to women veterans cites insufficient numbers of clinicians with specific training and experience in

women's health issues among the challenges VA faces in implementing comprehensive primary care.[20] To help address the knowledge gap, VA is using "mini-residency" training sessions on women's health. These training sessions—which VA designed to enhance the knowledge and skills of primary care providers—consist of two and one-half days of case-based learning and hands-on training in gender-specific health care for women. During the mini-residency, providers receive specific training in performing pelvic examinations, cervical cancer screenings, clinical breast examinations, and other relevant skills.

VA Medical Facility and Vet Center Officials Identified Challenges Hiring Mental Health Providers with Training and Experience in Treating PTSD and MST

VA medical facility and Vet Center officials reported challenges hiring psychiatrists, psychologists, and other mental health staff with specialized training or experience in treating PTSD and MST. Medical facility officials often noted that there is a limited pool of qualified psychiatrists and psychologists, and a high demand for these professionals both in the private sector and within VA. In addition, two officials reported that because it is difficult to attract and hire mental health professionals with experience in treating the veteran population, some medical facilities have hired younger, less experienced providers. These officials noted that while younger providers may have the appropriate education and training in some evidence-based psychotherapy treatment methods that are recommended for treating PTSD and MST, they often lack practical experience treating a challenging patient population.

Some officials reported that staffing and training challenges limit the types of group or individual mental health treatment services that VA medical facilities and Vet Centers can offer. For example, officials at one VAMC said that they had problems attracting qualified mental health providers to work at its affiliated CBOCs. The facility posted announcements for psychiatrist and psychologist positions, but sometimes received no applications. Because the facility has not been able to recruit mental health providers, it relies on contract providers and fee-basing to deliver mental health services to veterans in its service area. At one Vet Center, officials told us that because none of their counselors have been trained to counsel veterans who have experienced MST, patients seeking counseling for MST are usually referred to the nearby CBOC or VAMC. At one CBOC,

[20]Department of Veterans Affairs, *Report of the Under Secretary for Health Workgroup, Provision of Primary Care to Women Veterans*, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group (Washington, D.C.: November 2008).

a licensed social worker reported that he provides individual counseling for about seven women who have experienced MST, even though he has limited training in this area. He said that this situation was not ideal, but said that he consults with mental health providers at the associated VAMC on some of these cases, and that without his services some of these women might not receive any counseling.

VA officials told us that they are aware of the challenges involved in finding clinical staff with specialized training and experience in working with veterans who have PTSD or have experienced MST. A VA official told us that as part of a national effort to enhance mental health providers' knowledge of clinically effective treatment methods and make these methods available to veterans, VA has developed evidenced-based psychotherapy training for VA mental health staff. In particular, CPT, PE, and ACT are evidence-based treatment therapies for PTSD and also commonly used by providers who work with patients who have experienced MST.[21] A VA headquarters official who is responsible for these training programs told us that as of May 4, 2009, 1,670 VA clinicians had completed VA-provided training in evidence-based therapies. Although VA is providing training in these evidence-based therapies, VA officials stated that this training is not mandatory for VA mental health providers who work with patients who have PTSD or have experienced MST.

Some VAMC Officials Reported That Establishing the WVPM as a Full-time Position Has Raised Implementation Issues

Some VA officials expressed concerns that certain aspects of the new policy making the WVPM a full-time position may have the unintended consequence of discouraging clinicians from applying for or staying in the position, potentially leading to the loss of experienced WVPMs. One concern that some WVPMs raised during our interviews was that they were interested in performing clinical duties beyond the minimum required to maintain their professional certification, but would not be able to do so under the new policy. The new policy limits a WVPM's clinical duties to the minimum required to maintain professional certification, licensure, or privileges, typically no more than 5 hours per week. Another concern was that the change to full-time status could result in a reduction in salary for some clinicians because the position could be classified as an administrative position, depending on how the policy is implemented at

[21]According to VA officials, these therapies address the PTSD diagnosis commonly associated with sexual trauma. Other diagnoses commonly associated with MST are depression and generalized anxiety.

the VAMC. At two VAMCs we visited, such concerns had discouraged the incumbent WVPM from accepting the full-time position.

VA headquarters officials told us that they are aware of and have expressed their concerns to VA senior headquarters officials about unintended consequences of the new policy. VA headquarters officials provided VISN and VAMC leadership with some options that they could use to help avoid or minimize the potential loss of experienced WVPMs. For example, one option that could be approved on a case-by-case basis is to use a job-sharing arrangement that would allow the incumbent WVPM and another person to each dedicate 50 percent of their time to the WVPM position, performing clinical duties the other 50 percent, in order to transition staff into the full-time position or as a succession planning effort. VA headquarters officials said that action on this issue was important because VA does not have the time or resources to train new staff to replace experienced WVPMs who may leave their positions.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the committee have at this time.

For further information about this testimony, please contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made major contributions to this testimony are listed in appendix II.

Appendix I: Information on the Selection of VA Facilities Examined in This Report

We selected locations for our site visits using VA data on each VA medical center (VAMC) in the United States. Our goal was to identify a geographically diverse mix of facilities, including some facilities that provide services to a high volume of women veterans, particularly women veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF); some facilities that serve a high proportion of National Guard or Reserve veterans; and some facilities that serve rural veterans. We also considered whether VAMCs had programs specifically for women veterans, particularly treatment programs for post-traumatic stress disorder (PTSD) and for women who have experienced military sexual trauma (MST). For each of the factors listed below, we examined available facility- or market-level data to identify facilities of interest:

- total number of unique women veteran patients using the VAMC;
- total number of unique OEF/OIF women veteran patients using the VAMC;
- proportion of unique women veterans using the VAMC who are OEF/OIF veterans;
- proportion of unique OEF/OIF women veterans using the VAMC who were discharged from the National Guard or Reserves;
- within the VA-defined market area for the VAMC, the proportion of women veterans who use VA health care and live in rural or highly rural areas; and
- availability of on-site programs specific to women veterans, such as inpatient or residential treatment programs that offer specialized treatment for women veterans with PTSD or who have experienced MST, including programs that are for women only or have an admission cycle that includes only women; and outpatient treatment teams with a specialized focus on MST.

We selected a judgmental sample of the VAMCs that fell into the top 25 facilities for at least two of these factors. Once we had selected these VAMCs, we also selected at least one community-based outpatient clinic (CBOC) affiliated with each of the VAMCs and one nearby Vet Center, which we also visited during our site visits. In selecting these CBOCs and Vet Centers, we focused on selecting facilities that represented a range of sizes, in terms of the number of women veterans they served.

Tables 5 and 6 provide information on the unique number of women veterans served by each of the VAMCs and CBOCs we selected for site visits.

Table 5: Women Veterans' Health Care Utilization at Selected VA Medical Centers (VAMC)

VAMC, by number	Number of unique women veterans served in fiscal year 2008	Percentage increase between fiscal year 2006 and fiscal year 2008 in the number of women veterans served	Percentage increase between fiscal year 2006 and fiscal year 2008 in the total number of veterans served (both men and women)
VAMC 1	6,464	19.5	8.5
VAMC 2	6,360	22.4	12.8
VAMC 3	4,497	8.2	7.3
VAMC 4	3,588	19.4	10.2
VAMC 5	2,324	11.7	4.8
VAMC 6	1,846	20.2	3.9
VAMC 7	1,841[a]	19.8	5.1[a]
VAMC 8	999	12.5	1.0
VAMC 9	995	22.5	6.9

Source: VA data and GAO analysis.

[a]This VAMC is part of the same health care system as VAMC 1. Some of these veterans may also have received services at VAMC 1.

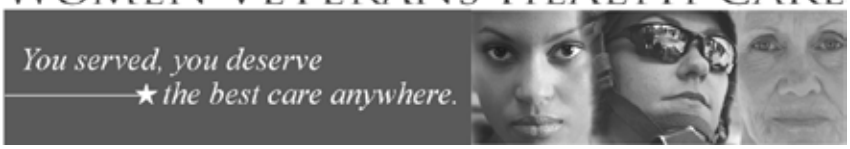
Table 6: Women Veterans' Health Care Utilization at Selected Community-Based Outpatient Clinics (CBOC)

CBOC, by number	Number of unique women veterans served in fiscal year 2008	Percentage increase between fiscal year 2006 and fiscal year 2008 in the number of unique women veterans served
CBOC 1	2,926	12.5
CBOC 2	1,750	27.0
CBOC 3	599	90.2
CBOC 4	554	51.0
CBOC 5	224	13.1
CBOC 6	115	8.5
CBOC 7	103	21.2
CBOC 8	88	54.4
CBOC 9	48	9.1
CBOC 10[a]	42	not applicable[a]

Source: VA data and GAO analysis.

[a]This facility opened in 2007, so percentage increase since fiscal year 2006 does not apply.

WOMEN VETERANS HEALTH CARE



Women Veterans Health Care

Patty Hayes, Ph.D.
Chief Consultant
Women Veterans Health
Strategic Health Care Group
April 2009

Roadmap

- ★ Changing Demographics
- ★ Underutilization of VA by Women
- ★ Population issues: race/ethnicity/geography
- ★ Quality Differences
- ★ Redesigning Primary Care for Women Veterans
- ★ Comprehensive Primary Care
- ★ Combat, military service, and post-Deployment Health Issues

WOMEN VETERANS HEALTH CARE

You served, you deserve the best care anywhere.

Expanding Population

- The number of women veterans is growing rapidly.
- Because of the large number of women on active duty and entering military service, the percentage of female veterans is projected to increase:
  - from 7.7 percent in 2008
  - to 10.0 percent in 2018
  - to 14.3 percent in 2033
- High utilization by women who served in Operations Enduring Freedom & Iraqi Freedom (OEF/OIF)
  - Over **102,126** Female OEF/OIF Veterans
  - 44.2% of women enroll; of these, 43.8% use from 2-10 visits
  - Compares to 15% average utilization by earlier era's of women

3

WOMEN VETERANS HEALTH CARE

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Women Active Duty Personnel by Branch of Service (Sept 07)

Branch of Service	Women as a % of Total Personnel	Number of Women	Officers	Enlisted
Army	13.7%	71,100	12,983	58,117
Navy	14.7%	48,755	7,611	41,144
Marine Corps	6.3%	11,706	1,138	10,568
Air Force	19.6%	64,430	11,835	52,595
Coast Guard	12.2%	4,950	1,160	3,790
Reserve & Guard	17.6%	145,769	22,131	123, 638

4

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Women Veterans Are Younger

- ★ Average age of VA users
  - Female veteran = 48
  - Male veteran = 61
- ★ Among women veterans returning from OEF/OIF:
  - 85.5% are below age 40
  - 58.9% are between ages 20-29

OEF/OIF Female Veteran Utilization			
Age Group	**Frequency**	**Percent**	**Cum %**
Under 20 years	3655	8.1%	8.1%
20–29	**26,182**	**58.0%**	**66.1%**
30–39	8,668	19.2%	85.3%
40 and over	5,996	13.3%	98.6%
Unknown	651	1.4%	100%

VA Healthcare Utilization Among 94,010 Female OEF/OIF Veterans through 1st Qtr. FY 2008 Environmental Epidemiology Service

5

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Comparison of women of different era's: Race& Ethnicity

	Females ALL (n=1,681,000)		Females OEF/OIF (n=102,126)	
	#	%	#	%
White	1,290,000	76.7	58,395	57.2
Black	314,000	18.7	26,318	25.8
Hispanic	23,000	1.4	10,017	9.8
Others	54,000	3.2	4,094	4.0
Unknown	105,000	6.2	3,302	3.2

6

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Women Veterans: Health Care

- Traditionally, Women Veterans have under-utilized VA Health care -- majority receive health care outside VA

All market penetration 2007
All living male veterans: 22%
All living women veterans: 15%
(255,374 users/1,744,580 living women veterans)

- Utilization data indicate current models of care delivery present barriers to women veterans using VA

7

WOMEN VETERANS HEALTH CARE

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Needs of Women Veterans

- Clinics to serve the needs of young, working women
  - Access, flexibility of hours, use of technology
  - Address sexual health, family planning
- Many have childcare responsibilities and eldercare demands
- Many are employed, difficult to get time off for appointments
- Adjustment and depression issues
- Age-related health effects
  - Cardiac risk, obesity and diabetes, lung cancer, colorectal cancer, breast and cervical cancer screening, osteoporosis screening

8

WOMEN VETERANS HEALTH CARE

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Fragmented Primary Care

- ★ Women's general health care and gender-specific health care often handled separately
  - 67% of VA sites provide primary care in "multi-visit, multi-provider model": primary care at one visit and gender-specific primary care at another
- ★ Too few primary care physicians trained in women's health
- ★ Inconvenient access to gender-specific care
- ★ Mental health care separate from primary care

9

WOMEN VETERANS HEALTH CARE

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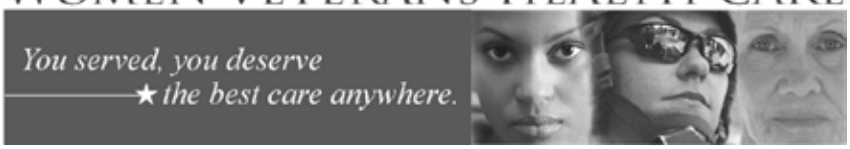
Gender Differences in Quality

- ★ Quality is high compared to the private sector
- ★ Quality challenges – significant gender differences in clinical prevention measures and mental health screenings
- ★ Most measures similar to the private sector
  - Cardiac risk measures lower for women
- ★ Some measures opposite the private sector
  - Influenza immunizations lower for women than men in VA

10

WOMEN VETERANS HEALTH CARE



Where is Women Veterans Health going?

WOMEN VETERANS HEALTH CARE

You served, you deserve
★ the best care anywhere.

Redesigning Primary Care Delivery for Women Veterans

- ★ Increase focus on quality of care issues and comprehensive longitudinal care for women veterans
- ★ Gender-specific care **IS** primary care
- ★ Defining Comprehensive Primary Care for Women Veterans:
  - Availability of complete primary care from one primary care provider at one site.
  - The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs, including acute and chronic illness, gender-specific, preventive, and mental health care.

12

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Comprehensive Primary Care for Women Veterans

- ★ Enormous undertaking by the VA
- ★ Frame shift in the way care is delivered
- ★ Our goal is to be a model of care for the nation

13

WOMEN VETERANS HEALTH CARE

You served, you deserve the best care anywhere.

Accurately Represent the Women Veterans Population through Data and Analysis

- ★ Provide ongoing data by gender and by race/ethnicity
  - Performance measures analyzed by gender by VISN
  - Analyze performance data points—OQP gathering data on reasons for differences in performance
  - Best practices and innovations
    - Review high outliers
    - Clinical and performance improvement grants

14

WOMEN VETERANS HEALTH CARE

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The future: Our mission is to understand and treat the health effects of military service and of combat exposure

- ★ Data being requested and analyzed by gender, by race, and by combined gender/race.
- ★ Prospective study of deployment health effects : population will align with race/ethnicity of population who served.
  - Conducted by Han Kang, Ph.D., OPHEH
  - 30,000 men sampled from 2002-2008 deployments
  - 6,000 women from 2002-2008 deployments
  - 30,000 matched military service controls

15

WOMEN VETERANS HEALTH CARE

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Women Veterans Health: Additional New Initiatives

- ★ Implementation of risk reduction in prescribing medications
  - Contraception when appropriate
  - Informed consent for teratogenic drugs
  - Sex is a vital sign — provider/patient discussion of sexual health

16

WOMEN VETERANS HEALTH CARE

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Post-Deployment Health in Women

- ★ Menstruation issues
- ★ Tracking use of contraceptives
  - Consequences of continuous use
- ★ Pregnancy and pregnancy outcomes, including miscarriages
- ★ Infertility
- ★ Urinary tract infections
  - Anecdotal reports of high rates; chronic presentations
  - Heat, poor hydration, less access to toileting and hygiene
- ★ Possible Exposures
  - Concerns about toxic substances, animal “exposures”
  - Evaluation for depleted uranium exposure from munitions and shielding
- ★ Injury patterns

17

WOMEN VETERANS HEALTH CARE

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Readjustment Issues

- ★ Transitioning to home and “mom” role
  - Differences for active duty, Guard, Reserve
  - Attachment disruption and parenting issues
  - Social supports network near military bases vs. Guard, Reserve community-based
- ★ Transitioning active duty “job” roles to private sector: a step-down for women?
- ★ Readjustment vs. PTSD diagnosis

18

WOMEN VETERANS HEALTH CARE

You served, you deserve ★ the best care anywhere.

Summary

- ★ The number of women veterans growing rapidly.
- ★ Increasing recognition of women veterans' unique and complex health needs—gear up for influx of younger women veterans.
- ★ Improve quality performance for women—seek best strategies and implement change.
- ★ Increase attention to comprehensive view of women's health—beyond reproductive health.
- ★ Redesign primary care service delivery for women.
- ★ Understand post-deployment health issues for women.
- ★ Understand our subpopulations of women veterans, by race, age, geography, and by combat experiences.

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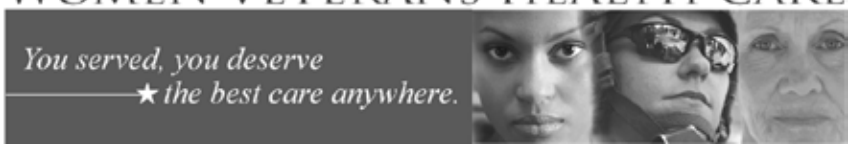
WOMEN VETERANS HEALTH CARE



Thank you for your interest in Women Veterans Health

Questions?

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1160.01
Transmittal Sheet
September 11, 2008

UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS

1. REASON FOR ISSUE. This revised Veterans Health Administration (VHA) Handbook defines minimum clinical requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain care in VHA, have access to needed mental health services.

2. SUMMARY OF MAJOR CHANGES. This VHA Handbook incorporates the new standard requirements for VHA Mental Health Services nationwide. It also specifies those services that must be provided at each Department of Veterans Affairs (VA) Medical Center and each Community-Based Outpatient Clinic (CBOC).

3. RELATED DIRECTIVES. VHA Directive 1160 (to be published).

4. RESPONSIBLE OFFICE. The Office of Patient Care Services, Office of Mental Health (116) is responsible for the contents of this VHA Handbook. Questions may be referred to (202)-461-7309.

5. RESCISSION. VHA Handbook 1160.01 dated June 11, 2008, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working date of September 2013.

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

DISTRIBUTION CO: E-mailed 9/12/08
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 9/12/08

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September 11, 2008 **VHA HANDBOOK 1160.01**

UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes minimum clinical requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain care in VHA, have access to needed mental health services. It also specifies those services that must be provided at each Department of Veterans Affairs (VA) Medical Center and each Community-Based Outpatient Clinic (CBOC). By building the requirements for services on specifications of what must be available to each veteran, no matter where in VHA that they receive care, it is designed to focus on the patient's perspective, and on meeting the care needs for each veteran. ***NOTE:*** *Throughout this Handbook, the term mental health services is meant to include services for the evaluation, diagnosis, treatment, and rehabilitation of both substance use disorders and other mental disorders.*

2. BACKGROUND

a. VHA places a high priority on enhancing mental health services for returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans, as well as for those who served in prior eras. This Handbook and the requirements for mental health services within it are significant steps in the process that began with approval of the VHA Comprehensive Mental Health Strategic Plan in 2004, and the allocation of funding through the Mental Health Enhancement Initiative to support its implementation beginning in 2005. ***NOTE:*** *Distribution of this Handbook will be followed by the distribution of the metrics that will be used to ensure the implementation of its requirements. When fully implemented, these requirements will complete the patient care recommendations of the Mental Health Strategic Plan, and its vision of a system providing ready access to comprehensive, evidence-based care.*

b. The VHA Comprehensive Mental Health Strategic Plan and the requirements included in this Handbook have been developed to implement the goals of the President's New Freedom Commission on Mental Health, including the principle that mental health care is an essential component of overall heath care. This means that services addressing substance use –related conditions must be integrated or coordinated with other components of mental health care, and that mental health services must be integrated or coordinated with other components of overall health care. Although this Handbook focuses specifically on mental health services, it does so within a comprehensive and integrated health care system.

c. Statutory and regulatory eligibility and enrollment criteria are different amongst the various programs discussed in this Handbook, which does not replace, change or supersede the existing statutory and regulatory criteria governing these programs. VHA employees are encouraged to become familiar with the statutory and regulatory eligibility and enrollment criteria for each of the programs discussed in this Handbook, and to consult their respective VHA program office or business office as needed.

3. SCOPE

a. This Handbook defines requirements for the services that must be provided as clinically needed at VA medical centers and CBOCs. The services that must be provided in CBOCs differ according to the size of the clinics. In this Handbook, very large CBOCs are those that serve more than 10,000 unique veterans each year; large CBOCs are those that serve 5000-10,000 veterans; mid-sized CBOCs are those that serve 1,500-5,000 veterans; and small CBOCs are those that serve under 1,500 veterans.

(1) In this Handbook, the services that must be "available" are those that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible.

(2) The services that must be "provided" are those that must be delivered when clinically needed to patients receiving health care at a facility by appropriate staff located at that facility, or by telemental health.

(3) Some services or other provisions are mentioned, with wording indicating such that they "may" be delivered, or that facilities are "encouraged" or "strongly encouraged" to provide them. These indicate suggestions, not requirements.

b. It is not the purpose of this Handbook to describe all mental health programming that could be appropriate and effective. Sites are strongly encouraged to go beyond these specifications in developing their mental health programming, in accordance with their challenges, resources, and opportunities. As in the past, VISNs and facilities are strongly encouraged to engage in research and clinical innovation to develop new strategies of care. Ongoing improvements in the VHA system depend on these approaches to developing best practices.

c. Program specifications are not described in detail, allowing opportunities for local choice, within the specifications, and for developing programs that address local variation in presenting problems. For example, some areas of the country have far more homeless veterans than do other areas, and their specific programming can be expected to vary accordingly.

d. Care must be provided with fidelity to these specifications. Fidelity includes attention to good program design, to delivery of evidence-based psychotherapy in ways that capture those therapy procedures, and to the provision of pharmacotherapy using evidence-based strategies for choosing medications, implementing treatment, monitoring both side effects and therapeutic outcomes, and modifying treatment when appropriate. Details that are not provided in this Handbook can be found in program documents and Clinical Practice Guidelines. ***NOTE:*** *Contact the VA Central Office, Office of Mental Health Services with questions or requests for technical assistance at: 202-461-7309.*

e. Care must be delivered by qualified, trained, competent staff. In general, this Handbook does not specify the professions who must provide the services described, but there must be attention to ensuring that care is provided by those at an appropriate level of training and clinical privileging. All professional staff must have the administrative and clinical support(s) they require to allow them to work efficiently.

f. These specifications of the mental health services that must be available as needed to each veteran and those that must be provided as needed at each type of facility supplement other requirements for timely access and quality of care. Because VHA is responsible for mental health care to a defined population, it has responsibilities for ensuring ready access to care for new patients, as well as for the continuity and quality of care for established ones. At a time when large numbers of veterans are returning from deployment and combat, ensuring access to care for patients in need must be considered VA's highest priority.

g. In order to ensure full coverage across a spectrum of needs, the specifications are laid out according to particular program areas. Individual veterans typically present with more than one mental health problem, and, typically, they also present with other health problems as well. Services must not be set up in isolation. It is expected that there will be communication and coordination between services. Every program element described in this Handbook must be understood as an integrated component of overall health care.

4. RESPONSIBILITIES

a. **Facility and Veterans Integrated Service Network (VISN) Mental Health Leadership.** Facility and VISN Mental Health Leadership must work in collaboration with overall leadership at each level to ensure:

(1) There is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for mental health conditions and other components of health care for all veterans.

(2) Every veteran seen in mental health services is assigned a principal mental health provider. When veterans are seeing more than one mental health provider and when they are involved in more than one program, the identity of the principal mental health provider must be made clear to the patient and identified in the medical record. The principal mental health provider must be identified on the patient tracking database for those patients who need case management.

b. **The Principal Mental Health Provider**

(1) The principal mental health provider must ensure that:

(a) Regular contact is maintained with the patient as clinically indicated as long as ongoing care is required.

(b) A psychiatrist reviews and reconciles each patient's psychiatric medications on a regular basis.

(c) Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity).

(d) Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained.

(e) The treatment plan is revised, when necessary.

(f) The principal therapist or principal mental health provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as patients with a diagnosis of schizophrenia or schizoaffective disorder, such communications needs to include discussions regarding future mental health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2).

(g) The treatment plan reflects the patient's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the principal mental health provider suspects that the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure that the veteran's decision making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogates' verbal consent to the treatment plan.

(2) Each principal mental health provider must collaborate with the Suicide Prevention Coordinator (SPC) in each facility to support the identification of those who have survived suicide attempts and others at high risk, and to ensure that they are provided with increased monitoring and enhanced care.

5. SPECIFICATIONS

a. These specifications describe both general mental health services and a number of specific programs focusing on conditions or problems, such as: substance use disorders, Post-Traumatic Stress Disorder (PTSD), military sexual trauma (MST), homelessness, and psychosocial rehabilitation. Although facilities differ in the way they organize and administer these services, when facilities have distinct services or programs, they must develop service agreements defining when and how patients are transferred or co-managed between them (see current VHA policy regarding service agreements).

b. The specifications in this Handbook for enhanced access, evidence-based care, and recovery or rehabilitation must not be interpreted as deemphasizing respect for the needs of those who have been receiving supportive care. No longstanding supportive groups are to be discontinued without consideration of patient preference, planning for further treatment, and the need for an adequate process of termination or transfer.

(l) All veterans receiving mental health care need to be enrolled in a VA primary care clinic to receive primary care. When veterans are not already engaged in primary care in VHA, mental health providers need to assist them in arranging a first visit to primary care. Patients who decline primary care involvement must receive all required screening and preventive interventions in the mental health clinic.

(2) Mental health services must be recovery-oriented. According to the National Consensus Statement on Mental Health Recovery (found at: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/): "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of the person's choice while striving to achieve ... full potential."

(a) The Consensus Statement lists ten fundamental components of recovery:

1. Self-direction,

2. Individualized and person-centered,

3. Empowerment,

4. Holistic,

5. Non-linear,

6. Strengths-based,

7. Peer support,

8. Respect,

9. Responsibility, and

10. Hope.

(b) As implemented in VHA recovery, it also includes:

1. Privacy,

2. Security,

3. Honor, and

4. Support for VA patient rights.

(3) All mental health care must be provided with cultural competence.

(a) All staff who are not veterans must have training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.

(b) All staff must receive cultural competence training addressing ethnic and minority issues.

(4) There must be a mental health treatment plan for all veterans receiving mental health services.

(a) The treatment plan must include the patient's diagnosis or diagnoses and document consideration of each type of evidence-based intervention for each diagnosis.

(b) The treatment plan needs to include approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.

(c) As appropriate, the plan needs to consider interventions intended to reduce symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.

(d) The plan needs to be recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.

(e) The treatment plan needs to be developed with input from the patient, and when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

6. IMPLEMENTATION

a. VA Central Office recognizes that local and regional issues may affect the implementation of these clinical requirements. ***NOTE:*** *The Office of Mental Health services needs to be kept informed about such difficulties as they arise and evolve.* Potential barriers to implementation can include:

(1) Space limitations within VA facilities;

(2) A relative lack of availability in certain regions of mental health clinicians who could be recruited to the VA;

(3) Difficulties in meeting information technology needs;

(4) The distances for patient travel;

(5) Limitations in the availability of community-based providers who could provide services using a sharing agreement, contract, or non-VA fee basis care to the extent that the veteran is eligible; and

(6) The time that may be required to develop contacts or other arrangements with local provider organizations.

b. Each VISN must request modifications or exceptions for each medical center and CBOC for those requirements that cannot be met in fiscal year (FY) 2008 and FY 2009 with available and projected resources.

c VISNs must submit requests for modifications and exceptions to these clinical requirements to the Office of Mental Health Services (116) for informational purposes and to the Deputy Under Secretary for Health for Operations and Management (10N) for approval. Any unresolved issues between the program office and (10N) must be presented to the Principal Deputy Under Secretary for Health for resolution. Requests are to include mark-ups to this document indicating the specifications of the package of services that will be delivered in each facility together with justifications for the modifications or exceptions, and, where relevant, requests for the additional resources that would enable implementation. These may include requests for medical care funds, medical facilities funds, informatics resources, legal support for contracting, or other resources.

d. Requests for modifications and exceptions need to include plans for ensuring the availability of all required services for veterans who need them, and, where relevant, timetables and milestones for implementation of the clinical requirements at relevant facilities.

7. STRUCTURE AND GOVERNANCE OF MENTAL HEALTH SERVICES

a. Each VISN must include a mental health professional as a member of its principal decision-making body. Each facility must include such leadership in its governance.

b. Where there are mental health service lines, or equivalents, recruitment of leadership must be compliant with current VHA policy, which specifies that all mental health leadership positions must be advertised for all of the core mental health professions (Psychiatry, Psychology, Social Work, and Nursing), and that selection must be equitable among candidates. Evaluation of candidates and selection of leadership needs to consider all relevant factors.

c. Mental health programs must not function as isolated entities. Regardless of the structure of mental health services and of their leadership, there must be mechanisms for ensuring that leadership has coordinated input from all of the mental health professions that serve patients in relevant facilities, and from each of the specialized programs. Mental health leadership has the responsibility to build a coherent program; much like the Chief of Medicine coordinates the activities of a diverse group of specialists.

(1) Within each medical center, each of the core mental heath professions needs to be represented by a designated leader in that profession who takes responsibility for the professional practice of that discipline and has responsibilities for mentoring and professional development of

staff in that profession. This person needs to have responsibilities for, or direct input into, hiring decisions and performance evaluations.

(2) Each VA medical center must establish and maintain a Mental Health Executive Council that includes representation from core mental health professional disciplines and specialty VA mental health programs with administrative support from the medical center. ***NOTE:*** *Facilities are encouraged to include representation from Readjustment Counseling Centers (Vet Centers) in this Council.* The facility Director may decide whether other professions (e.g., Recreation Therapists, Occupational Therapists, Chaplains, as well as representatives from the Integrated Ethics program, and others) are also to be represented.

(a) Reporting

1. Where there is a mental health service line or equivalent, the Mental Health Executive Council reports to its leadership.

2. Where the core disciplines function more independently, the Mental Health Executive Council reports to the Chief of Staff.

(b) Responsibilities. The Mental Health Executive Council is responsible for:

1. Proposing strategies to improve care and consulting with management on methods for improvement and innovation in treatment programs.

2. Working to coordinate communication among and between various departments and specialty mental health programs.

3. Reviewing the mental health impact of facility-wide policies that include, but are not limited to policies on:

a. Patient rights, privileges, and responsibilities;

b. Restraints and seclusion;

c. Management of suicidal behavior; and

d. Management of mental health emergencies.

d. Leadership of mental health services in medical centers needs to have professional oversight of the delivery of mental health care in associated CBOCs. However, this oversight cannot diminish or replace formal lines for reporting for staff at the clinic, or for decision-making about allocation of clinic resources. There must be mechanisms for ensuring communication between the leadership of mental health services and that of the associated CBOCs, such that their mental health delivery needs, activities, and evaluation outcomes are appropriately considered in the governance and decision-making processes for those facilities. ***NOTE:*** *This requirement for oversight and communication is intended to ensure the ability of*

the CBOC to respond to patients' mental health needs, regardless of the processes used to address them. It applies whether or not the CBOC has specific mental health staffing.

8. COMMUNITY MENTAL HEALTH

a. Each VISN and each medical center must appoint mental health staff responsible for liaison with State, county, and local mental health systems and with community providers, ensuring coordination of VA activities with those of other public mental health and health systems. Such activities include:

(1) Informing State, county, and local mental health providers about VA services.

(2) Working through or with existing programs providing liaison with State National Guard programs, and with Vet Centers in their outreach to Post Deployment Health Re-Assessment (PDHRA) events.

(3) Maintaining awareness of community-based public and private mental health assets, particularly with respect to veterans and their families.

(4) Developing models for coordinating services for veterans and families (e.g., sharing agreements, collocation of staff, providing telemental health).

(a) Coordination of telemental health programs needs to be overseen by the Office of Care Coordination.

(b) Sharing agreements with the Department of Defense (DOD) and the military services must be coordinated through the office designated for that function.

(5) Addressing issues regarding involuntary mental health treatment that occur under State laws and sometimes across state lines.

b. When responsibilities for care within a State are divided between two or more VISNs, the VISNs need to coordinate their State liaison activities.

c. VISNs must designate a mental health professional, usually one of the facilities' SPCs, to serve on each State's council or workgroup on suicide prevention.

d. Each VISN and each medical center must designate at least one mental health professional to serve as public spokespersons for specific mental health issues. These individuals must work collaboratively with public affairs, communications offices, and leadership at the local, regional, and national levels. ***NOTE:*** *Media training is encouraged.*

e. Each facility must designate at least one individual to serve as a liaison with Vet Centers in the area (if any), to ensure care coordination and continuity of care for veterans served through both systems.

f. Facilities need to develop processes and procedures for promoting collaborations between mental health providers and VA Chaplains. Mental health services are encouraged to work with Chaplaincy to develop interactions with community clergy, including training to facilitate collaboration, appropriate referral, and coordination of services.

g. VISNs and facilities must collaborate with Vet Centers in outreach to returning veterans. Outreach activities can include presentations at National Guard or Reserve sites and PDHRA events.

(1) Outreach to OEF and OIF veterans has several goals:

(a) Informing recently discharged veterans of the nature of VA benefits including, but not limited to health care benefits;

(b) Screening veterans for signs and symptoms of mental health conditions; and

(c) Supporting engagement in clinical services as needed.

(2) Outreach can involve veterans' families, as well as the veterans themselves, consistent with VA's legal authority.

h. Facilities are strongly encouraged to implement and maintain a local mental health Consumer-Advocate Liaison Council to facilitate input from stakeholders on the structure and operations of mental health services.

(1) Mental health Consumer-Advocate Liaison Councils are composed of consumers and family members of consumers, and may include other stakeholders including, but not restricted to:

(a) Veteran Service Organizations (VSOs),

(b) Representatives from the National Alliance for the Mentally Ill (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health advocacy groups active within the local community; and

(c) Local community employment and housing representatives;

(2) If a facility has a Mental Health Consumer-Advocate Liaison Council, at least one VA mental health staff member must be designated to serve as a liaison to the Council to facilitate communication with the leadership of the facility's mental health program.

(3) The Federal Advisory Committee Act (FACA) may be applicable to the Consumer-Advocate Liaison Council. Facilities must consult with Regional Counsel to ensure compliance with FACA, if applicable.

9. GENDER-SPECIFIC CARE

a. Mental health services need to be provided to those who need them in a manner that recognizes that gender-specific issues can be important components of care.

(1) Facilities are strongly encouraged, when clinically indicated, to give veterans (women and men) being treated for MST the option of being assigned a same-sex mental health provider, or opposite-sex provider if the trauma involved a same-sex perpetrator.

(2) Facilities are strongly encouraged to give patients treated for other mental health conditions the option of a consultation from a same-sex provider regarding gender-specific issues. ***NOTE:*** *Facilities are encouraged to offer men and women treated for other mental health conditions the option of a consultation or treatment from an opposite-sex mental health provider, when clinically appropriate.*

b. All VA facilities must accommodate and support women and men with safety, privacy, dignity, and respect.

c. All inpatient and residential care facilities must provide separate and secured sleeping accommodations for women. Mixed gender units must ensure safe and secure sleeping and bathroom arrangements, including, but not limited to door locks and proximity to staff.

10. 24 HOUR A DAY, 7 DAYS A WEEK (24/7) CARE

a. VHA policy requires that all VHA Emergency Departments (EDs) have mental health coverage by an independent, licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, or advanced practice nurse) either on site or on call, on a 24/7 basis. For "Level 1A" facilities (those facilities that have higher utilization, higher risk patients, specialized intensive care units, and research, educational, and clinical missions), mental health coverage must at a minimum be on-site (based in the ED) from 7 am to 11 pm. At other times, it may be on-site or on-call. For other facilities, coverage may be either on-site or on-call at all times. On-call coverage requires a telephone response within 20 minutes and the ability to implement on-site evaluations within a period of time to be established on a facility-by-facility basis. Psychiatric residents and psychology postdoctoral fellows, where available, may provide ED coverage. If that coverage is on site, then a psychiatry or psychology supervising attending must also be present in the ED. Psychiatry residents or psychology fellows who are on call and respond to requests for ED consultation are expected to contact their supervising practitioners while the patient is still in the ED in order to discuss the case and to develop and recommend a plan of management.

b. All medical centers with emergency departments must have resources to allow extended observations or evaluations for up to 23 hours when clinically necessary. This may be accomplished through accommodations such as observation beds in the EDs, or, when consistent with State law and accreditation standards, through arrangements with inpatient units. These may be especially important to allow observations and evaluations of patients presenting in states of intoxication.

c. Urgent care centers must have mental health coverage during their times of operation. "Level 1a" complexity sites must have mental health coverage from a licensed independent mental health provider available on-site during their times of operation at least from 7 am to 11

pm with on-call coverage at other times. For other facilities, urgent care centers must have mental health coverage during their times of operation that may be on-site or on-call.

d. Providers in EDs and Urgent Care Centers, as well those in mental health care settings must be aware of relevant State laws for involuntary hospitalization, and consult Regional Counsel as needed.

(1) Facilities with locked and secure mental health inpatient units must be prepared when it is feasible to accept involuntary admissions resulting from civil commitments for those veterans for whom VHA provides health care services.

(2) All other facilities must have agreements with appropriate agencies or hospitals to allow them to arrange involuntary hospitalization when it is appropriate.

(3) Requirements for facilities to accept involuntary hospitalizations resulting from civil commitments do not apply when another agency of Federal, State, or local government has the duty to give the care or services in an institution of such government.

e. All telephone triage programs must have the capacity to evaluate mental health problems by having:

(1) Staff, training, and protocols to allow responders to screen for mental health conditions and to know when to contact the mental health provider on-call for an evaluation of the screening findings.

(2) A mental health provider on-call to provide back-up decision-support when needed.

(3) Procedures to facilitate access to the national suicide prevention hotline when appropriate.

f. All CBOCs and facilities without EDs or 24/7 urgent care must have predetermined plans for responding to mental health emergencies when they occur during times of operation. They must:

(1) Identify at least one accessible VA or community-based ED where veterans are directed to seek emergent care when necessary,

(2) Develop contracts, sharing agreements or other appropriate arrangements with them for sharing information, and

(3) Develop financial arrangements for payment for authorized emergency services and necessary subsequent care.

g. Patients in ED or urgent care settings must be evaluated to establish the urgency of care. When indicated, interventions must be initiated immediately, with follow-up as appropriate. Follow-up for mental health conditions determined to be non-urgent must be within 14 days.

11. INPATIENT CARE

a. Inpatient care must be available to all veterans who require hospital admissions for a mental disorder, either in the VA medical center where they are treated, a nearby facility, or by contract, sharing agreement, or non-VA fee-basis referral to a community facility to the extent that the veteran is eligible.

b. Secured (locked) inpatient mental health units must be available for these veterans when symptoms or conditions require them. Secured inpatient units in VA medical centers must be prepared when it is feasible to accept involuntary hospitalizations resulting from civil commitments for veterans for whom VHA provides health care services.

(1) Requirements for facilities to accept involuntary hospitalizations resulting from civil commitments do not apply when another agency of Federal, State, or local government has the duty to give the care or services in an institution of such government.

(2) Facilities must consult regional counsel, as needed, to ensure that local policies are consistent with Federal, State, and other applicable laws.

c. Inpatient units must promote a positive therapeutic and least restrictive environment and strive to be restraint- free.

d. Acute hospitalization must be available without delay for those who require urgent or emergent admissions.

e. Staff on inpatient units must function as care teams with close coordination of their activities to ensure continuity of care, safety, and effective treatment for all patients.

f. All patients on inpatient units must be evaluated as clinically indicated for warning signs of self-destructive and dangerous behaviors, including risks of suicide and violence. When such symptoms or warning signs are observed, the care team must act immediately to optimize safety.

g. All inpatient units must be surveyed at least quarterly with the Environment of Care checklist at: http://vaww.ncps.med.va.gov/Dialogue/pslog/view.asp?eid=280 . ***NOTE:*** *This is an internal VA web site not available to the public.* Safety problems need to be remedied or mitigated prior to the next quarterly review. Requests for exceptions must be approved by the VISN Director and the VA Office of Mental Health Services.

h. Acute inpatient psychiatry units need to be staffed at a level that ensures that all patients are safe in the environment of care. One on one (1:1) care may be necessary for patients with a high risk for suicide.

i. Privacy and a safe environment for all patients are required in all inpatient mental health programs, as well as access to gender-specific staff when clinically indicated.

j. Inpatient, as well as outpatient care, must be guided by principles of psychosocial rehabilitation with an expectation of recovery. Specifically:

(1) The veteran or the veteran's authorized surrogate and, with the veteran's consent, family members must be encouraged to participate in inpatient treatment planning and discharge planning to the fullest extent possible. ***NOTE:*** *Involuntarily committed patients are to be presumed to have decision-making capacity, unless a formal assessment has determined they lack capacity for a specific treatment decision.*

(2) Staff evaluations of inpatients must include attention to the veteran's goals, activities directed toward improved functioning, involvement in community activities, and other indices of functioning and role performance.

(3) Treatment goals for inpatients need to be congruent with those expectations for functioning, including discharge to a less restrictive level of care.

k. Discharge planning needs to include:

(1) Consideration of referral to Mental Health Intensive Case Management (MHICM) programs or utilization of other recovery-oriented resources, such as Psychosocial Rehabilitation and Recovery Centers (PRRC) (see subpar. 17.b); and

(2) Communication and coordination with primary care.

12. RESIDENTIAL REHABILITATION AND TREATMENT PROGRAMS (RRTP)

NOTE: *Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) provide residential rehabilitative and clinical treatment for veterans who have a wide range of problems, illnesses, or rehabilitative care needs. These can be medical, psychiatric, vocational, educational, and social and could be related to Substance Use Disorder (SUD), homelessness and other conditions or problems. The term MH RRTP is used to refer to those facilities currently designated as Psychosocial Residential Rehabilitation Treatment Programs (PRRTPs), Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Programs (PTSD-RRTPs), Substance Abuse Residential Rehabilitation Treatment Programs (SARRTPs), and Compensated Work Therapy (CWT)-Transitional Residence (TRs), as well as Domiciliaries, also designated as Domiciliary Residential Rehabilitation Treatment Programs (DRRTPs), and Domiciliary Care for Homeless Veterans (DCHVs). Although these programs have different histories and different eligibility policies, the clinical policies and clinical practices are identical.*

a. Given their distinct mission to serve veterans with multiple and severe deficits, MH RRTPs must <u>not</u> be used as a substitute for community housing or as VA lodging or Hoptel facilities. Additionally, VA lodging or Hoptel facilities do not provide the necessary structure, programming, support, and are not an appropriate alternative or replacement for an MH RRTP

b. Each veteran who requires domiciliary care or residential rehabilitation and treatment programs must have timely access to these residential care programs as medically necessary to

meet the veteran's need for specialized, residential, intensive mental health treatment, and rehabilitation services.

c. Each medical center must provide access to MH RRTP services for veterans who require this type of care. This requirement can be met:

(1) On a local basis through the availability of MH RRTP at the facility,

(2) On a regional basis through service agreements with other VA facilities, or

(3) By sharing agreements, contracts, or non-VA fee basis care to the extent the veteran is eligible, in community facilities.

d. Each VISN must have residential care programs able to meet the needs of women veterans and veterans with a Serious Mental Illness (SMI), PTSD, MST, SUD, Homelessness, and Dual Diagnoses either through special programs or specific tracks in general residential care programs. However, the needs for some types of sub-specialty care (e.g., women with PTSD or veterans with PTSD and SUD) may be limited, and regional or national resources may be needed.

e. Mental health services must be provided as needed to female veterans at a level equivalent to their male counterparts at each facility. MH RRTP clinicians must possess training and competencies to meet the unique mental health needs of women veterans.

f. MH RRTPs must be Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited in Behavioral Health Residential Standards.

g. Facilities must ensure that waits for admission to a MH RRTP do not delay the implementation of care by instituting processes that include:

(1) Ongoing monitoring and case management of referred patients.

(2) Provision of treatment as needed to ensure stabilization of target conditions and management of comorbidities. ***NOTE:*** *This may include inpatient care.*

(3) Utilizing waiting periods to provide pre-group preparation to enhance the experience and benefits of group treatment. Pre-group preparation can be provided on an outpatient basis provided veterans are in a safe and secure environment.

h. Whenever veterans awaiting admission to an RRTP have an urgent need for mental health care, appropriate mental health services must be provided.

i. Whenever there is a gap of greater than 2 weeks for any veteran accepted into an MH RRTP, providers must maintain clinical contact with the veteran until the time of admission, and address any urgent mental health care needs that arise.

j. When the referral to the MH RRTP involves a transfer between facilities, the referring facility must maintain full responsibility for the patient until the time of admission.

Responsibility for travel arrangements and transfer expenses must be determined in accordance with current VHA inter-facility transfer policy.

k. The use of cohort-based or closed group modalities can enhance the levels of trust and cohesiveness between group members, especially when highly-sensitive topics are discussed. However, they can also introduce delays in admission and the start of treatment. Use of cohort-based or closed groups is authorized in a VHA facility only when the care system within the facility is designed to ensure that they do not lead to any veteran being turned away from care.

(1) When VHA facilities utilize cohort or closed group treatment, the facility must ensure that this does not limit access to needed care. This may require immediate provision of all required treatment that can be provided for veterans outside of the closed group in ambulatory, inpatient, or other residential care settings as appropriate.

(2) Pre-group preparation can be provided when needed on outpatient basis provided veterans are in a safe and secure environment or in open beds in a MH RRTP.

l. Facilities must ensure that discharge planning, including an aftercare plan, occurs for all veterans leaving an MH RRTP and that these veterans are provided services based on a plan of care addressing clinical needs at time of discharge.

m. Facilities must ensure full compliance with MH RRTP Safe Medication Management (SMM) procedures. ***NOTE:*** *VHA Handbook 1108.3 Self Medication Program does not apply to MH RRTPs.*

n. Facilities must ensure safety and security of all MH RRTPs. Facilities must ensure that each MH RRTP is in compliance with VA and accrediting body standards for safety and security.

o. MH RRTPs require 24/7, on site-supervision. At least one staff member must be physically present on the unit at all times that veterans are present on the unit. The only exception to this requirement is for mental health rehabilitation and treatment services provided in CWT-TR. Because residents in these facilities are more stable and functional than those in other MH RRTPs, a peer "house manager" may supervise the residence in lieu of staff. However, professional staff must be available when needed on an emergency basis**.**

p. Each MH RRTP must be staffed by an interdisciplinary clinical team or teams of health care professionals and paraprofessionals. Attention to the veteran's medical, social, and psychological needs must be ensured through adequate medical staff, social workers, and psychologists. Appropriate supporting administrative and clerical staff must be provided to allow for efficient operation.

q. In most MH RRTPs, staffing includes full-time staff assigned directly to the program and part-time staff from other inpatient or outpatient units providing treatment and rehabilitation services.

r. Special attention must be given to meeting the unique needs of women veterans, especially in the areas of SMI, sexual trauma, homelessness, and interpersonal violence.

s. All MH RRTPs must be sensitive to the special needs of veterans, and to the needs of specific populations, including, but not limited to: the homeless; ethnic minorities; women; geriatric patients; those with SUD, PTSD, and other psychiatric comorbidities; infectious disease; Spinal Cord Injury (SCI); and Traumatic Brain Injury (TBI).

t. Based on the MH RRTP's mission and patient demographics, MH RRTP staff must have competencies to meet the individual needs of special populations.

u. Evidenced-based psychosocial treatment interventions must be provided when they are needed clinically in each MH RRTP. ***NOTE:*** *MH RRTPs are strongly encouraged to include Seeking Safety, motivational interviewing, motivational incentives for recovery-related behaviors, and supported employment.*

v. All MH RRTPs must have staffing with the training and expertise needed to provide interventions, designed to benefit the veteran, that include residents' families when these are included in the treatment plan.

13. AMBULATORY MENTAL HEALTH CARE

NOTE: *Evaluations and treatment for mental health conditions can be provided in mental health care services, through primary care and other medical care settings, or by arrangements with non-VA community services.*

a. All new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days.

(1) The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs, and to trigger hospitalization or the immediate initiation of outpatient care when needed.

(2) The initial 24 hour evaluation can be conducted by primary care, other referring licensed independent providers, or by licensed independent mental health providers.

b. Waiting times for all services for established patients must be less than 30 days from the desired date of appointment.

c. Telemental Health services require a qualified professional at the facility and support staff at the distal end who can arrange appropriate time and space for the veteran, and staff who can provide technical support as needed.

(1) Use of Telemental Health to support the delivery of services is allowed and encouraged as a mechanism for meeting requirements throughout this document. Nevertheless, it is important to recognize that there may be limits to the services that can be provided using this technology. These may include certain highly interactive and "high-touch" evaluations or interventions.

(2) Sufficient band width is required for satisfactory communication. The Mental Health Service needs to consult with the medical center and VISN Information Technology Offices to determine specific requirements to have satisfactory clinical video conferencing capabilities.

d. Psychotherapy groups can be closed or cohort-based, or they can continually be open to new members. There are a number of arguments in favor of closed groups. However, waiting for the formation of a new group can lead to delays in the institution of treatment. Accordingly, closed or cohort-based groups are allowable in VHA facilities only when the facility's care system ensures that they do not lead to the denial of care for any veteran, and that waiting for the start of a new psychotherapy group does not lead to delays in the implementation of care

(1) Whenever veterans have an urgent need for mental health care, appropriate mental health services must be provided.

(2) Patients awaiting the start of a therapy group must be monitored on an ongoing basis. Their care needs must be evaluated, and alternative treatments must be implemented when needed, for example:

(a) When patients are a danger to themselves or others,

(b) When they are experiencing increasing degrees of impairment, or

(c) When they are suffering from severe symptoms.

(3) Waiting periods need to be utilized to provide pre-group preparation to enhance the experience and benefits of group treatment. Whenever patients need to wait for the start of a group, they must be offered an appropriate form of interim treatment.

e. VA medical centers must provide general and specialty mental health services when those receiving care from the medical centers need them.

(1) General mental health services include:

(a) Diagnostic and treatment planning evaluations for the full range of mental health problems;

(b) Treatment services using evidence-based pharmacotherapy, or evidence-based psychotherapy for patients with mental health conditions and substance use disorders;

(c) Patient education;

(d) Family education when it is associated with benefits to the veterans;

(e) Referrals as needed to inpatient and residential care programs; and

(f) Consultation about special emphasis problems including PTSD and MST.

(2) Specialty mental health services include:

(a) Consultation and treatment services for the full range of mental health conditions;

(b) Evidence-based psychotherapy;

(c) MHICM;

(d) Psychosocial Rehabilitation Services, including: PRRCs, family psycho-education, family education, skills training, peer support, and CWT and supported employment;

(e) PTSD teams or specialists;

(f) MST special clinics;

(g) Homeless programs; and

(h) Specialty substance abuse treatment services.

f. Clinics in medical centers must offer a full range of services during evening hours at least 1 day per week. Additional evening, early morning, or weekend hours need to be offered when they are required to meet the needs of the facility's patient population.

(1) Like medical centers, very large CBOCs, those seeing more than 10,000 unique veterans each year, must provide mental health services to those who need them during evening hours at least 1 day per week. Like medical centers, they must offer services during additional evening, early morning, or weekend hours when they are required to meet the needs of the facility's patient population.

(2) Other CBOCs are strongly encouraged to provide mental health services to those who need them evenings and weekends.

g. Facilities must offer options for needed mental health services to veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible.

(1) This may be through providing care in a MH RRTP when this is clinically necessary.

(2) It can include provision of telemental health services with secure access available near the veteran's home, or

(3) It can also include making services available by using a sharing agreement, contract, or non-VA fee basis to the extent that the veteran is eligible from appropriate community-based providers, when available.

(4) When veterans decline these options because they prefer to receive care from VA providers, this must be documented.

h. Very large CBOCs, those serving 10,000 or more unique veterans each year, are encouraged to provide MHICM teams, PRRCs, intensive outpatient programs for SUD, and Grant and Per Diem programs for homeless veterans. They are required to provide the other ambulatory care services listed in paragraph 13 when these are needed.

i. Large CBOCs, those serving 5,000 or more unique veterans annually, must provide the general and specialty mental health services required (see subpar. 13e) for those who need them, using telemental health as needed to meet this requirement. They must provide a substantial component of the mental health services required by their patients on-site or by telemental health, but they may supplement these services by referrals to geographically-accessible VA medical centers, or through sharing agreements, contracts or non-VA fee-basis mechanisms to the extent that the veteran is eligible.

j. Mid-sized CBOCs, those serving between 1,500 and 5,000 unique veterans annually, must provide general mental health services as required by their patients, using telemental health as needed. Other services must be available to those who need them by using:

(1) On-site or telemental health;

(b) Referral to a VA MH RRTP when this type of care is needed;

(c) Referral to mental health services at a geographically-accessible VA medical center; or

(d) A sharing agreement, contract, or non-VA fee basis to the extent that the veteran is eligible .

k. Smaller CBOCs with less than 1,500 unique veterans are:

(1) To provide access to the full range of general and specialty mental health services to those who need them through on-site services, telemental health, referral to a VA MH RRTP when this type of care is needed, by referral to mental health services at a geographically accessible VA medical center, or through either contracts or non-VA fee-basis to the extent the veteran is eligible with local providers or organizations.

(2) Strongly encouraged to provide evaluation and treatment-planning services, as well as general mental health services on-site or by telemental health.

14. CARE TRANSITIONS

Facilities must ensure continuity of care during transitions from one level of care to another. When veterans are discharged from inpatient or residential care settings, they must;

a. Receive information about how they can access mental health care on an emergency basis.

b. Be given appointments for follow-up at the time of discharge.

c. Receive follow-up mental health evaluations within 1 week of discharge.

(1) Facilities are strongly encouraged to provide follow-up within 48 hours of discharge.

(2) When necessary because of the distance of the veteran's home from the facility where the veteran receives follow-up care or other relevant factors, the 1-week follow-up may be by telephone.

(3) Any indications of clinical deterioration, non-adherence with treatment, or danger to the veteran or others must trigger appropriate and timely interventions.

(4) In all cases, veterans must be seen for face-to-face evaluations within 2 weeks of discharge. When veterans refuse these evaluations, the refusal must be documented. When veterans miss scheduled appointments, there must be follow-up and documentation in the clinical record.

d. Receive follow-up medical evaluations within a time frame established through communication and coordination with primary care or another relevant service.

15. SUBSTANCE USE DISORDERS (SUD)

a. **Patient-Centered Requirements**

(1) Appropriate services addressing the broad spectrum of substance use conditions including tobacco use disorders must be available for all veterans who need them.

(2) Services for tobacco-related disorders need to be provided to those who need them in a manner that is consistent with the VA-DOD Clinical Practice Guideline for Management of Tobacco Use, which can be found at: http://www.oqp.med.va.gov/cpg/TUC3/TUC_Base.htm

(a) During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for tobacco use.

(b) In addition to education and counseling about smoking cessation, evidence-based pharmacotherapy needs to be available for all adult patients using tobacco products. When provided, pharmacotherapy needs to be directly linked to education and counseling.

(3) To the greatest extent practicable and consistent with clinical standards, interventions for substance use conditions must be provided when needed in a fashion that is sensitive to the needs of veterans and of specific populations including, but not limited to: the homeless; ethnic minorities; women; geriatric patients; and patients with PTSD, other psychiatric conditions, and patients with infectious diseases (human immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and hepatitis C); TBI; and SCI.

(4) Services addressing substance use conditions can be provided in VA facilities in SUD specialty care, in primary care and other medical care settings (especially in programs that integrate mental health and primary care), through programs integrating treatment for co-occurring mental health disorders and SUD (dual diagnoses) in mental health settings, or in community settings through sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible. Regardless of the setting, the process of care must recognize the principle that SUDs are, in most cases, chronic or episodic and recurrent conditions that require ongoing care.

(5) Consistent with the National Voluntary Consensus Standards for Treatment of Substance Use Conditions endorsed by the National Quality Forum (2007) and the VA-DOD Clinical Practice Guidelines for Management of Patients with SUD in Primary and Specialty Care Settings, the following services must be readily accessible to all veterans when clinically indicated.

(a) During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for alcohol misuse.

(b) Because population screening is not evidence-based for substance use conditions other than alcohol misuse and tobacco use; primary care, medical specialty, and mental health services need to use targeted case-finding methods to identify patients who use illicit drugs or misuse prescription or over-the counter agents. These methods need to include evaluation of signs and symptoms of substance use in patients with other relevant conditions (e.g., other mental health disorders, hepatitis C, or HIV disease).

(c) Patients who have a positive screen for, or an indication of, a substance use problem must receive further assessments to determine the level of misuse and to establish a diagnosis. Diagnostic assessment can be conducted by primary care or other medical providers, mental health providers, or specialists in substance use disorders. Patients diagnosed with a substance use illness must receive a multidimensional, bio-psychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting psychiatric or general medical conditions.

(d) All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines need to receive education and counseling regarding drinking limits and the adverse consequences of heavy drinking. When the excessive alcohol use is persistent, the patients are to receive brief motivational counseling by a health care worker with appropriate training in this area, referral to specialty providers, or other interventions depending upon the severity of the condition and the patient's preferences. For patients who are identified as dependent on alcohol, further treatment must be offered, with documentation of the offer and the care provided.

(e) All health care providers caring for an individual veteran must systematically promote the initiation of treatment and the ongoing engagement in care for patients with SUD.

1. For patients with SUD who decline referral to specialty SUD treatment, providers in primary care, mental health, or other settings need to continue to monitor patients and their substance use conditions. They are to utilize their interactions with the patient to address the substance use problems and to work with them to accept referrals. ***NOTE:*** *Strategies that may enhance motivation to seek SUD specialty care include: providing the patient easy-to-read information on the adverse consequences of drinking; having the patient identify problems that alcohol has caused; urging the patient to maintain a contemporaneous diary of alcohol use and the circumstances and consequences associated with it; and frequent appointments with the patient.* Interventions with SUD treatment-reluctant patients are always to be characterized by a high-degree of provider empathy.

2. Motivational counseling needs to be available to patients in all settings who need it to support the initiation of treatment.

3. When patients are evaluated as appropriate and are willing to be admitted to inpatient or residential treatment settings for substance use conditions, but admission to those settings is not immediately available, interim services must be provided as needed to ensure patient safety and promote treatment engagement.

(f) All facilities must make medically-supervised withdrawal management available as needed, based on a systematic assessment of the symptoms and risks of serious adverse consequences related to the withdrawal process from alcohol, sedatives or hypnotics, or opioids.

1. Although withdrawal management can often be accomplished on an ambulatory basis, facilities must make inpatient withdrawal management available for those who require it. Services can be provided at the facility, by referral to another VA facility, or by sharing arrangement, contract, or non-VA fee basis arrangements to the extent that the veteran is eligible with a community-based facility.

2. Withdrawal management alone does not constitute treatment for dependence and must be linked with further treatment for SUD. Appointments for follow-up treatment must be provided within 1 week of completion of medically-supervised withdrawal management.

(g) Coordinated and intensive substance use treatment programs must be available for all veterans who require them to establish early remission from the SUD. These coordinated services can be provided through either or both of the following:

1. Intensive Outpatient services at least 3 hours per day at least 3 days per week in a designated program delivered by staff with documented training and competencies addressing SUD.

2. An MH RRTP, either in a facility that specializes in SUD services or a SUD track in another MH RRTP that provides a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regimen.

(h) Multiple (at least two) empirically-validated psychosocial interventions must be available for all patients with substance use disorders who need them, whether psychosocial

intervention is the primary treatment or as an adjunctive component of a coordinated program that includes pharmacotherapy. Empirically-validated interventions include motivational enhancement therapy, cognitive behavioral therapy for relapse prevention, 12-step facilitation counseling, contingency management, and SUD-focused behavioral couples counseling or family therapy.

(i) Pharmacotherapy with approved, appropriately- regulated opioid agonists (e.g., buprenorphine or methadone) must be available to all patients diagnosed with opioid dependence for whom it is indicated and for whom there are no medical contraindications. It needs to be considered in developing treatment plans for all such patients. Pharmacotherapy, if prescribed, needs to be provided in addition to, and directly linked with, psychosocial treatment and support. When agonist treatment is contraindicated or not acceptable to the patient, antagonist medication (e.g., naltrexone) needs to be available and considered for use when needed. Opioid Agonist Treatment can be delivered in either or both of the following settings:

1. Opioid Treatment Program (OTP). This setting of care involves a formally-approved and regulated opioid substitution clinic within which patients receive opioid agonist maintenance treatment using methadone or buprenorphine.

2. Office-based Buprenorphine Treatment. Buprenorphine can be prescribed as office-based treatment in non-specialty settings (e.g., primary care), but only by a "waivered" physician. Buprenorphine is not subject to all of the regulations required in officially-identified OTPs, but must be delivered consistent with treatment guidelines and Pharmacy Benefits Management criteria for use.

(j) Pharmacotherapy with an evidence-based treatment for alcohol dependence is to be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, must be provided in addition to, and directly linked with, psychosocial treatment and support.

(k) Patients with substance use illness need to be offered long-term management for substance use illness and any other coexisting psychiatric and general medical conditions. The patient's condition needs to be monitored in an ongoing manner, and care needs to be modified, as appropriate, in response to changes in their clinical status.

(l) When PTSD or other mental health conditions co-occur with substance use disorders, evidence-based pharmacotherapy and psychosocial interventions for the other conditions need to be made available where there are no medical contraindications, with appropriate coordination of care.

(m) Substance use illness must never be a barrier for treatment of patients with other mental health conditions. Conversely, other mental disorders must never be a barrier to treating patients with substance use illnesses. When it is appropriate to delay any specific treatment, other care must be provided to address the clinical needs of the veteran.

(6). Consultations from specialists in substance use disorders or dual diagnosis must be available when needed to establish diagnoses and plan treatment.

b. **Facility- and Service-Based Requirements**

(1) Medical centers must provide all of the services listed in subparagraph 15a(5) for veterans who clinically require them.

(2) CBOCs must make all of the services listed above available to veterans who need them. For each service that they do not provide, they must identify available sites within the VA or community to support timely referral when required.

(3) Primary Care Clinics, whether in medical centers or CBOCs, must provide the components of care listed in subparagraphs 15a(5)(a) through 15a(5)(d), 15a(5)(e)1, and 15a(5)(e)2, for those who need them; they may also provide additional services. Specifically, they are encouraged to provide pharmacotherapy, when indicated, in combination with psychosocial interventions through on-site staff or by telemedicine. Those services that are not provided in the clinics must be made available to those who need them by referral to other accessible VA clinics or facilities, or through referral using a sharing arrangement, contract or non-VA fee basis services in the community to the extent that the veteran is eligible.

(4) Medical centers and very large CBOCs must provide care to meet the needs of veterans with other coexisting mental health and substance use disorders.

(a) To support the care of patients whose primary problem is a mental health condition, general mental health services must provide the components of care listed in subparagraphs 15a(5)(a) through 15a(5)(d), 15a(5)(e)1, and 15a(5)(e)2, for those who need them.

(b) When care for mental health conditions and substance use disorders are provided in distinct services, there must be mechanisms in place to ensure coordination of care, e.g., care management.

(5) EDs must have the resources to evaluate substance-related conditions including intoxication and withdrawal. All medical centers with EDs must have resources to allow extended observations or evaluations for up to 23 hours when clinically necessary. This may be accomplished through accommodations, such as observation beds in the ED, or through arrangements with inpatient units.

(6) Trained providers need to be available to administer appropriate brief treatments as needed for substance use disorders face-to-face, by telemental health, or by telephone within 2 weeks of the time that the need is identified.

16. SERIOUSLY MENTALLY ILL (SMI)

a. Recovery and rehabilitation-oriented programs must be available for all SMI patients.

b. Medical care for SMI patients must meet the same performance measures and quality standards as other patients.

c. Based upon the evidence for the effectiveness of Assertive Community Treatment services as modified for use in the VA, MHICM programs must be available to patients in all facilities with more than 1,500 patients on the Serious Mental Illness Research and Evaluation Center (SMITREC) psychosis registry. SMITREC distributes facility-specific counts to the facilities through 10N on at least an annual basis. At least four "on the street" Full-time Equivalent (FTE) employees are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA Medical Center in order that they can provide 24-hour coverage and emergency services.

(1) Each team must have a full time registered nurse and at least either a Psychiatrist or other M.D who is knowledgeable about psychopharmacological treatment, or an Advanced Practice Registered Nurse (APRN) as a prescriber dedicated to the team for at least 20 percent time.

(2) MHICM teams must provide the majority of their services in a community setting with an average of two to three contacts per patient per week; they are strongly encouraged to provide 75 percent of their services in the community.

d. VISNs and facilities are strongly encouraged to provide MHICM-Rural Access Network for Growth Enhancement (RANGE) programs for those who need them in smaller facilities, especially in more rural areas. When implemented in smaller and more rural settings, the MHICM model may need to be modified. The RANGE model, designed for use rural settings, is based on two FTE teams that have collaborative linkages with other VA mental health professionals and with experienced full MHICM teams in the same VISN.

e. Clozapine (CLZ) prescribing must be available to all veterans who may benefit from this agent.

(1) VA medical centers must have relevant mental health and pharmacy patches installed. CBOCs must be connected by a real-time computer link to the parent VA medical center to derive the full benefit of safety intercepts that prevent dispensing in case of unacceptably low levels of neutrophil or white blood cell counts in compliance with Federal Drug Administration (FDA) regulations.

(2) The Chief of the Mental Health Service at each facility is responsible for overseeing the implementation and maintenance of the CLZ Patient Management Program. If a psychiatrist, this individual may function as the CLZ Treatment Manager or may delegate this role to another qualified psychiatrist. If the Chief, Mental Health Services is not a psychiatrist, a qualified psychiatrist must be selected to serve in this role. All patients, physicians, and pharmacies using CLZ must be registered with the FDA. The VA National CLZ Coordinating Center (NCCC) performs the required registrations for all VA medical centers.

(3) Except where it is medically contraindicated, all veterans diagnosed with schizophrenia or schizoaffective disorders with severe residual suffering, symptoms, or impairments must be offered CLZ after two trials of other antipsychotic medications, with an explanation of its potential risks and its potential benefits consistent with procedures for informed consent as outlined in VHA Handbook 1004.1. The patient's informed consent for CLZ treatment, their

informed refusal of CLZ, or a psychiatrist's documentation of contraindications must be documented on the medical record.

f. Facilities are encouraged to develop procedures for advance care planning for patients with SMI as individuals in this patient population may be at risk for losing decision-making capacity (see VHA Handbook 1004.2).

g. Facilities are encouraged to add structured programs for care management for patients with bipolar disorder.

17. REHABILITATION AND RECOVERY-ORIENTED SERVICES

a. **Local Recovery Coordinators**. Each VA medical center must maintain the Local Recovery Coordinator (LRC) position first authorized in FY 2007 to help transform local VA mental health services to a recovery-oriented model of care, to sustain those changes, and to support further systemic change as new evidence becomes available on optimal delivery of recovery-oriented mental health care.

(1) The LRC is located within the mental health services line or the facility's equivalent. In general, this position needs to report to the service line director or equivalent.

(2) The LRC is responsible for:

(a) Leading the integration of recovery principles into all mental health services provided at the Medical Center and its affiliated CBOCs.

(b) Working collaboratively with the other LRCs in the VISN, one of whom must serve in a coordinator role for VISN level activities, and with national leadership.

(c) Being directly involved in the direct provision of recovery-oriented clinical services.

(d) Providing training and consultation to facility leadership, staff, veterans, and family members regarding the recovery transformation.

(e) Promoting the integration of recovery services across all mental health programs.

(f) Promoting activities to eliminate any stigma associated with mental illness.

(g) Ensuring that veterans with SMI are given every opportunity to pursue and be responsible for their own goals.

b. **Psychosocial Rehabilitation and Recovery Center (PRRC).** These PRRCs are distinct from MH RRTPs in that they provide ambulatory, not residential, services. Medical centers with 1,500 or more current patients included on the National Psychosis Registry (NPR) must have a PRRC. Other medical centers with over 1,000 patients on the NPR are strongly encouraged to have a PRRC.

(1) Facilities currently having Day Treatment Centers (DTCs), day hospitals, partial hospitals, or analogous programs must transform their existing programs into PRRCs.

(2) PRRCs must provide a therapeutic and supportive learning environment for veterans in the program designed to maximize functioning in all domains.

(a) Hours of operation are typically Monday through Friday from 8:00 am to 4:30 pm. However, the actual hours of operation can vary according to the number of patients served and their clinical needs.

(b) Evening and weekend hours must be available when the needs of the population require them.

(c) Typical admission criteria include a Global Assessment of Functioning (GAF) of 50 or lower (i.e., serious psychiatric symptoms or any serious impairment in social, occupational, or school functioning) and an SMI (diagnosis of psychosis, schizoaffective disorder, major affective disorder, or severe PTSD).

(d) Following the evaluation and treatment planning process, most patients initially participate in the program on a daily or near daily basis.

(e) PRRCs offer a menu of daily treatment alternatives with sufficient variety to support meaningful choice. Veterans need to be encouraged to make choices to participate in specific programming alternatives based on their perception of how their programming choices will assist them with goal attainment.

(f) In general, the intensity of each veteran's participation in the program diminishes over time, as skills are acquired so that the veteran can assume roles in the community roles that they consider meaningful.

(g) While services must be available as long as necessary, discharge from the program is mutually determined by the veteran in treatment and the PRRC treatment team. Successful discharge from the program is expected when the veteran has gained mastery over key mental health challenges and has acquired or mastered the skills enabling the veteran to function in meaningful roles in the community. Following successful discharge from the program, the veteran may participate in any element of the program on an as-needed basis in the future.

(3) A minimum array of services available to veterans in the program through PRRC staff must include:

(a) Individual psychotherapy (e.g., cognitive behavioral therapy);

(b) Social skills training;

(c) Psycho-educational groups;

(d) Illness management and recovery groups;

(e) Wellness programming;

(f) Family psycho-educational and family educational programs;

(g) Peer support services; and

(h) Treatment of co-occurring substance use disorders.

(4) Additional services that need to be available to PRRC participants as clinically indicated and coordinated with the program include:

(a) Mental health diagnostic and treatment services;

(b) Primary medical care;

(c) Case management services (including MHICM); and

(d) CWT, Transitional Work Experience, or Supportive Employment.

(5) Staffing recommended in the initial Request for Proposals (RFP) establishing PRRCs includes a program coordinator, a social worker, a nurse, a psychologist, peer support technicians, and a program support assistant. Actual staffing in each program is determined by the number of veterans served and the services provided.

(6) The services provided within PRRCs need to be available to veterans in the full program and to others with SMI who require these services for rehabilitation and recovery.

(7) The VISN Director must make the services provided through PRRCs available to veterans living in areas distant from PRRCs who need them. These services can be provided through MH RRTPs when this level of care is needed, or in community-based programs by sharing arrangement, contracting, or non-VA fee-basis care to the extent that the veteran is eligible.

c. **Family Involvement**

(1) Providers need to discuss family involvement in care with all patients with SMI, at least annually and at the time of each discharge from an inpatient mental health unit. The treatment plan needs to identify at least one family contact, or the reason for the lack of a contact (e.g., absence of a family, veteran preference, lack of consent). As part of this process, providers must seek consent from veterans to contact families in the future, as necessary, if the veteran experiences increased symptoms and families are needed to assist in care. If the veteran's consent is unobtainable, this must be documented.

(2) Family consultation, family education, or family psycho-education within existing statutory and regulatory counseling authority for veterans with SMI must be provided for those who need them at all VA medical centers and very large CBOCs (see subpar. 3a).

(3) Opportunities for family consultation, family education, or psycho-education within existing statutory and regulatory counseling authority must be available to all veterans with SMI

on-site, by telemental health, or with community providers through sharing arrangements, contracting, or non-VA fee basis care to the extent that the veteran is eligible.

d. **Social Skills Training**

(1) Social skills training is an evidence-based psychosocial intervention that must be provided when clinically indicated at all medical centers and very large CBOCs (see subpar. 3a).

(2) Social skills training must be available to all veterans with SMI who would benefit from it, including those receiving care at CBOCs, whether it is provided on site, by referral, or by telemental health.

e. **Peer Counseling**

(1) All medical centers and very large CBOCs must provide individual or group counseling from peer support technicians for veterans treated for SMI when this service is clinically indicated and included in the veteran's treatment plan.

. (2) Other CBOCs must make peer counseling available for veterans with SMI when it is clinically indicated and included in the veteran's treatment plan. Peer counseling may be made available by telemental health, referral to VA facilities that are geographically accessible, or by referral to community-based providers using contract mechanisms. Contracts for peer support services must ensure that peer providers have competencies and supervision equivalent to those required in VA facilities.

f. **CWT, Transitional Work Experience, and Supported Employment**

(1) Consultations about the need for and the likely benefits from therapeutic work-related rehabilitation programs must be available to veterans who may benefit from these programs in all facilities. This can be accomplished through outreach from medical centers or other mechanisms.

(2) Each medical center must offer CWT with both Transitional Work Experience and Supported Employment services for veterans with occupational dysfunctions resulting from their mental health conditions, or who are unsuccessful at obtaining or maintaining stable employment patterns due to mental illnesses or physical impairments co-occurring with mental illnesses.

(3) Participation in the CWT program must be available to any veteran receiving care through VA whom VA finds would benefit therapeutically from participation. To this end, information about the CWT Program and criteria for participation must be made available to staff of VA medical centers, to VA providers furnishing services through VA's telemental health programs or CBOCs, and to non-VA providers furnishing authorized health care services to veterans. Whether a particular patient's participation in the CWT program would be appropriate is a medical determination to be made by the responsible clinician, consistent with CWT Program criteria.

18. EVIDENCE-BASED TREATMENTS

a. **Evidence-based Psychotherapies**

(1) **Evidence-based Psychotherapy for PTSD.** All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy as designed and shown to be effective. Medical Centers and very large CBOCs must provide adequate staff to allow the delivery of evidence-based psychotherapy when it is clinically indicated for their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary.

(2) **Evidence-based Psychotherapy for Depression and Anxiety Disorders.** All veterans with depression or anxiety disorders must have access to Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy. Medical Centers and very large CBOCs must provide adequate staff capacity to allow the delivery of evidence-based psychotherapy when it is clinically indicated for their patients. Large and mid-sized CBOCs may provide these services through telemental health when necessary.

b. **Evidence-based Somatic Therapies**

(1) All care sites, medical centers and CBOCs need to provide evidence-based pharmacotherapy when indicated for mood disorders, anxiety disorders, PTSD, psychotic disorders, SUD, dementia, and other cognitive disorders. Such care must be consistent with current VA clinical practice guidelines and informed by current scientific literature. ***NOTE:*** *Current VA clinical practice guidelines can be found at:* *http://vaww.oqp.med.va.gov/CPGintra/cpg/cpg.htm ; and* *http://vaww.national.cmop.va.gov/PBM/Clinical%20Guidance/Forms/AllItems.aspx . These are internal VA sites that are not available to the public.*

(2) Care can be provided by a physician or appropriately credentialed and supervised advanced practice nurse or physician assistant, and may be provided using telemental health when appropriate.

(3) Because in many cases combined psychosocial and psychopharmacological treatment has been shown to be more effective than either intervention alone, veterans must have access to combined treatment when indicated. Pharmacotherapy needs to be coordinated with other psychosocial or psychological interventions patients may be receiving, as well as primary and other specialty medical care.

(a) VISNs and medical centers are encouraged to develop and implement mechanisms for making technical assistance and decision-supports for use of psychopharmacological treatments available to providers at CBOCs as necessary.

(b) Medical centers are strongly encouraged to include clinical pharmacists on their care teams to provide patient and family education and patient monitoring.

(4) Veterans must have access to electroconvulsive therapy (ECT) in the VISN in which they receive care.

(a) ECT must be provided when it is clinically indicated consistent with VA clinical practice guidelines found at: http://vaww.oqp.med.va.gov/CPGintra/cpg/MDD/MDD_Base.htm , as well as those of the American Psychiatric Association. ***NOTE:*** *VA guidelines are located on an internal VA site that is not available to the public.*

1. Staff needs to be knowledgeable about the current scientific literature.

2. Electroconvulsive therapy needs to be coordinated with other psychosocial, psychological, psychopharmacological, and medical care that patients may be receiving.

(b) Patients who respond to ECT require some form of continuation or maintenance treatment to prevent relapses or recurrences.

19. HOMELESS PROGRAMS

a. To ensure the availability of outreach and referral services to homeless veterans, all Medical centers and very large CBOCs must designate at least one outreach specialist, usually a clinical social worker, to provide services to homeless veterans. ***NOTE:*** *In smaller facilities, this may be a collateral assignment.*

b. All veterans who are homeless, or at risk for homelessness, must be offered shelter through collaborative relationships with providers in the community. Facility staff must ensure that homeless veterans have a referral for emergency services and shelter or temporary housing. To the extent that it is possible under existing legal authority, facilities must facilitate the veteran's transportation to the shelter or temporary housing.

c. Each facility must develop and maintain collaborative formal, or informal, agreements with community providers for shelter, temporary housing, or basic emergency services. Medical centers may establish contracts for transitional therapeutic housing for the treatment of homeless veterans or those at risk of becoming homeless who are diagnosed with a SMI including those with co-occurring SUD. ***NOTE:*** *Contract authority for transitional therapeutic housing is provided in Title 38 United States Code (U.S.C.) 2031, which has been extended until December, 2011.*

d. Each medical center is to develop and maintain relationships with community agencies and providers to support them in working together to allow appropriate placement for veterans together with their families when they are homeless or at risk of homelessness.

e. All facilities must provide homeless veterans who require mental health treatment and rehabilitation programs with care in programs offering these services. This may include placement in a Grant and Per Diem Program, a VA Domicilary, another VA MH RRTP, or other care settings that provide needed services. ***NOTE:*** *Eligibility criteria may differ between different types of programs.*

f. Use of emergency shelter services should generally not exceed 3 days, and is only to be used as a last resort. Within that period of time, homeless outreach staff or other qualified

clinical staff must evaluate the veteran's clinical needs, and refer or place the veteran for treatment and rehabilitation in therapeutic transitional housing, a MH RRTP, or another appropriate care setting. When longer stays in emergency shelters are unavoidable, this must be documented in the medical record; in these cases, ongoing Case Management, assessment and evaluation, and referral services must continue until more stable arrangements for transitional housing providing treatment or rehabilitation have been made.

g. All VA medical centers with an estimated 100 homeless veterans or more in their Primary Service Area must have one Grant and Per Diem Program or alternative residential care setting for homeless veterans.

h. Grant and Per Diem Programs must ensure residential supervision by trained staff on a 24/7 basis. If the supervision is provided by a program volunteer or senior resident, a paid staff member (from the Grant and Per Diem funded program) must be on call for emergencies 24/7. ***NOTE:*** *Refer to Grant and Per Diem program authority in 38 U.S.C. 61.80(b)(13).*

i. Each VA medical center that has a designated Grant and Per Diem-funded program in its area is responsible for designating a Grant and Per Diem Liaison. Each liaison is to provide case management services for Grant and Per Diem patients, and oversight of the Grant and Per Diem funded program as outlined in VHA Handbook 1162.01.

j. Department of Housing and Urban Development (HUD)-VA Supported Housing (VASH) Programs have been established in areas that have a high concentration of homeless veterans. Through a partnership agreement, HUD provides rental assistance vouchers to homeless veterans referred by VA case management staff for permanent housing. VA provides case management and other clinical services to veterans in this program. When appropriate, the housing vouchers can be provided to veterans together with their families. HUD-VASH programs require one case manager for each 35 veterans in the program.

k. Each VA medical center is required to hold one Community Homeless Assessment Local Education and Networking Groups (CHALENG) meeting annually with community partners to collaboratively asses the need for services to homeless veterans. Each VA medical center is required to have a designated Point of Contact (POC) for CHALENG.

l. **Stand Downs.** Facilities are strongly encouraged to hold Stand Downs annually as part of their outreach activities to homeless veterans and their families. Stand Downs are a significant part of the VA's efforts to provide services to homeless veterans.

(1) They are typically 1 to 3 day events providing services to homeless veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment.

(2) Stand Downs are collaborative events, coordinated between local VA facilities, other government agencies, and community agencies who serve the homeless.

20. INCARCERATED VETERANS

a. Each VISN must appoint and maintain at least one full-time Health Care for Reentry Veterans (HCRV) Specialist to support veterans being released from State and Federal prisons. VISNs are encouraged to provide one such specialist for each State, collaborating with other VISNs when States are served by more than one VISN. With assistance from VISN Mental Health leadership, the HCRV Specialist is responsible for:

(1) Identifying and maintaining a system of VA POCs at each VISN medical center in primary care, homeless, substance abuse, and mental health service programs; and

(2) Working with POCs to engage with veterans being released from prison in need of care.

b. VA is committed to the principle that when veterans' non-violent offenses are products of mental illness, veterans and their communities are often better served by mental health treatment than incarceration. Police encounters and pre-trial court proceedings are often missed opportunities to connect veterans with VA mental health services as a negotiated alternative to incarceration or other criminal sanctions. Therefore, each VA medical center is strongly encouraged to appoint and maintain an individual who fills two inter-related roles, both components of the facility's overall outreach and community education efforts:

(1) A police training coordinator, with a commitment to educating law enforcement personnel about PTSD, TBI, and other mental health issues relevant to the veteran population; and

(2) A Veterans' Justice Outreach coordinator, committed to interfacing and coordinating with the local criminal justice system, including jails and courts.

c. This individual is responsible for:

(1) Working with community agencies in providing training to law enforcement personnel.

(2) Facilitating mental health assessments of veterans charged with non-violent crimes.

(3) Working either alone or as part of a team of community and justice system partners to develop and provide to the court a plan of community-based alternatives to incarceration.

(4) Collaborating with HCRV Specialists in supporting engagement in care for veterans recently discharged from State and Federal prisons.

21. INTEGRATING MENTAL HEALTH INTO MEDICAL CARE SETTINGS

a. VA medical centers and very large CBOCs, those seeing more than 10,000 unique veterans each year, must have integrated mental health services that operate in their primary care clinics on a full-time basis. These services need to utilize a blended model that includes co-located collaborative care and care management.

(1) The co-located, collaborative care model involves one or more mental health professionals who are integral components of the primary care team and who can provide assessment and psychosocial treatment as needed for a variety of mental health problems, which include depression and problem drinking.

(2) The care management component can be based on the Behavioral Health Laboratory, the Translating Initiatives for Depression into Effective Solutions (TIDES) model, or other evidence-based strategies approved by the Office of Mental Health Services. It must include:

(a) Monitoring adherence to treatment, treatment outcomes, and medication side effects;

(b) Decision support;

(c) Patient education and activation; and

(d) Assistance in referral to specialty mental health care programs, when needed.

b. Large CBOCs, those seeing between 5,000 and 10,000 unique veterans each year, must have on-site integrated care clinics utilizing a blended model that includes co-located collaborative care and care management, using the Behavioral Health Laboratory, TIDES, or other evidence-based models. The hours and days of availability of integrated care services can vary depending upon the clinical needs of the patient population.

c. Mid-sized CBOCs, those seeing between 1,500 and 5,000 unique veterans, must have an on-site presence of mental health services available to primary care patients who need them. The distribution of services between integrated care and mental health clinics can vary depending upon the clinical needs of the patient population.

d. Smaller CBOCs must provide access to general and specialty mental health services for those who require them by:

(1) On-site full, or part-time, mental health staff;

(2) Telemental health;

(3) Referrals to nearby VA medical centers;

(4) Referrals to nearby Vet Centers, when the services in these Centers meet the patient's needs and clinical standards of care;

(5) Either sharing arrangements, contracts or non-VA fee basis care to the extent that the veteran is eligible with local providers; or organizations.

e. Mental health services including cognitive testing, diagnosis, evaluation, management of mental health and behavioral symptoms, and family consultations (when appropriate and when

veterans with adequate decision-making capacity consent) must be available for all patients with TBI who may require these services.

f. Mental health staffing must be included in polytrauma programs. The extent of staffing must be sufficient to meet the clinical needs of the patient population, and the educational needs of patients, families, and staff.

g. Within 24 hours of requests or referrals, each medical center must provide mental health consultations and evaluations on inpatient units, including evaluations of decision-making capacity.

h. Each SCI Center must have integrated mental health assessment and intervention services as part of the inpatient SCI team and outpatient SCI clinics. The extent of staffing must be adequate to address clinical needs of the patient population and the educational needs of patients, families, and staff.

i. Each Blind Rehabilitation Center must have integrated mental health assessment and intervention services as part of the Visual Impairment Service Team. The extent of staffing needs to be adequate to address the clinical needs of the patient population and the educational needs of patients, families, and staff.

j. Each VA Palliative Care Consult Teams must include a mental health professional as a core member of the team who can focus on the delivery of mental health services. The extent of staffing must be adequate to address the clinical needs of the patient population and the educational needs of patients, families, and staff.

22. INTEGRATING MENTAL HEALTH SERVICES IN THE CARE OF OLDER VETERANS

a. Integrated mental health services are especially critical to ensuring access, quality, coordination, and continuity of care for older veterans who are often otherwise much less likely to access mental health services. Accordingly, mental heath specialists need to be included in teams serving the needs of older veterans. The extent of staffing must be sufficient to ensure timely access to high quality, integrated care services in each of the following settings:

b. Each VA Community Living Center (CLC), previously known as Nursing Home Care Unit, needs to have a full range of integrated mental health services consisting of, at minimum, 1.0 FTE psychologist for a 100 bed facility. Services must include:

(1) Psychological assessment;

(2) Cognitive evaluations;

(3) Psychological treatment services, specifically including psychosocial, environmental, and behavioral management services; and

(4) Geriatric psychopharmacology treatment capacity available to meet the needs of its residents.

c. Each VA Home-Based Primary Care (HBPC) team must have a full-time psychologist or psychiatrist as a core member of the interdisciplinary HBPC team.

(1) The duties of the HBPC mental health provider include:

(a) Psychological assessment,

(b) Cognitive screening,

(c) Capacity evaluations,

(d) Evaluations of decision-making capacity, and

(e) Evidence-based psychosocial treatment and prevention services.

(2) Each HBPC team needs to have geriatric psychopharmacology treatment capacity available to meet the needs of its patients.

d. All VA medical centers and very large CBOCs must have the capacity for conducting dementia screening, diagnostic evaluations, and evidence-based interventions. When families, or significant others, are involved in care giving, the management of veterans with late life dementia needs to include education and support for them, when this is consistent with existing legal authority for including families in care processes. ***NOTE:*** *There is a robust evidence-base demonstrating that these interventions benefit the patient.*

e. All VA medical centers and very large CBOCs must have the capacity for evaluating the ability older veterans have for independent living and medical decision-making.

NOTE: *It is strongly recommended that each geriatric clinic have integrated, co-located mental health services consistent with the specifications described in paragraph 21 for general Primary Care clinics, with such services provided by professionals with specific experience in mental health and aging issues.*

23. SPECIALIZED PTSD SERVICES

a. Veterans with PTSD can be treated in Specialized PTSD Services, general Mental Health Services, or primary care.

b. All VISNs must have specialized residential or inpatient care programs to address the needs of veterans with severe symptoms and impairments related to PTSD. Each VISN must provide timely access to residential care services to address the needs of those veterans with severe conditions.

c. VISNs and facilities must make services available to address the needs of veterans awaiting admission to PTSD residential care programs. ***NOTE:*** *Both condition-focused treatment and pre-group preparation need to be considered.*

d. All VA medical centers and very large CBOCs must have:

(1) Specialized outpatient PTSD programs and the ability to provide care and support for veterans with PTSD.

(2) Staff with training and expertise to serve the OEF and OIF population either through an OEF and OIF team, or PTSD program staff.

(3) Ether a PTSD Clinical team (PCT) or PTSD specialists, based on locally-determined patient population needs. PCT or specialist care or consultation must be available to all veterans who may have PTSD.

e. All inpatient mental health units must have the capability to treat patients with PTSD. This can be accomplished by:

(1) Establishing units or tracks with staff trained to address the needs of acutely ill veterans with PTSD, including those from OIF and OEF; or

(2) Making care or consultation from members of PCTs or PTSD specialists available to inpatients

f. All CBOCs must:

(1) Have the capacity to provide diagnostic evaluations and treatment planning for PTSD through full- or part-time staffing or by telemental health with parent VA medical centers.

(a) CBOCs seeing more than 1,500 unique veterans each year must provide mental health treatment services for those who need them.

(b) When CBOCs seeing less than 1,500 unique veterans are within 1 hour of other VA facilities, they may make services for PTSD available to those who need them by referral to these other facilities

(c) When there are no nearby facilities, smaller CBOCs must provide needed services by telemental health, or by referral to community-based providers using sharing arrangements, contracts, or non-VA fee-basis to the extent that the veteran is eligible .

(2) Make PCTs or Specialist available for consultation or care for veterans who may have PTSD, either on site, by referral to nearby VA medical centers, or by telemental health.

g. All PTSD or Specialist programs must be able to address the care needs of veterans with both PTSD and SUD. These needs can be addressed in two ways with:

(1) Distinct PTSD dual diagnosis programs or tracks that include providers with specific expertise in both PTSD and SUD, or

(2) Structures, processes and formal mechanisms to support the coordination of care for PTSD with that provided in SUD programs. These may include specialized programs of care management for these patients.

h. Care of the intensity available in a PTSD Day Hospital or MH RRTP needs to be available to all veterans receiving care from VHA to the extent that it is clinically indicated.

(1) Medical centers must provide these services for those who need them in a Hospital or a PTSD track in PRRC (see par. 17) or an equivalent program.

(2) CBOCs must make the services available for veterans who need them by:

(a) Referral to a program at a geographically-accessible medical center or a MH RRTP when this level of care is needed (see par. 17); or

(b) Through sharing arrangements, contracts, or fee-basis care to the extent that the veteran is eligible with community providers.

i. Although specialized residential care for women and residential dual diagnosis programs can provide needed services, the number of those who require this type of care may currently be below the threshold that would require a facility in each VISN. ***NOTE:*** *There is a need to consider developing a number of these programs as national resources and to arrange processes for referral, discharge, and follow-up. VISNs or VA medical centers that do not have these programs need to develop Memoranda of Understanding (MOUs) with VISNs that have these services.*

24. MILITARY SEXUAL TRAUMA (MST)

NOTE: *This Handbook supplements current VHA policy with requirements related to the identification and treatment of mental disorders resulting from MST.*

a. **Medical Center Director.** Each Medical Center Director is responsible for ensuring that:

(1) A designated MST Coordinator is appointed; that a MST Counselor(s) or team is available so that all enrolled veterans, including OEF and OIF veterans, are screened for MST; and that necessary staff education and training is provided.

(2) Veterans receiving MST-related counseling and treatment are not billed for inpatient, outpatient, or pharmaceutical co-payments; however, applicable co-payments may be charged for services not related to MST or for other non-service connected conditions.

(3) Scheduling priority for outpatient sexual trauma counseling, care, and services is consistent with VHA performance standards for scheduling clinics.

(4) Accurate documentation of screening, referral, and treatment services provided to veterans, aggregated by gender, is maintained. This process includes use of the MST software and the MST clinical reminder to track and monitor the level of compliance with the standard (100 percent of enrolled veterans screened). The nationwide tracking system to ensure consistent data on screening and treatment of victims of MST must be used. ***NOTE:*** *The use of clinic stop code 524 or Purpose of Visit code 55 of the Fee Package is recommended so that collection of MST treatment data is accessible and consistent across the system.*

(5) MST counseling is provided by contract with a qualified mental health professional if it is clinically inadvisable to provide MST counseling in VA facilities or when VA facilities are not capable of furnishing such counseling to the veteran economically because of geographic inaccessibility or the inability of the medical center to provide counseling in a timely manner. ***NOTE:*** *Referral to the local Vet Center may be an appropriate alternative.*

(6) Veterans who report experiences of MST, but who are otherwise deemed ineligible for VA health care benefits based on length of military service requirements, may only be provided MST counseling and related treatment.

(7) The MST software application that activates the MST Clinical Reminder within CPRS has been installed at the facility. All veterans receiving VHA health care must be screened for MST using this clinical reminder.

(8) Veterans screening positive and requesting treatment are provided free care, with no inpatient, outpatient, or pharmacy copayments, for mental and physical health conditions resulting from their experiences of MST. Determination as to whether care is MST-related is made by the clinician providing care. All MST-related care must be designated by checking the MST box on the encounter form for the visit.

(9) The time frames for evaluations of veterans for possible mental disorders resulting from MST must follow the requirements in paragraph 13.

(10) Evidence-based mental health care is available to all veterans diagnosed with mental health conditions resulting from MST.

NOTE: *Facilities are strongly encouraged to provide same sex providers for veterans, men and women, receiving treatment in their facility for conditions related to MST, when clinically indicated.*

b. **VISN Director.** Each VISN Director is responsible for ensuring access is provided to MH RRTPs able to provide treatment, when clinically needed, for conditions resulting from MST for veterans who have severe conditions.

c. **Facility MST Coordinator.** The facility MST coordinator is responsible for:

(1) Monitoring and ensuring that national and VISN-level policies related to MST screening, education, training, and treatment are implemented at the facility;

(2) Serving as a point person and source of information and problem-solving for MST-related issues at the facility; and

(3) Establishing and monitoring mechanisms to ensure that veterans receiving VHA health care are screened for MST experiences and that those who screen positive have access to clinically-indicated treatments for conditions resulting from MST.

25. SUICIDE PREVENTION

a. Each VA Medical Center and very large CBOC must appoint and maintain a Suicide Prevention Coordinator (SPC) with a full-time commitment to suicide prevention activities. SPCs in medical centers must have adequate support to meet these responsibilities in the parent medical center and in the associated CBOCs (except for those with their own SPCs). ***NOTE:*** *Mechanisms for support may include appointing more than one SPC, appointing care managers for high-risk patients, or providing program support assistants.*

b. The SPC's commitment to suicide prevention activities must include, but is not limited to:

(1) Tracking and reporting on veterans determined to be at high risk for suicide and veterans who attempt suicide;

(2) Responding to referrals from the National Suicide Prevention Hotline and other staff;

(3) Training of all VA Staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with veterans, so they know how to get immediate help when veterans express any suicide plan or intent;

(4) Collaborating with community organizations and partners, and providing training to their staff members who have contact with veterans;

(5) Providing general consultation to providers concerning resources for suicidal individuals, as well as expertise and direction in the areas of system design to prevent suicidal deaths within their local VA medical centers.

(6) Working with providers to ensure that:

(a) Monitoring and treatment is intensified for high risk patients; and

(b) High-risk patients receive education and support about approaches to reduce risks.

(7) Reporting on a monthly basis to mental health leadership and the National Suicide Prevention Coordinator on the veterans who attempted or completed suicide along with requested data that is used to determine characteristics and risks associated with these groups of veterans. ***NOTE:*** *This information is tracked and trended on a national level by the Center of Excellence at Canandaigua, NY.*

(8) Ensuring that providers follow-up on missed appointments for high-risk patients to ensure patient safety and in order to initiate problem-solving about any tensions or difficulties in the patient's ongoing care. The facility's SPC and each patient's principal mental health providers must work together to monitor high-risk patients to ensure that both their suicidality and their mental health or medical conditions are addressed.

d. Each VA medical center must establish a high risk for suicide list and a process for establishing a Category II Patient Record Flag (PRF) to help ensure that patients determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments (see current VHA policy for more detailed information).

NOTE: *VISNs, VA medical centers, and CBOCs must support and implement each component of VA's Suicide Prevention Program, and support the activities of the SPCs by ensuring they have the time and resources needed.*

26. PREVENTION AND MANAGEMENT OF VIOLENCE

Each VA medical center must have a Disruptive Behavior Committee responsible for meeting the current training requirements on the prevention and management of disruptive behavior. This training is to extend to all CBOC staff.

27. DISASTER PREPAREDNESS

All facilities must have a designated Mental Health Disaster POC, who can serve as a member of the Facility's Disaster Response Team. Training for the Mental Health Disaster POC needs to be coordinated with training for other disaster response clinicians and emergency management teams at the facility and VISN levels.

28. RURAL MENTAL HEALTH CARE

a. The specifications for those mental health services that must be made available to veterans to the extent that they are clinically necessary, and those services that must be provided for veterans who require them at medical centers or CBOCs, depending upon their size, apply to veterans in rural, and highly rural (which is defined as a county with less than seven civilians per square mile), as well as urban areas.

b. When there are gaps between needed services, and those that are available at the VA facility nearest to the patient's home, the facility must extend the services available at the facility by:

(1) Increasing staffing or telemental health,

(2) Referring to another nearby VA facility,

(3) Making such services available through a referral to residential rehabilitation and treatment programs when it is clinically necessary, and

(4) Referring to community providers using sharing arrangement, contacts, or non-VA fee basis care to the extent that the veteran is eligible.

c. Combat veterans who require counseling to address problems related to their adjustment back to civilian life need to be referred to Vet Centers for these services. However, except where similar treatments are offered, services at Vet Centers are not to be provided in lieu of clinically-indicated outpatient mental health services.

d. Basic principles of care for veterans in rural areas include:

(1) **Ambulatory Mental Health Care.** Facilities must offer options for needed mental health services to veterans living in rural areas from which medical centers or clinics offering relevant services are geographically inaccessible. When necessary, this can include the provision of telemental health services with secure access near the veteran's home, or sharing arrangements, contracts, or non-VA fee basis care to the extent that the veteran is eligible from appropriate community-based providers, as available. It must be documented if the veteran declines these options because the veteran prefers to receive care from VA providers.

(2) **Residential Care.** Each veteran receiving VHA health care services must have timely access to MH RRTPs as medically necessary to meet the veteran's mental health needs. MH RRTPs provide specialized, intensive treatment and rehabilitation services to veterans who require them in a therapeutic environment. Veterans living in rural areas need to be referred to these programs when they are medically necessary to treat the veteran's mental health condition.

(3) **SMI.** VISNs and facilities are strongly encouraged to provide MHICM-RANGE programs for veterans who need them in smaller facilities, especially in more rural areas. When implemented in smaller and more rural settings, the MHICM model may need to be modified. The RANGE model, designed for use rural settings, is based on two FTE teams that have collaborative linkages with other VA mental health professionals and with experienced full MHICM teams in the same VISN.

Female veterans call for changes at VA

By Mark D. Faram
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NORFOLK, Va. — Sen. Mark Warner, D-Va., set out to help female veterans get help for post-traumatic stress disorder by holding a roundtable discussion here Dec. 14 — and wound up getting an earful about shortfalls at the Veterans Affairs Department.

After getting legislation passed recently to have VA conduct an inspector general study of how the agency cares for women who've experienced combat-related stress, he decided to hear for himself what the problems are.

"We realize that an IG study is a great step in the right direction, but it's not going to be conclusive, and we're probably going to need for further action to be taken," Warner said in his opening remarks to a room full of female veterans, some representing organizations such as the Veterans of Foreign Wars, Blue Star Families and American Women Veterans.

Warner heard that women often don't exhibit PTSD symptoms the same way men do and that they're often less likely to seek help. When they do seek help, they are banned from bringing children to VA appointments, and victims of sexual assault must await treatment in rooms full of men.

"We've been marginalized for so long that all the issues are coming up at the same time," said Army Reserve Staff Sgt. Genevieve Chase, founder and executive director of American Women Veterans.

Chase said she hopes the IG study "identifies what the VA needs to do to improve its own internal practices. And really, if substantive changes come from this, it won't just benefit women, but men,. as well."

Chase has experienced combat stress firsthand in Afghanistan but said many female veterans are treated differently when they return home because of the assumption that women are always far from combat. Better documentation by the Defense Department could help more female veterans prove that they need help because they experienced combat, she said.

Still, she thinks Warner is on the right track.

"I think after yesterday's meeting and a few more like it, he'll have a pretty good idea [of] ... what needs to be done," she said.

A member of the VA inspector general's office also was present at the discussion, though he declined to speak to Military Times.

VA must take into account that women are the fastest-growing part of the veteran population, Warner said. And the yearlong study will be only the first step, he said.

"Really, we have a twofold issue here," Warner said. "How do we encourage or make sure women veterans feel comfortable and can present to the VA post-traumatic stress so it can be assessed and treated?" And, he added, "even if there's appropriate treatment, is there an appropriate benefits package to go along with that treatment?" □

UMUC

offers more guidance on veterans benefits

REBECCA KIRBY
U.S. ARMY SIGNAL CORPS
UMUC GRADUATE STUDENT ■ MANAGEMENT

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More support for female veterans needed, group says

By Rick Maze
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A group representing Iraq and Afghanistan veterans is pushing for cultural changes in military and veterans programs to provide better treatment for women.

The campaign launched Oct. 14 by Iraq and Afghanistan Veterans of America focuses on removing barriers facing women while they are in the military and after they separate.

Startling statistics play a key role in their effort: The divorce rate among women in the military is three times higher than that of military men, IAVA researcher Erin Mulhall said. Why this is happening is not clear; it's an area that needs more research, she said. But it underscores the difficulties women face in balancing careers and families, she added, and could be a reason why women are less likely than men to report satisfaction with their careers.

On average, female veterans earn $10,000 less a year than male veterans, which Mulhall said is a sign that they have more problems translating their military skills into civilian jobs.

Fourteen percent of female Iraq and Afghanistan veterans seeking care from veterans hospitals have screened positive for sexual trauma, and an estimated 20 percent of female veterans are expected to develop post-traumatic stress disorder or other mental health issues. Both figures are troubling, IAVA said, because mental health care is one of the services that is difficult for female veterans to obtain.

Iraq war veteran Cara Hammer, a former sergeant who left the Army in 2006 and is now a veteran support associate with IAVA, tried to get mental health care from a Veterans Affairs Department facility — and gave up.

Hammer said she made one visit for a mental health appointment but left before seeing anyone other than the veterans in the waiting room. She described them as five or six older veterans who were "all staring a hole through me." The message she took away was: "I wasn't wanted there," she said.

Hammer said that wasn't the only issue. When she arranged for screening for traumatic brain injury or PTSD — common ailments in Iraq and Afghanistan veterans — the tests determined that she was suffering instead from attention deficit disorder.

"It is kind of amazing that at the age of 29, I was diagnosed with ADD," she said.

Paul Rieckhoff, IAVA's founder and executive director, said he hopes the "really shocking" statistics, contained in an IAVA report released Oct 14 "will inspire some real action."

He said the problems faced by Hammer are not unusual for a veterans health care system that has for generations been aimed at helping men.

Rieckhoff said military and veterans health care systems need to better help women, and VA should look to hire some younger female counselors to work with female Iraq and Afghanistan combat veterans. □

Female Marines, Sailors Assist Afghan Women

By By Marine Corps Lance Cpl. Dwight Henderson
Special to American Forces Press Service

HELMAND PROVINCE, Afghanistan, Dec. 29, 2009 - Throughout Afghanistan's Garmsir district, Marines and sailors of 2nd Battalion, 2nd Marine Regiment, interact with key leaders and locals to learn the needs of local Afghan villagers.

Marine Corps 2nd Lt. Carly E. Towers and Sahima Sheren, an interpreter, interact with local Afghan children during a patrol through Tajik Khar in Garmsir, Afghanistan, Dec. 18, 2009. U.S. Marine Corps photo by Lance Cpl. Dwight Henderson
(Click photo for screen-resolution image);high-resolution image available.

However, there is one gap that is hard to bridge -- the interaction between Marines and Afghan women.

This is an issue that female Marines and sailors of the U.S. military engagement team worked to solve as they conducted patrols through the village of Tajik Khar Dec. 16 through 20.

With help from male Marines and members of the Afghan National Army, female Marines moved from compound to compound, hoping to speak to Afghan women to ascertain their medical and humanitarian assistance requirements.

"This is extremely important," said Marine 2nd Lt. Carly E. Towers, the officer in charge of the engagement team. "Our mission out here is to talk to and work with the locals to build cooperation and security."

Because of local culture, male Marines are not allowed to look at, let alone talk to, any Afghan women. Even Afghan soldiers are not supposed to talk to the women of any compound, so the female Marines' efforts not only benefit other Marines, but the local Afghan military, as well.

"It is good news for us," said Sgt. Shokorunnah, an Afghan soldier. "The female Marines came and talked to the women and found out their problems. I am very happy."

Before the all-female Marine team can enter a compound, they must first talk to the owner, generally a male who is not used to interacting with Marine females.

"The general perception has been ranging from positive to dumbfounded," said Towers, who hails from Modesto, Calif. "We've had a lot of success in the past few days."

The key to her unit's mission success is to establish a connection with the Afghan women, Towers said.

"We just try to sit down, talk to them, and get to know them a bit," said Towers, a Naval Academy graduate. "We ask them if they have any questions for us. We're trying to build rapport."

In deference to Afghan culture, Tower and her team members remove their helmets and don head scarves to cover their hair whenever they enter a compound.

Through their interactions, Towers said, the female Marines have encountered many Afghan females who claim to have never left their compounds for fear of firefights and homemade bombs.

"We hear a lot of things from the women that we wouldn't hear from the men, or that would be said in a different way," Towers said.

Towers' team has a female corpsman that can provide medical care to the Afghans if they so desire.

Relationships established through these interactions, Towers said, help to build bonds of trust between the Afghans and the Marines.

April: Sexual Assault Awareness Month

Capt. Rey Agullana, *Sexual Assault Response Coordinator*

SALEM, Ore. -- April is Sexual Assault Awareness Month (SAAM) and the Theme from the Department of Defense is "Hurts one. Affects all . . . Preventing sexual assault is everyone's duty." Posters will be distributed to each unit with this theme to post on your unit's bulletin boards in observance of SAAM.

As stated in the DoD campaign announcement, a sexual assault can reverberate throughout a unit and beyond, degrading readiness by harming the life of a victim, and the military's ability to work effectively as a team. Experts and practitioners often describe the negative consequences of sexual assault as having a ripple effect, starting with the victim and expanding outward to include families, friends, work colleagues, neighbors, and increasingly larger parts of the population. The same can be said for the effects in the military. This was confirmed with the focus groups conducted this year with commanders of all grades, Sexual Assault Response Coordinators (SARCs) and Victim Advocates (VAs). The crime of sexual assault diminishes the armed forces' ability to function proficiently at the levels of servicemember, unit, and command. Its impact is both immediate and long-lasting for individuals in the military and for the institution as a whole. Sexual assault particularly diminishes a unit's mission readiness. Mission readiness is negatively impacted in three ways.

1. The alleged perpetrators are often placed on administrative hold and therefore cannot deploy with their units.

2. Victims may not be able to fulfill their duties or may otherwise have their ability to perform the mission compromised as a result of the traumatic events.

3. The attention of the unit leadership shifts from the normal duties involved in maintaining readiness to addressing a victim's needs, investigating the alleged perpetration, and restoring the unit's cohesion and trust.

Divisiveness may exist not only within a unit but also between units if an alleged perpetrator is in one unit and the victim is in another. To aid victims of sexual assault, Sexual Assault Prevention and Response (SAPR) programs have been a DoD requirement to be established in each state and territory of the United States.

Per Oregon TAG's Oregon SAPR Program SOP dated 1 OCT 2009, the SAPR Program reinforces the Oregon National Guard's commitment to eliminate incidents of sexual assault through a comprehensive policy that centers on awareness and prevention, training and education, victim advocacy, response, reporting, and accountability. The Oregon National Guard's policy promotes sensitive care and confidential reporting for victims of sexual assault and accountability for those who commit these crimes.

The goals of the Sexual Assault Prevention and Response Program are to:

1. Create a climate that minimizes the occurrence of sexual assault incidents.

2. Ensure that victims and suspects are treated according to Oregon National Guard policy.

3. Create a climate that encourages victims to report incidents of sexual assault without fear.

4. Establish sexual assault prevention training and awareness programs to educate Airmen and Soldiers.

5. Ensure sensitive and comprehensive treatment to restore victims' health and well-being.

6. Ensure leaders understand their roles and responsibilities regarding response to sexual assault victims, thoroughly investigate allegations of sexual assault and take appropriate administrative and disciplinary action.

Sexual assault is a criminal offense that has no place in the Oregon National Guard. It degrades mission readiness by disrupting the organization's ability to work effectively as a team. Every airman and soldier who is aware of a sexual assault should report incidents within 24 hours. Sexual assault is incompatible with Army and Air Force values and is punishable under the Uniform Code of Military Justice (UCMJ), Oregon Code of Military Justice (OCMJ), Oregon Revised Statutes (ORS) and other federal and local civilian laws.

The Oregon National Guard will use training, education and awareness to minimize sexual assault; to promote the sensitive handling of victims of sexual assault; to offer victim assistance and counseling; to hold those who commit sexual assault offenses accountable; to provide confidential avenues for reporting, and to reinforce a commitment to Army and Air Force values.

The Oregon National Guard will treat all victims of sexual assault with dignity, fairness, and respect.

The Oregon National Guard will treat every reported sexual assault incident seriously by following proper guidelines. The information and circumstances of the allegations will be disclosed on a need-to-know basis only.

If you need to report a sexual assault or have any questions about the above article please contact the JFHQ SARC, Capt. Rey Agullana at: office (503) 584-3844, cell (503) 756-5327, or email at *rey.agullana@us.army.mil*

San Diego Union-Tribune
September 20, 2010

Female Marines A New Weapon In Afghanistan

By Gretel C. Kovach

MARJAH, Afghanistan — Sgt. Vanessa Jones and her teammates filed through the countryside with a squad of U.S. infantrymen and Afghan troops. They pushed through tall grass and leaped over canals, spilling into fields of sunflowers and the emerald spikes of marijuana plants rustling above their helmets. Then they waited, tucked into a ridge of dirt, while fellow Marines checked on a bomb dug into the road.

Jones and her partner, Lance Cpl. Yvonne Blanco, were among a group of 40 volunteers who deployed to Afghanistan this spring to serve as Female Engagement Teams, a detachment organized by the 1st Marine Expeditionary Force at Camp Pendleton.

The new teams were sent to the highly segregated Pashtun south of the country to connect with the female half of the population that is inaccessible to male Marines, to assess their needs, convey information, perform security searches, and whenever possible, win the support of Afghan mothers and daughters.

The Marines knew it would be a tough assignment. Keeping up with the all-male infantry units is perhaps the least of their many obstacles. Jones and Blanco's first patrol in Marjah, one of the most hostile areas of the Taliban heartland for U.S. and NATO forces, underscored the challenge.

After two hours of walking, the Marines saw many men and boys, but no women. Except for a shrouded passenger on the back of a motorcycle who passed in a blur of billowing fabric.

"It's a slow process," said Capt. Emily Naslund, the officer in charge of the teams. "If you keep returning, maybe weeks or months later they might open up."

The engagement teams grew out of the Lioness program in Iraq, when female soldiers and Marines were used largely in a search capacity to protect the privacy of local women. Now the teams are spread across 16 locations in Helmand Province.

Their experiences and results vary greatly by team, depending on the level of combat in the area, the reception of village leaders or heads of households, and even their U.S. military commanders.

At their best, the female teams have been able to help women start their own businesses sewing and making handicrafts, particularly among widows, and to host clinics flocked with women seeking basic medical care. In those areas, village elders vie among themselves for the work of the female teams and Afghan men sometimes share information with them that they are reluctant to divulge to male Marines, commanders said.

"We soften the conversation," said Staff Sgt. Nela Gomez.

As the teams' seven-month tour draws to a close, their replacements are training for the battlefield, and NATO regional commands throughout Afghanistan have instituted similar programs. But the female teams are still finding their footing.

Some infantry commanders were reluctant initially to let female Marines leave base. Several of the teams have bounced from battalion to battalion, starting over each time in the struggle to gain the respect of American infantrymen, then Afghan men who act as gatekeepers to the women, and finally the women themselves.

Jones found a potential opening into the hidden world of Marjah's women at the bazaar. As she bantered with a group of boys, who told her they most certainly did not want their sisters to attend school, three little girls studied her from afar.

"I am a girl!" Jones yelled, speaking in Pashto. (In her combat gear it wasn't obvious.) "Are you a girl, too?"

"Yes!" the smallest shouted. Then she looked around to see if anyone heard and jumped to hide behind her brother, smiling sheepishly.

It was a good start, Jones reported back at Combat Outpost Reilly, home of Golf Company, 2nd Battalion, 9th Marine Regiment. They had distributed information about schools and other services in the area, and the children might eventually lead them to their mothers.

But Lance Cpl. Jacob Vineyard told the squad he was concerned about balancing engagement with safety: "Talking to the kids, it's not a good idea in an open field to stand there with that many people for so long. We can only pull so much security for so long."

The female teams have grappled with pressures from the homefront as well, among those who feel women should not work in areas exposing them to ground combat. When the perennial issue boiled over on Capitol Hill this summer, the female teams were recalled to the rear for a two-week operational pause.

Out in the field, the women Marines are limited by the dearth of female translators who can withstand the rigors of life on remote patrol bases, with Afghan men who insist on speaking for their wives, and doors that remain perennially closed to them.

But the potential payoff for their persistence is great, Naslund said. “In the long run, if they’re supporting us they’re not supporting the Taliban.”

The Golf Company commander, Capt. Daniel Nilsson, had requested a female team for his area. He hopes they will better engage both men and women, opening a dialogue and “a different dimension between the local populace and the Marines that are here.”

Heaven is at the feet of the mother in this part of the world, said Maj. Dallas Shaw, the battalion operations officer. “There is key physical terrain – roads, mountains. But there is also key human terrain. You can stand on key physical terrain all day and still lose. The key in the home is the mother.”

The U.S. counterinsurgency manual, citing influential Australian strategist David Kilcullen, says, “In traditional societies, women are hugely influential in forming the social networks that insurgents use for support.

“Co-opting neutral or friendly women through targeted social and economic programs builds networks of enlightened self-interest that eventually undermine insurgents.”

By that parameter, victory in Afghanistan will be measured in simple things, Jones said: “Simple for us but difficult for them in this place and these times,” like boys and girls going to school, and women free to walk without an escort or own their own shops.

“What we are doing is going to help get there, but sometimes it seems like it’s going to take years to do this, not whenever we’re slated to pull out,” she said. In the end Afghans will be responsible for winning: “We are just showing them the way.”

In another area of northern Marjah, a little boy sitting along a canal recognized the black spectacles and tight blond bun wrapped beneath a Marine’s helmet. “Mariam!” he called, using Cpl. Kathryn Mannion’s Afghan nickname.

After a month in that locale, Mannion and Lance Cpl. Sharhonda Jones have a good rapport with the men of Echo Company. Their commander, Capt. Chuck Anklam, sends the female team out with the infantrymen several times a week.

At the bazaar’s flour mill, Mannion stopped to chat with a group of men and children. “Do you know any women here who can sew?” she asked one gentleman. “In the coming weeks we hope to get some sewing machines and I’d like to give them to people who need them.”

The man she spoke to shook her hand and seemed open to the idea. He agreed to discuss it again when the machines arrived.

A 10-year-old boy named Azadoo asked Mannion for one of the plastic bracelets he knew she kept in her pack. “I will give it to my sister,” he said, trying it on for size. Then the men drove away, the boys perched behind the tractor on sacks of fresh-milled flour, and the Marines walked home.