WOMEN VETERANS HEALTH CARE

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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

November 2008

Department of Veterans Affairs

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Patricia Hayes, Chair
Chief Consultant, Women Veterans
Health Strategic Health Care Group
Office of Public Health and Environmental Hazards

VA Under Secretary for Health Workgroup on Provision of Primary Care to Women Veterans

◊ **Madhulika Agarwal**
Chief Patient Care Services Officer
Office of Patient Care Services

★ **Phyllis Ahlman**
Associate Clinical/Quality Assurance Liaison
Office of the Deputy Under Secretary for Health for Operations & Management

◊ **Anna Alt-White**
Program Director for Research
Office of Nursing Services

★ **Linda Bergofsky**
Program Analyst
Office of Assistant Deputy Under Secretary for Health for Policy & Planning

◊ **Malcolm Cox**
Chief Academic Affiliations Officer
Office of Academic Affiliations

★ **Stanlie Daniels**
Deputy Chief Officer
Office of Patient Care Services

◊ **Lawrence Deyton**
Chief Public Health and Environmental Hazards Officer
Office of Public Health and Environmental Hazards

★ **Christine Engstrom**
Program Director
Office of Nursing Services

◊ **William Feeley**
Deputy Under Secretary for Health for Operations & Management

★ **Judy Feldman**
VISN 3 Chief Medical Officer

★ **Stephan Fihn**
Chief Quality & Performance Officer
Office of Quality and Safety

★ **Stuart Gilman**
Director, Special Fellowships
Office of Academic Affiliations

★ **Amy Hertz**
Acting Deputy Chief Consultant
Women Veterans Health Strategic Health Care Group
Office of Public Health and Environmental Hazards

★ **Mandy Krauthamer**
Deputy Director, Women's Comprehensive Health
Women Veterans Health Strategic Health Care Group
Office of Public Health and Environmental Hazards

◊ **Joel Kupersmith**
Chief Research and Development Officer
Office of Research and Development

★ **Connie LaRosa**
Deputy Field Director
Women Veterans Health Strategic Health Care Group
Office of Public Health and Environmental Hazards

★ **Odette Levesque**
Clinical/Quality Assurance Liaison
Office of the Deputy Under Secretary for Health for Operations & Management

★ **Linda Lipson**
Health Science Specialist
Office of Research and Development

★ **Meri Mallard**
Deputy Field Director
Women Veterans Health Strategic Health Care Group
Office of Public Health and Environmental Hazards

◊ **Michael Mayo-Smith**
Network Director
VISN 1 VA New England Healthcare System

★ **Susan McCutcheon**
Director, Family Services, Women's MH and MST
Office of Mental Health Services

★ **Melissa McNeil**
Physician, Pittsburgh VA Health Care System, Section Chief
Women's Health Department of General Internal Medicine
University of Pittsburgh

◊ **Laura O'Grady**
Clinical Executive
Office of the Principal Deputy Under Secretary for Health

★ **Catherine Rick**
Chief Nursing Officer
Office of Nursing Services

★ **Richard C. Stark**
Director of Primary Care Clinic Operations
Office of Primary Care Services

◊ **Patricia Vandenberg**
Assistant Deputy Under Secretary for Health for Policy & Planning
Office of Assistant Deputy Under Secretary for Health for Policy & Planning

◊ **Joseph Williams**
Assistant Deputy Under Secretary for Health for Operations & Management

★ **Steven Wright**
Director of Epidemiology
Office of Quality and Performance

◊ **Elizabeth Yano**
Deputy Director
VA Greater Los Angeles Health Services Research & Development Center of Excellence

◊ Member
★ Contributor

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★ EXECUTIVE SUMMARY

"I need you to make sure you take it back and make sure it's happening on the ground—like I have seen in so many places and like I haven't seen in some places—where we are providing a portal of entry for these women, so they don't have to feel like they are fighting their way through that old boys', largely men's network, and they have the access to mental health, primary care, and gynecologic care in a single portal, with appropriate privacy and waiting rooms, and sensitivity to the needs, that our women veterans deserve."

James B. Peake, MD
Secretary, Department of Veterans Affairs
VHA Senior Management Conference, August 28, 2008

The Under Secretary for Health Workgroup on Provision of Primary Care to Women Veterans was charged by the Under Secretary for Health (USH) in March 2008 to define actions needed to ensure that every woman veteran has access to a VA primary care provider who meets all her primary care needs, including gender-specific and mental health care, in the context of an ongoing patient-clinician relationship.[1]

BACKGROUND AND WORKGROUP FINDINGS

The USH Workgroup has surveyed the current state of women veterans health care delivery, convened with VA experts, reviewed the literature, and analyzed data on the quality of care in order to arrive at the best solutions for improvement.[2] This report describes our findings, conclusions, and formal recommendations.

Because of the number of women on active duty and the numbers entering military service, the percentage of veterans who are female is projected to increase from 7.7 percent in 2008 to 10 percent in 2018 and to 14.3 percent in 2033.[3] Within the next 15 years, females are projected to represent one in every seven enrollees versus one in every 16 today. Beyond the expanding number of women veterans, the USH Workgroup notes that when compared to men, women veterans have consistently under-utilized VA health care services. The relative utilization for men has been measured at 22 percent for the past five years; however, the last complete year of data shows relative utilization for women at 15 percent in FY 2007.[4]

Women now make up 11 percent of veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF)—equating to nearly 98,000 veterans. Among

1 See Appendix A for the USH Memorandum: Proposal Women Veteran Health Care Delivery Responsibilities.

2 See Appendix A for the Interim Report: USH Workgroup and Provision of Primary Care to Women Veterans, July 17, 2008.

3 VHA Office of Policy and Planning, August 2008.

4 Relative utilization is defined as total users divided by total number of living veterans, per VETPOP census data. See page 9 for chart of FY 2007 relative utilization by VISN.

OEF/OIF women veterans, 42.6 percent are enrolled and 28.5 percent are users of VHA.[5] Furthermore, almost all OEF/OIF women veterans accessing VA care are under age 40 and of childbearing age, creating a need for a significant, focused shift in provision of health care.[6]

Taking the increasing numbers of women using VA health care services into account, along with a commitment to attract a higher percentage of women into VA care, the USH Workgroup concluded that there are sufficient numbers of women veterans to support coordinated models of service delivery to meet their needs. While women always will constitute a minority of veterans, they represent a "critical mass" as a group and should be factored in as a population in new strategic plans for service delivery.

The USH Workgroup found that women veterans have higher physical and mental health burdens than their female non-veteran counterparts[7] and health burdens comparable to or worse than that of male veterans.[8,9,10] Recent research demonstrates substantial comorbidities, with 31 percent of women veterans having medical and mental health conditions vs. 24 percent of men.

While women veterans have a higher physical and mental health disease burden than their male counterparts, they receive their primary care in a fragmented service delivery model. Fragmentation refers to the fact that the general primary care needs and gender-specific primary care needs of women veterans frequently are handled by different types of providers in different settings. For example, a primary care clinician such as an internist handles general primary care health care needs, e.g., an acute respiratory illness or diabetes management; a specialist such as a gynecologist handles gender-specific primary care health needs, e.g., breast exams, contraceptive counseling, and menopausal management. This model of multi-visit, multi-provider primary care delivery is linked to the historical predominance of male veterans in VA health care settings. The USH Workgroup considered this multi-visit, multi-provider model of primary care delivery to interfere with continuity of care and increase access barriers. The USH Workgroup defined "fragmented care" as care in which women are required to see two or more providers in order to receive the full range of routine primary care.

According to the VHA Plan of Care Survey for FY2007, 33 percent of the VA sites delivering care to women offer a "one-visit model." In comparison, 67 percent of sites provide primary care in a fragmented, "multi-visit model," where general primary care is conducted at one visit and gender-specific primary care at a second visit.[11] Beyond these

5 OEF/OIF Utilization Data, FY 2008 2nd Quarter, Kang H. Dept Veterans Affairs, OPHEH.

6 VSSC women veteran workload report, FY 2007, 4th Quarter cumulative.

7 Skinner KM, Furey J. The focus on women veterans who use Veterans Administration health care. Milit Med. 1998; 163:761-766.

8 Skinner KM, Sullivan LM, Tripp TJ, et al. Comparing the health status of male and female veterans who use VA health care: Results from the VA Women's Health Project. Women & Health. 1999; 29:17-33.

9 Romeis JC, Gillespie KN, Virgo KS, Thorman KE. Female veterans' and non-veterans' use of health care services. Med Care. 1991 Sep; 29(9):932-6.

10 Frayne SM, Parker VA, Christiansen CL, et al. Health status among 28,000 women veterans: The VA women's health program evaluation project. J Gen Intern Med (JGIM). 2006, 21(Suppl3):S40-46.

11 VHA's Plan of Care Survey for FY2007, Office of Women Veterans Health Strategic Health Care Group, SAIC Web Solutions.

process differences in the provision of comprehensive care to women veterans as compared to male veterans, a consistent difference in VHA performance scores exists between men and women on aggregate outpatient quality measures. Low-density lipoprotein (LDL) control, diabetes measurements, and measures such as vaccination rates, colorectal cancer screening, depression screening, and post traumatic stress disorder (PTSD) screening were all statistically significantly less favorable for women veterans.[12]

In addition to the results of the VHA Plan of Care Survey, the USH Workgroup noted the research done within the VA system showing that access and wait time scores were better at sites where gender-specific services are available in an integrated women's primary care setting, i.e., one stop or one appointment to receive all primary care needs regardless of whether the care was delivered in a separate space (or women's clinic) or incorporated within general primary care clinics. VA facilities that already have established a one-stop type of primary care delivery (in women's clinics or in general primary care) had better patient satisfaction scores on care coordination for contraception, sexually transmitted disease (STD) screening, and menopausal management than facilities that separated these services across multiple clinics. For example, a cross-sectional survey of 1,081 women veteran VA users throughout southern California and southern Nevada found that women veterans prefer "one-stop shopping," with 55 percent of VA users reporting that it is very important to them to receive general and women's health care from the same provider or clinic.[13]

The USH Workgroup examined research evidence from the private sector on HHS-designated National Center of Excellence (CoE) facilities in Comprehensive Primary Care Women's Health that show similar results to the studies done within the VA. Women served in the CoEs were significantly more likely than women in national and community comparison samples to receive a range of age-appropriate screening services (Pap tests, breast exams, mammograms, cholesterol tests, and colon cancer screenings) and counseling on health topics (smoking cessation, exercise, alcohol/drug use, domestic violence, and STDs). Patients served in the CoEs also reported significantly higher patient satisfaction levels than women served in the community.[14]

CONSENSUS DEFINITION: COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS

The changing demographics of the women veteran population, the predominant systemic fragmentation of primary care delivery, the ongoing quality disparities, and an understanding of the research have led the USH Workgroup to conclude that a new definition of Comprehensive Primary Care for Women Veterans is needed. The USH Workgroup's proposed consensus definition follows:

12 Wright SM, Lucatorto MA, Yano E. An Analysis of the Quality of Care Provided to Men and Women in the VA Health Care System. Office of Quality and Performance. Unpublished report, July 2008.

13 Washington DL, et al. To Use or Not to Use. JGIM. 2006 Mar; 21:S11-18.

14 Anderson RT, Weisman CS, Scholle SH, Henderson JT, Oldendick R, Camacho F. Evaluation of the quality of care in the clinical care centers of the National Centers of Excellence in Women's Health. Women's Health Issues. 2002;12(6):309-326.

Comprehensive primary care for women veterans is defined as the 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. The full range of primary care needs for women veterans includes:

- Care for acute and chronic illness, including routine detection and management of disease such as acute upper respiratory illness, cardiovascular disorders, cancer of the breast, cervix, colon, and lung, diabetes mellitus, osteoporosis, thyroid disease, chronic obstructive pulmonary disease (COPD), etc.
- Gender-specific primary care delivered by the same provider, encompassing sexuality, contraception counseling, pharmacologic issues related to pregnancy and lactation, management of menopause-related concerns, and the initial evaluation and treatment of gender-specific conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, etc.
- Preventive care, including services such as age-appropriate cancer screening, weight management counseling, smoking cessation, immunizations, etc.
- The same primary care provider who screens and appropriately refers patients for military sexual trauma[15] as well as evaluates and treats uncomplicated mental health disorders and substance use disorders.
- A primary care provider who, when specialty care is needed, will coordinate this care and communicate with the specialty provider regarding the evaluation and treatment plan to ensure continuity of care.

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 new consensus definition for comprehensive primary care given above.

This recommended, comprehensive, coordinated model of primary care for women veterans is based in, and fully aligned with, the following VA policies and leadership directives:

- VHA Directive 2006-031 Primary Care Standards
- VHA Handbook 1330.1 Services for Women Veterans
- 2008 Executive Career Field (ECF) Performance Plan.

This workgroup fully endorses the work that has begun already in order to deliver coordinated, comprehensive primary care for all women veterans including:

- The Women's Comprehensive Health Implementation Planning (WCHIP) tool, developed to aid individual facilities, and in turn each Veterans Integrated Services Network (VISN), to assess and make decisions about which services need to be developed, in what sequence, and to identify what resources will be required to deliver comprehensive primary care for women.
- Women Veterans Program Manager (WVPM) created as a full-time position in

15 Military Sexual Trauma is defined 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.

every VA facility.
- Work to strengthen VA-based Women's Health Fellowships and include trainee educational needs in plans for changes to the delivery of care for women veterans.
- Mini-residency programs focused on basic skills development in women's health, offered in geographically dispersed VA locations.
- Development of the first comprehensive VA women's health research agenda spanning biomedical, clinical, rehabilitation, and health services research directed by the VA Office of Research and Development (ORD).

This workgroup adopts as a fundamental goal that each woman veteran has access to a VA primary care provider who is proficient, interested, and engaged and who meets all her primary care needs, including gender-specific and mental health care, in the context of an ongoing patient-clinician relationship. This will ensure the highest quality care for our women veterans. The ultimate goal is not only to provide a model for care of women in the VA, but to provide a national model for women's health care.

USH WORKGROUP RECOMMENDATIONS

To achieve this important goal, the USH Workgroup on Provision of Primary Care to Women Veterans recommends the following:

Recommendation 1. Deliver coordinated, comprehensive primary women's health care at every VA facility. Recognizing models of best practice, develop systems and structures for care delivery that ensure that every woman veteran has access to a VA primary care provider who can meet all her primary care needs, including gender-specific, acute and chronic illness, preventive, and mental health care.

Actions

1.1 Assess current status of care delivery and resources at each facility. Use the WCHIP tool to identify steps needed to achieve coordinated, comprehensive primary care for women, including gender-specific health care by the same provider. Implement the optimal practice configuration for delivering coordinated, comprehensive primary care fitted to a facility's particular configuration and women veteran population.

1.2 As indicated by each facility's WCHIP resource assessment, provide recurring funds to build adequate infrastructure and program capacity (facilities, equipment, and staff).

1.3 To increase relative utilization for women, provide resources and staff time to conduct outreach/education to women veterans.

1.4 Collect data and analyze and report regularly on issues of access, panel size, clinic staffing flexibility, and cost and on the implementation of women's comprehensive health care to the National Leadership Board, the VISN Chief Medical Officers (CMOs), the Health Systems Committee, and to the USH annually.

1.5 Ensure academic leaders at affiliated facilities are involved early in planning optimal practice configuration for delivering coordinated, comprehensive primary care in order to successfully fulfill the VA's educational mission for health professional trainees.

Recommendation 2. Ensure integration of women's mental health care as part of primary care, including co-locating mental health providers.

Actions

2.1 Assign mental health providers who can provide assessment and psychosocial treatment as needed for a variety of mental health problems, including depression and problem drinking per VHA Handbook 1160.1, to participate in women's primary care health delivery.

2.2 Facilitate collaboration by behavioral health with primary care to provide ancillary services, including pain management, weight management, and smoking cessation programs designed to meet the needs of women veterans.

Recommendation 3. Promote and incentivize innovation in care delivery by supporting local best practices fitted to the particular configuration and women veteran population.

Actions

3.1 Share best practice models and accomplishments in comprehensive women's health care through an improved web portal, interdepartmental and interagency conferences, and other methods of information transfer and collaboration.

3.2 Develop and issue ongoing Requests for Proposals for innovative pilot efforts using new technology and/or novel delivery models in the provision of health care to women.

3.3 Explore, with the Office of Care Coordination and the Office of Information, new ventures in telehealth inclusive of women veterans.

3.4 Recognize and promote local achievements in creating environments of care that support privacy, safety, and comfort for women veterans.

Recommendation 4. Cultivate and enhance capabilities of all VA staff—medical providers, clinical support, non-clinical, and administrative—to meet the comprehensive health care needs of women veterans.

Actions

4.1 Aggressively recruit and train practitioners to be proficient, knowledgeable, engaged providers of women's health.

- Fund additional and ongoing mini-residency programs in Women's Primary Care for current VA providers. This will require recurring budget for training and travel support.
- Develop recruitment and retention strategies to increase numbers of trained women's health providers.
- Improve career path for primary care practitioners and other women's health providers by developing and promoting VA primary care.

4.2 Train and sensitize all VA staff on issues specific to women's health care.

Recommendation 5. Achieve gender equity in provision of clinical care.

Actions

5.1 Work with Associate Deputy Under Secretary for Health for Quality and Safety (10G) to assure continual measurement of women veterans' health outcomes for both gender-specific and gender-neutral parameters. In collaboration with the Deputy Under Secretary for Health for Operations and Management,VISN CMOs, and the Office of Patient Care Services (PCS), this work must address the systemic reasons for the identified disparities in quality in order to effect change in clinical practice.

5.2 Work with ORD to foster continued research that addresses best practice models for delivery of care to women veterans. Collaborate closely with ORD to better understand the health concerns of post-deployed women veterans in terms of reproductive health, urinary tract infections, STDs, contraceptive use, sexual violence, injuries, exposures, prosthetics needs, etc.

5.3 Develop and implement a validated tool for assessment of sexual activity, sexual risk behaviors, and anticipation of pregnancy as a routine part of all clinical encounters.

★ INTRODUCTION

The face of the VA is changing. The number of women veterans will rise dramatically over the next two to four years. Women make up 11 percent of veterans from OEF/OIF—equating to nearly 98,000 veterans. Women veterans coming into the VA system are younger and have health needs distinct from their male counterparts. Demographic changes are one of the challenges in providing health care to our women veterans. A consistent difference in VHA performance scores persists between men and women on aggregate outpatient quality measures. Additionally, the provision of routine primary care to women veterans has required multiple providers and multiple sites of care.

Because of the partitioning of primary care between two or more providers and variation in VHA performance scores between men and women, coupled with the challenges of a rapidly expanding women veteran population, VA has undertaken the mission to improve the delivery of primary care to women.

THE CHARGE

Accordingly, in March 2008, the Under Secretary for Health charged this workgroup on Provision of Primary Care to Women Veterans to review the current health care delivery structure and identify actions that will ensure that women veterans' primary health care is equal in quality to that provided to male veterans.

Excellence is a core element of the VHA Strategic Plan. As stated in the 2008 ECF Performance Plan, Strategy 3, the VHA will "continuously improve veteran and family satisfaction with VA care by promoting patient-centered care and excellent customer service."

Under Secretary for Health Charge to Workgroup on Provision of Primary Care to Women Veterans

This workgroup will define actions necessary to ensure that every woman veteran has access to a VA primary care provider who can meet all her primary care needs, including gender-specific care, in the context of an ongoing patient-clinician relationship. The workgroup will review the current organization and structure of VHA's women's health care delivery, current and expected future needs, and propose recommendations on the most appropriate organizational initiatives.

~ March 30, 2008

With women comprising 14 percent of active duty service members and with full integration in all branches including combat units, women are changing the face not only of our military but of our veteran population as well. Women now make up a larger percentage of the veteran population, add to its diversity, and require veteran health care services geared to both their general and gender-specific needs. Until recently, VA has not addressed development of the most appropriate health care services for our women veterans at each facility. The debt owed to all our veterans and to women veterans in particular demands nothing less than our full attention and action.

CURRENT CHALLENGES

To succeed in meeting the Under Secretary for Health's charge, the VA must implement sustained strategies and overcome challenges in its ability to deliver quality,

comprehensive, coordinated primary care to women veterans.

Challenge 1: Under-serving women veterans. Relative utilization for males has held at 22 percent for many years, while relative utilization for females ranges from 11 to 19 percent. Relative utilization is defined as total users divided by total number of living veterans, per VetPop 2007 census data. The table below shows how many women veterans are using VA health care services across all VISNs in 2007.

Table 1: Relative Utilization of VA Health Care by Female Veterans, 2007

VISN	Total Female Veteran Population	Female Unique Users	Relative Utilization
1	69,379	9,377	13.52%
2	31,132	5,573	17.90%
3	55,251	5,842	10.57%
4	83,874	10,992	13.11%
5	73,266	8,620	11.77%
6	116,115	18,398	15.84%
7	126,764	21,090	16.64%
8	129,284	24,451	18.91%
9	70,320	11,208	15.94%
10	61,322	8,116	13.23%
11	81,191	9,541	11.75%
12	66,797	9,059	13.56%
15	61,857	9,231	14.92%
16	137,353	22,534	16.41%
17	94,640	16,772	17.72%
18	71,020	13,088	18.43%
19	58,518	8,798	15.03%
20	92,116	13,797	14.98%
21	82,224	11,073	13.47%
22	109,538	13,812	12.61%
23	62,865	10,459	16.64%
90	9,751	Unknown	
Grand Total	**1,744,580**	**261,831**	**15.01%**
Males	**22,245,866**	**4,806,760**	**21.61%**

Source: VetPop2007, Version 1.0, VA Office of the Actuary, 9/30/2007

The Secretary's Advisory Committee on Women Veterans has recommended that VHA reach out to all eligible women veterans beyond those who already are enrolled. Research

shows that women veterans do not identify themselves as veterans and are more likely to be unaware of their enrollment eligibility.[16] The study found that non-VA users were more likely to perceive an unwelcoming VA environment and VA physicians as not being skilled in treating women. The non-VA users lacked knowledge of their eligibility for VA services and perceived the quality of care to be lower than that in the private sector. Of greatest concern is that among women veterans who had not had access to health care in the past 12 months, 18.7 percent of this group is service-connected.[17] The USH Workgroup is concerned with the finding that service-connected women without access to health care are not enrolled nor utilizing VHA services.

Challenge 2: Increased need for service delivery. The number of male veterans is steadily declining, but the number of women veterans is and will continue to increase significantly, regardless of whether the nation is involved in a conflict. A large population of OEF/OIF women recently has been deployed and discharged from service. Cumulative data to date indicate that 43.4 percent of all discharged women have utilized VA health care at least once, and of that group, 44.8 percent have visited a VA facility between two and 11 times.[18]

Active duty military today is 14 percent female. As of September 2007, 346,710 women were on active duty service.

Table 2: Women Active Duty Service Personnel by Branch of Service as of September 30, 2007

Branch of Service	Women as % 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

Source: Women in the Military, Sixth Edition. Report of the Women's Research and Education Institute.

Given the increasing number of women using VA health care services, along with a commitment to attract a higher percentage of women into VA care, the case for "insufficient numbers" has become obsolete. There are sufficient numbers of women veterans to support coordinated models of service delivery to meet their needs. Although women always will constitute a minority of veterans, they represent a "critical mass" as a group and should be factored in as a population in new strategic plans for service delivery.

16 Washington DL, et al. To Use or Not to Use: What Influences Why Women Veterans Choose VA Health Care. JGIM. 2006 Mar; 21:S11-18.

17 Ibid.

18 OEF/OIF Utilization Data, FY 2008 2nd Quarter, Kang H. Dept Veterans Affairs, OPHEH.

Challenge 3: Demographic shifts and impacts on age-related health concerns. The average age of women veterans is 48 years, significantly lower than the average age of male veterans (61 years). It is important to realize that almost all new women veterans accessing VA care are under age 40 and of childbearing age, creating a need for a significant, focused shift in the provision of health care.

The VA also must be sensitive to continuing to meet the needs of older women veterans, even as we focus on returning OEF/OIF veterans. VA continues to strive for excellence in care to our women veterans of the Gulf I, Vietnam, Korean, and World War II eras, most of whom are over age 55. The over-55 age group faces high risks for cardiac disease, cancers including lung cancer, and the consequences of obesity such as diabetes.

Challenge 4: Gender disparities in quality of care. Despite positive results on gender-specific measures (e.g., screening for cervical and breast cancer), a significant difference in VHA performance scores exists between men and women on aggregate outpatient quality measures. For example, prevention measures, including vaccination, colorectal cancer screening, depression screening, and PTSD screening, were less favorable for women veterans.

Challenge 5: Fragmentation of women veteran health care delivery. Fragmentation is a worrisome outcome of our predominant models of primary care delivery to women veterans (multi-visit, multi-provider). "Fragmentation" may be defined as when a primary care clinician such as an internist handles general health care needs, and a specialist such as a gynecologist handles gender-specific health care. To a large extent, the health care offerings to women veterans have evolved in a patchwork fashion, with the model of health care delivery based in part on the academic leanings of the women's health champion(s) on site. In some facilities, no particular model was developed, leading to a default system that heavily utilizes fee-basis care.

Challenge 6: Insufficient numbers of clinicians in VHA with specific training and experience in women's health issues. The historical predominance of male veterans in VA health care settings also has resulted in many VA providers having little or no exposure to women patients,[19] even though women veterans are more likely to depend on the VA as their sole source of health care.[20] Women veterans' numerical minority has created logistical challenges in trying to create delivery systems that assure their equitable access to high quality comprehensive health services that include gender-specific care.

Researchers at the VA Greater Los Angeles Health Services Research and Development CoE found that VA sites with the highest reported barriers to care for women veterans had lower female caseloads, fewer providers experienced in women's health care, fewer women's health-focused resources (e.g., insufficient space, insufficient staffing, too few appropriately equipped exam rooms), problems with assuring adequate women's privacy, fewer women's health-related Quality Improvement (QI) activities, and limited authority over how women's health programs were organized.

19 Miller PM, King LA, et al. A model of gender awareness in VA health care. Veterans Health System Journal. August 1999; 27-30.

20 Shen Y, Hendricks A, Zhang S, Kazis LE. VHA enrollees' health care coverage and use of care. Med Care Res Rev. 2003; 60:253–267.

Challenge 7: Inconsistent policy for women's health. Policy plays an important role in driving change in care provision to women veterans. In earlier VHA handbooks, provision of gender-related care on site in VA was "mandated," but in the 2003 VHA Handbook 1330.1, gender-specific care provision was changed to "preferred." A decline in on site offering of gynecology has occurred in the interim[21] with a corresponding increase in fee-basis referral. In contrast, gender-related care always has been recognized as an integral part of primary care delivery for male veterans.[22]

BECOMING A NATIONAL LEADER IN WOMEN'S HEALTH CARE

In this report, the workgroup offers policy recommendations regarding access to providers and clinics, mental health integration, and the overall development and enhancement of women's health care delivery. Leadership in Congress and in VA has embraced the call to improve health care for women veterans. VA is moving quickly to deliver care that will address the needs of women veterans beyond gender-specific screening for breast and cervical cancer. VA has launched a number of programs that address provider and trainee education, increased access through clinic enhancements and home telehealth, developed and improved diagnostic services including laboratory and mammography, and is focusing on continuity of care systemwide.

Women Veterans Health Strategic Health Care Group Goals

The VHA is committed to providing the highest quality primary care to every woman veteran. All eligible women veterans requesting VA care are assured of:

- **Gender-specific primary care by a proficient and interested primary care provider**
- **Privacy, dignity, and sensitivity to gender-specific needs**
- **State-of-the-art health care equipment and technology**
- **Gender parity in performance measures**
- **The right care in the right place and time.**

21 Yano, EM. How VA Women's Primary Care is Organized: Impacts on Service Availability and Quality of Care. Invited Briefing to the Under Secretary for Health, VHA. Washington DC, March 2008.

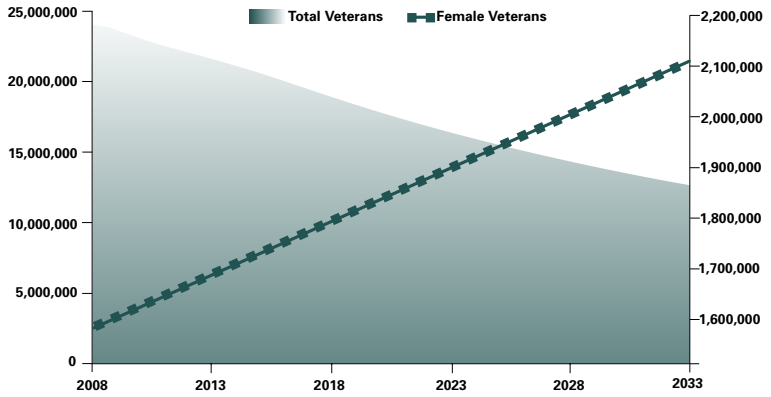
22 Standards of Primary Care, VHA Directive 2006-031.

VA WOMEN'S PRIMARY HEALTH CARE TODAY

ENROLLMENT AND UTILIZATION TRENDS

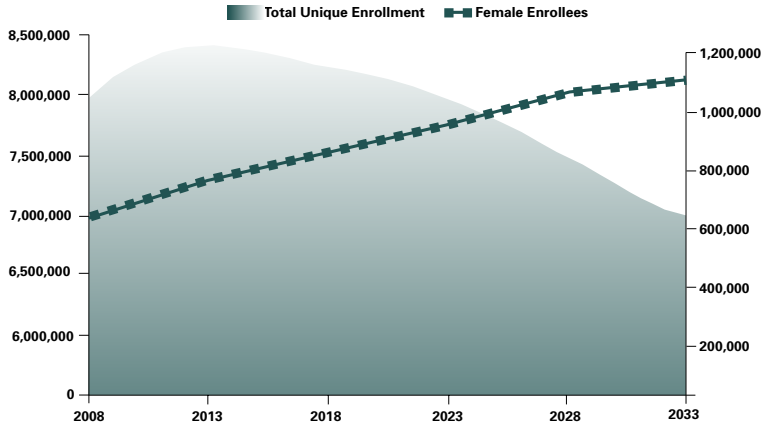
The percentage of veterans who are female is projected to increase from 7.7 percent in 2008 to 10 percent in 2018 and to 14.3 percent in 2033. As shown in Figure 1, the total veteran population is expected to decline 37 percent between 2008 and 2033. During the same period, the total number of female veterans in the United States is expected to increase by a little more than 310,500 or 17.2 percent.[23]

Figure 1: Projected growth in female veteran population, 2008–2033



As shown in Figure 2, the total enrolled veteran population is expected to decline by 11 percent during the next 25 years. In contrast, female enrollees will more than double between 2008 and 2033, from just under half a million to more than a million. By 2033, females will represent one in every seven enrollees versus one in every 16 today. Among OEF/OIF women veterans, 42.6 percent are enrolled and 28.5 percent are users of VHA. Of those female enrollees who used VHA in 2007, 78.5 percent were under the age of 40.[24]

Figure 2: Projected growth in female enrollee population, 2008–2033



23 Analysis performed by VHA ADUSH for Policy and Planning, Sept. 2008.

24 Analysis performed by VHA ADUSH for Policy and Planning, Sept. 2008.

In FY 2007, out of five million unique patients, approximately 250,000 or 5 percent were women. Just over one third of those women who sought treatment in 2007 (95,400) were veterans from the Persian Gulf War while approximately 26 percent were from the post-Vietnam era.[25]

Based on an analysis conducted by the VA Office of the Actuary in 2007, women veterans are younger, in the aggregate, than their male counterparts. In 2007, for example, the estimated median age of women veterans was 47, whereas the estimated median age of male veterans was 61. Although the median age of women veterans is projected to increase steadily over the next two decades, women veterans will still be younger than male veterans in the aggregate.

Only 1 percent of female enrollees reside in highly rural areas, 30 percent in rural areas, and 69 percent in urban areas. However, approximately 62 percent of rural and highly rural female enrollees were users of VA health services in 2007 compared to 59 percent of female enrollees residing in urban areas. The geographic distribution of women veterans will be an important factor addressed in plans for development of women's health clinics.

HEALTH PROFILE OF WOMEN VETERANS

Women veterans have higher physical and mental health burdens than their female non-veteran counterparts[26] and health burdens comparable to or worse than that of male veterans.[27,28,29] Women veterans have substantial chronic disease and mental health burdens, with top diagnoses including PTSD, hypertension, depression, hyperlipidemia, chronic low back pain, gynecologic problems, and diabetes.[30] Recent research demonstrates substantial comorbidities, with 31 percent of women veterans having medical and mental health conditions (vs. 24 percent of men). Of women veterans with diabetes, 45 percent have comorbid serious mental illness (SMI) or substance use disorders, while among those with cardiovascular disease, 21 percent have major depressive disorder.[31]

Greater recognition of the rates of sexual harassment and assault among women veterans has led to expansion of screening and management programs for PTSD and military sexual trauma (MST)[32] and the concomitant need to create care environments that promote safety

25 Analysis performed by VHA ADUSH for Policy and Planning, Sept. 2008.

26 Skinner KM, Furey J. The focus on women veterans who use Veterans Administration health care. Milit Med. 1998; 163:761-766.

27 Skinner KM, Sullivan LM, Tripp TJ, et al. Comparing the health status of male and female veterans who use VA health care: Results from the VA Women's Health Project. Women & Health. 1999; 29:17-33.

28 Romeis JC, Gillespie KN, Virgo KS, Thorman KE. Female veterans' and nonveterans' use of health care services. Med Care. 1991 Sep; 29(9):932-6.

29 Frayne SM, Parker VA, Christiansen CL, et al. Health status among 28,000 women veterans: The VA women's health program evaluation project. JGIM. 2006; 21(Suppl3):S40-46.

30 Frayne SM, Yu W, Yano EM, Ananth L, Iqbal S, Thrailkill A, Phibbs CS. Gender and use of care: planning for tomorrow's Veterans Health Administration. J Womens Health. 2007 Oct;16(8):1188-99.

31 Banerjea R, Sambamoorthi U, Smelson D, Pogach LM. Expenditures in mental illness and substance use disorders among veteran clinic users with diabetes. J Behav Health Serv Res. 2008 Jul;35(3):290-303. Epub 2008 May 30.

32 Military Sexual Trauma is defined 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.

and privacy.[33,34] More than one quarter of women veterans who use the VA for health care screen positive for PTSD, with more than a third not having any mental health care in the previous 12 months.[35] Earlier cohorts of women in the military have had similar screening outcomes. MST has in turn been associated with increased risk of depression, PTSD, and substance use disorders, and confers a six-fold increase in risk for having three or more mental health conditions.[36] Among women veteran outpatients there is considerable prevalence of mental illness diagnoses. In both FY2006 and FY2007, the top three diagnostic categories for women veterans treated by VHA were PTSD, hypertension, and depression.[37]

SYSTEMIC FRAGMENTATION DUE TO STRUCTURE OF CARE DELIVERY

While women veterans have a high disease burden, they receive the most fragmented care. Fragmentation refers to the fact that the reproductive and non-reproductive components of women's basic primary health care are frequently provided by different types of providers in different settings. What would be routine primary care in community settings is referred out to specialty women's health clinics in the facility or to fee-basis or contract providers, thus causing a woman veteran to need two appointments and two providers to receive her complete primary care. For example, 54 percent of VA facilities serving 300 or more women veterans refer them out of primary care for Pap smears to screen for cervical cancer. Nearly half of VA facilities refer women out of primary care for a clinical breast exam (47 percent), for contraceptive counseling (47 percent), for evaluation of vaginitis (46 percent), and for menopausal management (46 percent).[38] Osteoporosis management is referred to specialty women's health clinics in 16 percent of VA sites. Moreover, 15 percent of VA facilities nationally do not screen women veterans for sexual trauma in primary care but instead schedule a separate clinic visit in a women's health clinic.[39] Such fragmentation not only raises challenges to continuity of care, it is inefficient and costly for the VA system.

Clinical breast exams, contraceptive counseling, evaluation of vaginitis, menopausal management, osteoporosis management, etc., are all traditional components of routine primary care for women similar to the provision of prostate exams and management of erectile dysfunction for men. The current models of primary care delivery result in many women veterans scheduled to see two or more providers in order to receive routine

33 Coyle BS, Wolan DL, Van Horn S. The prevalence of physical and sexual abuse in women veterans seeking care at a Veterans Affairs Medical Center. Mil Med. 1996; 161:588-593.

34 Goldzweig CL, Balekian TM, Rolon C, Yano EM, Shekelle PG. The state of women veterans' health research: Results of a systematic literature review. JGIM. 2006, 21(Suppl3):S82-92.

35 Dobie DJ, Kivlahan DR, Maynard C, Bush KR, Davis TM, Bradley KA. Posttraumatic stress disorder in female veterans: association with self-reported health problems and functional impairment. Arch Intern Med. 2004 Feb 23;164(4):394-400.

36 Kimerling R, Gima K, Smith MW, Street A, Frayne S. The Veterans Health Administration and military sexual trauma. Am J Public Health. 2007 Dec;97(12):2160-6. Epub 2007 Oct 30.

37 VSSC. Women Veterans Health Workload Report. October 2008.

38 Yano EM, Washington DL, Bean-Mayberry B. Impact of Practice Structure on the Quality of Care for Women Veterans (Final Report). Sepulveda, CA: VA HSR&D Center of Excellence for the Study of Healthcare Provider Behavior. March 2008.

39 Yano EM, Bean-Mayberry B, Canelo I, Lanto AB, Washington DL. What does women's health look like in the Veterans Health Administration?: Results of a national organizational survey. Oral presentation at AcademyHealth, Washington DC. June 11, 2008.

preventive primary care. This presents access barriers for women veterans and may impact the overall quality of care delivered.

QUALITY

As measured by standard indicators such as HEDIS, the quality of care provided to women in VHA exceeds that received by women receiving care in the private sector. Although there are important differences in data sources and definitions, VHA consistently performs better than the private sector on nearly all HEDIS measures. In particular, the VA outperforms the private sector on the gender-specific measures of breast and cervical cancer screening (Table 3).

Table 3: Gender-Specific Quality of Care Indicators

Clinical Performance Indicator	VA FY08*	VA FY08*	HEDIS** Commercial 2007	HEDIS** Medicare 2007	HEDIS** Medicaid 2007
Breast cancer screening	87%	86%	69%	67%	50%
Cervical cancer screening	92%	91%	82%	N/A	65%

Source: Office of Quality and Performance, updated 10-23-08.

* VA comparison data are obtained by abstracting medical record data using similar methodologies to matched HEDIS methodologies.

** HEDIS data were obtained from the 2008 "State of Health Care Quality Report" available on the NCQA website: www.ncqa.org.

Despite these impressive results, a consistent difference persists between men and women veterans in VHA on measures that are common to both men and women. As stated in the Hospital Quality Report Card, "there are differences in the care which is delivered to male and female veterans; where differences are found in the composite HEDIS scores, they show higher quality care is delivered to men."[40] Women veterans continue to lag behind their male counterparts in some quality measurements.[41] Considerable variation in the magnitude of the quality disparities was seen across VISNs; however, performance differences occurred in every VISN throughout the country.[42]

Differences in HEDIS scores by gender are not unique to VA; the disparity also is evident in the private sector.[43] While the underlying causes of the disparities are not yet fully understood, such causes must be addressed.

Because breast and cervical cancer screening rates reflect only a small segment of care delivered to women veterans, the USH Workgroup looked beyond these to other measures that could have broader implications. The USH Workgroup particularly was interested

40 VHA Office of Quality and Safety (10G), Hospital Quality Report Card accessed at: http://www.va.gov/health/docs/Hospital_Quality_Report.pdf.

41 VHA Office of Quality and Safety (10G).

42 VHA Office of Quality and Safety (10G), Hospital Quality Report accessed at: http://www.va.gov/health/docs/Hospital_Quality_Report.pdf.

43 Clancy CM, Massion CT. American Women's Health Care, a Patchwork Quality with Gaps. 1992. JAMA 268:1918-20.

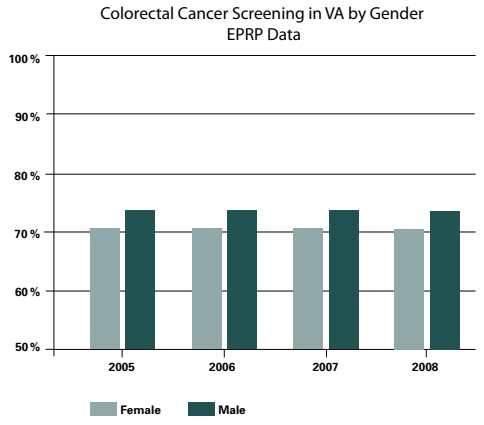
in looking at cardiovascular disease measures—the number one cause of death of female veterans. The USH Workgroup found that scores related to management of high blood pressure, high cholesterol, and diabetes, all of which contribute to cardiovascular disease risk, were worse for women when compared to men.[44]

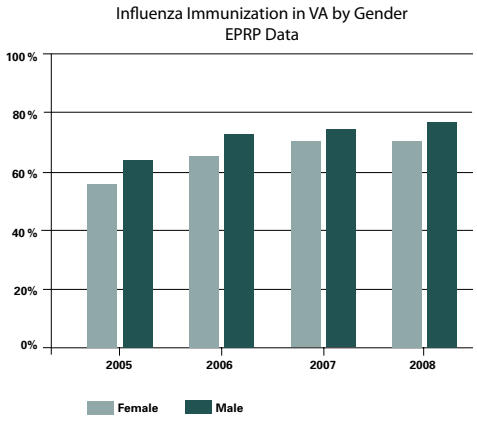
Cholesterol Control: Control of cholesterol, measured as low-density lipoprotein (LDL), is especially important to consider in diabetic patients. Significant differences were found for LDL-cholesterol control measures (Goal of LDL<130) among diabetic patients. For diabetic patients ages 51-65, 75 percent of women had LDLs below 130 versus 83 percent of men. Similarly, for diabetic women over age 65, 77 percent of women had LDL below 130 compared to 89 percent of men in the same age stratum.[45]

Diabetes Measures: Women had less favorable scores on several measures assessing quality of care for diabetic patients.[46]

- Prescription of an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) to control hypertension and slow kidney damage. For ages 51-65, 67 percent of women were given an ACEI/ARB prescription vs. 77 percent of men.
- Testing for microalbuminuria to detect early kidney disease. For age ≤50: 71 percent of women were tested vs. 87 percent of men.
- Completion of a retinal exam to detect diabetic retinopathy. For ages 51-65: 79 percent of women had a retinal exam within the prior year vs. 86 percent of men.

Prevention Measures. Gender-neutral prevention measures for colon cancer screening, depression screening, and immunizations show a disparity between men and women. Furthermore, unlike other successes in quality performance, immunization rates for women veterans are lower than the private sector. As illustrated in the graphs below, the differences between men and women in colorectal cancer screening and influenza immunizations have persisted from 2005 to 2008.[47]





44 Wright SM, Lucatorto MA, Yano EM. An Analysis of the Quality of Care Provided to Men and Women in the VA Health Care System. Office of Quality and Performance. Unpublished report, July 2008.

45 Ibid.

46 Ibid.

47 Presentation by Dr. Linda Kinsinger to the Secretary's Advisory Committee on Women Veterans, Washington DC, October 29, 2008.

When comparing VHA quality performance to the Medicare population performance on the HEDIS measure of colorectal cancer screening, VHA performed significantly better than the Medicare population in 2007.[48] However, only 75 percent of women veterans were screened for colorectal cancer compared to 83 percent of male veterans. In regards to immunization screening, not only were women veterans receiving immunizations at lower rates than male veterans, they also fell below the Medicare population benchmark (Table 4).

Table 4: Gender-Specific Quality of Care Indicators

Clinical Performance Indicator	VA Women FY07*	VA Men FY07*	HEDIS** Medicare 2007
Colorectal screening (age >65)	75%	83%	50%
Immunizations: pneumococcal (age >65)	51%	69%	67%
Immunizations: influenza (note patients' age groups HEDIS 50-64)	60%	64%	72%

Source: Office of Quality and Performance. Wright SM et al. Unpublished report. July 2008.

* VA comparison data are obtained by abstracting medical record data using similar methodologies to matched HEDIS methodologies.

** HEDIS data were obtained from the 2008 "State of Health Care Quality Report" available on the NCQA web site: www.ncqa.org.

In response to the assessment that women were receiving influenza vaccines at lower rates than men and at lower rates than the private sector, the VA modified its patient-oriented influenza campaign materials to better appeal to women veterans and highlighted to clinicians the need to assure that women received their flu shots. Currently, follow-up data are being gathered. VHA must continue to explore and address the observed difference in treatment of men and women.

CURRENT STRUCTURES OF CARE DELIVERY

To evaluate primary care women's health delivery, it is important to understand what type of care is currently delivered in the field. Several tools are available to measure the current status of care delivery to women. These tools include the Plan of Care/Clinical Inventory (POC/CI) and the Snapshot Analysis.

Plan of Care/Clinical Inventory. The POC/CI, an annual web-based survey tool,[49] was developed in order to assess compliance with the Services for Women Veterans Handbook 1330.1. The survey collects data at the facility level on the population of women veterans, the model of care delivery, staff levels, the environment of care, the level of privacy, and the type of mental health services offered.

FY2008 will mark the fifth year of data collection using this web-based reporting tool. In

48 Wright SM, Lucatorto MA, Yano E. An Analysis of the Quality of Care Provided to Men and Women in the VA Health Care System. Office of Quality and Performance. Unpublished report, July 2008.

49 POC/CI Survey conducted by VACO 13E Women Veterans Health Strategic Health Care Group (WVHSHG), completed by the WVPM at facility. CMOs have access to review all data entry.

FY2007, the tool was expanded to collect baseline data regarding care provision to women veterans in VA's 696 Community-Based Outpatient Clinics (CBOCs). The data from the POC/CI are used to better understand the provision of health care to women veterans, allowing for longitudinal evaluations and providing a picture of the program nationwide and at the local level.

Two highlights from the POC/CI 2007—the models of care delivery and the clinical inventory—help illustrate the current delivery of services to women.

Table 5: Women's Health Care Delivery Models in the VA — POC/CI FY 2007

Model		Where Available
A	Separate women's health center providing comprehensive, multidisciplinary care, including primary care, gender-specific care, mental health services, and surgical services within dedicated space	19 sites (12.4%)
B	Separate women's health center providing primary care and gender-specific care within dedicated space	31 sites (20%)
C	Separate gender-specific and/or gynecology clinic, primary care provided in a designated women's primary care team within the facility	15 sites (9.8%)
D	Separate gender-specific and/or gynecology clinic, primary care provided in mixed-gender primary care teams within the facility	76 sites (49.7%)
E	Integrated gender-specific and/or gynecology services provider by primary care practitioners within the facility	12 sites (7.8%)

According to the POC FY2007, approximately 33 percent of the care currently being offered to women involves a "one-visit model."[50] In comparison, 67 percent of sites continue providing primary care in a fragmented, two-visit model, where general primary care is conducted at one visit and gender-specific primary care at a second visit. See Appendix B for a breakdown of the models of care by facility and VISN.

> **"Disparities in treatment and satisfaction based on gender or ethnic background are unacceptable. VA has a robust program to look at disparities and deal with the underlying causes."**
>
> *~ James B. Peake, MD*
> *Secretary, Department of Veteran Affairs*
> *Remarks on Hospital Quality*
> *Report Card, June 13, 2008*

Clinical Inventory 2007. The clinical inventory reports the care services for women veterans available within VA, by contract or through referral. There are 153 facilities in the database. The totals may be greater than 153 if more than one type of access is available at a facility.

50 Combining A@12.4 percent + B@20.3 percent.

Table 6: Clinical Inventory of Services Available to Women Veterans, 2007

Name	In House	Contract	Fee Basis	Referral to Other VA
Primary care	153	2	3	2
Routine physical exams	153	0	2	1
Routine gynecology care (annual exam)	151	2	16	8
Urgent/emergent gender related care-normal hours	143	9	72	23
Urgent/emergent gender related care-evenings, weekends, holidays	109	13	96	27
Pregnancy testing-Urine	149	1	12	3
Pregnancy testing-Serum	147	6	8	3
Contraceptive counseling	151	1	10	5
Contraceptive management	152	4	13	8
Sexually transmitted disease (STD) screening	152	3	7	5
STD counseling	152	3	7	4
STD treatment	152	3	8	4
Menopause counseling	152	4	9	4
Hormone therapy	151	4	10	9
Infertility services	80	9	109	47
Pap smears	151	4	13	8
Reflex HPV testing	120	16	13	16
Clinical breast exam	152	3	10	5
Bone densitometry	120	4	34	7
Osteoporosis management	150	2	7	6
Screening mammography	36	51	87	13
Diagnostic mammography	29	51	88	14
Sexual trauma screening	152	2	3	5
Intimate partner violence screening	149	1	6	5
Intimate partner violence counseling	147	3	9	7
Depression screening	153	1	4	2
Depression treatment	153	2	9	7
Smoking cessation counseling	153	0	0	1
Smoking cessation treatment	153	0	0	0
Mental health services	153	5	19	22
Surgical services: breast	97	7	86	55
Gyn-oncology	40	6	107	58
Gyn surgery	76	9	82	60
Oncology	114	3	41	44
Urology	136	3	28	32
Uro-gynecology	71	9	76	54

The Clinical Inventory shows that many sites are able to provide routine gender-neutral and gender-specific primary care on site. However, there are still gaps in specific services provided to women veterans. More attention is needed in the area of urgent/emergent care of women, especially in the evenings and on weekends. Furthermore, many specialty services, including mammography, are not able to be provided in-house, increasing the fragmentation of care. Clearly, a range of services is offered to women at most sites, but the next step is to organize the most common services in a well-coordinated, comprehensive manner.

Snapshot Tool. To enhance our understanding of care delivery offered at each VA facility, women veterans' utilization rates overall were measured by a Snapshot Tool administered by the Women Veterans Program Managers at every VA facility in July 2008. This analysis showed that while comprehensive "one-visit" models of care were offered at 33 percent of sites, many women seen at those facilities were not actually getting care in that setting. Rather, a large percentage of women were being seen in the multi-visit care models, even when a more coordinated and comprehensive model of care was available at a particular site.

For example, in VISN 1, Togus VAMC offers a "one-stop shop" model of care, yet only 76 percent of women are getting all their care in that model. Instead, 19 percent were going outside the VA to receive part of their primary care. The situation is more extreme at the West Haven VAMC where only 30 percent of women seen receive all their primary care at one visit (in the one-stop shop). The majority receive primary care in multiple locations.

Table 7: VISN 1 — Delivery Structures & Utilization Snapshot, FY2008 Third Quarter Cumulative Data

Facility Name	One-Stop Shop	Primary Care and Gender-Specific Care in separate clinics by different providers	Gender-Neutral Primary Care at facility, Gender-Specific at different location (i.e., other VA, community, fee basis)
Togus VAMC	76%	5%	19%
Manchester, NH	0%	30%	70%
Bedford	0%	16%	84%
West Haven, CT	30%	4%	66%
Northampton	0%	55%	45%
White River Junction	0%	41%	59%

A similar pattern is seen in VISN 22. At the Las Vegas VAMC, a "one-stop shop" is available to the women veterans. However, only 47 percent of the women who utilize that facility are receiving their care in the coordinated, one-visit clinic.

Table 8: VISN 22 — Delivery Structures & Utilization Snapshot, FY2008 Third Quarter Cumulative Data[51]

Facility Name	One-Stop Shop	Primary Care and Gender-Specific Care in separate clinics by different providers	Gender-Neutral Primary Care at facility, Gender-Specific at different location (i.e., other VA, community, fee basis)
Las Vegas	47%	0%	36%
Long Beach	0%	80%	3%
Loma Linda	0%	0%	78%
San Diego	80%	17%	0%
GLA	59%	17%	6%

Such examples underscore the importance of understanding both the models available and the utilization of these models. Offering the "one visit" care model is a large first step for facilities; however, actually having the women utilize the services is a critical accompanying step. Accordingly, when trying to understand quality data at the facility or VISN level, it also is important to understand the utilization percentages of the models of care by the women veterans. If only half the women access the "one-visit" clinic, aggregate data from all women (women cared for in and out of the "one-visit" clinic) cannot be used to assess the quality of care provided to women in a particular model of care. One of the problems that must be addressed is the under-utilization of the comprehensive service models.

51 Note: Data are self reported. Not all models of primary care delivery were captured in this analysis.

★ THE IMPACT OF PRACTICE STRUCTURE ON QUALITY OF CARE FOR WOMEN VETERANS

VHA Handbook 1330.1 Services for Women Veterans, Paragraph 4b states:

Research has shown that full-service women's primary care clinics and/or teams, which provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care to women veterans. It is recognized that there are alternative models of health care delivery, influenced by local circumstances that may be equally effective in the delivery of quality health care for women.

NOTE: ***Performance outcome data need to guide facilities in designing the process of health care delivery that ensures the highest degree of quality, as well as customer satisfaction.***

As of June 2008, evidence exists of persistent gender-based quality disparities in the delivery of preventive health care to women veterans. The Plan of Care Survey, now trended since 2006, also indicates that primary care women's health is not uniformly delivered to women veterans who utilize VHA services. Table 9 compares data on women veteran users of VHA, combined data on women and men users of VHA, private insurance market data, and Medicaid/Medicare data.

Based on an examination of VHA's performance measure outcomes for men vs. women and compared to private sector and Medicare data, the workgroup recommends that VHA assess primary care as it is delivered and further evaluate the relationship of care structure to quality outcomes for women veterans.

Table 9: Clinical Preventive Performance Scores FY2007

Quality Comparisons	Women VA Data FY07	VA Men & Women	Private Health Insurance	Medicaid Medicare
Cervical Pap Smears	91%	N/A	81%	66% Medicaid
Mammograms	86%	N/A	69%	49% Medicaid
Colorectal Cancer Screenings	70%	78%	55%	53% Medicaid
Cholesterol	80%	92%	83%	71% Medicaid
Diabetes BP <140/90	71%	77%	61%	57% Medicaid

Source: VHA Office of Quality and Safety, Hospital Quality Report Card 2008.

EVIDENCE FROM VA RESEARCH

VA health services researchers have examined the impact of practice structure on the quality of care by combining data from organizational surveys and from the VA Office of Quality and Performance (OQP).[52] OQP data included chart-based quality indicators from the VHA External Peer Review Program (EPRP) and patient survey-based indicators from the VHA Survey of Health Care Experiences of Patients (SHEP), both of which serve as foundations for VA performance measures.

52 Yano EM, Bean-Mayberry BA, Washington DL. VA HSR&D Center of Excellence for the Study of Healthcare Provider Behavior. March 2008. VA HSR&D PROJECT # IIR 04-036.

Access and Wait Times. Access and wait time ratings were better in sites where gender-specific services were available in an integrated women's primary care setting regardless of where that was (i.e., one stop or appointment in a separate women's clinic or within general primary care). Access and wait times were worse in facilities where all or almost all women were seen in general primary care for the majority of their health care needs (as opposed to a women's clinic) ($p<.05$).[53]

Organizational factors related to higher ratings of accessibility included having a separate women's health budget (or control point) ($p<.005$) and having staff with adequate clinical expertise in women's health ($p<.05$), who in turn were capable of training other providers ($p<.05$). VA facilities with active women's health-focused quality improvement programs also achieved higher accessibility scores ($p<.05$). VA facilities that funded their providers to attend women's health training programs ($p<.05$), earmarked special funds for education in women's health ($p<.0001$), or funded their own local conferences, workshops, or mini-residencies in women's health ($p<.01$) all had significantly higher women veterans' ratings of accessibility.[54]

In contrast, facilities without local women's health expertise had lower female patients' ratings of accessibility. Overall accessibility ratings were highly related to the availability of onsite gender-specific services (e.g., onsite bone scan equipment for osteoporosis screening/monitoring, onsite endometrial biopsy capability, and onsite IUD placement) (each $p<.05$).

Care Coordination. According to results derived from SHEP data, VA facilities that have established one-stop type of primary care delivery (in women's clinics or in general primary care) for contraception, STD screening, and menopausal management had, on average, better care coordination scores than facilities that separated these services across multiple clinics (each $p<.05$).[55] In other words, clinics where only one visit or one appointment was needed to obtain the entire spectrum of primary care services (gender-specific and acute and chronic care) had higher levels of care coordination. Care coordination was worse in facilities where primary care providers had to refer to another VA facility for women's health specialty care (e.g., for nonsurgical adjuvant breast cancer treatment) ($p<.05$) and in VA facilities using both designated women's health providers in primary care and women's clinic referrals to cover primary care needs ($p<.05$).

Facilities with better care coordination scores among women veterans also reported having sufficient clinical expertise and women's health staffing ($p<.05$), in addition to greater

53 Yano EM, Washington DL, Bean-Mayberry B. Impact of Practice Structure on the Quality of Care for Women Veterans (Final Report). Sepulveda, CA: VA HSR&D Center of Excellence for the Study of Healthcare Provider Behavior, March 2008.

54 Ibid.

55 Yano EM, Washington DL, Bean-Mayberry B. Impact of Practice Structure on the Quality of Care for Women Veterans (Final Report). Sepulveda, CA: VA HSR&D Center of Excellence for the Study of Healthcare Provider Behavior, March 2008.

authority over women's health staffing arrangements ($p<.05$). Like sites that achieved higher access scores, VA facilities that had initiated women's health-focused quality improvement activities also were more likely to achieve better care coordination scores ($p<.05$).[56]

Patient Satisfaction. A cross-sectional survey of 1,081 women veteran VA users throughout southern California and southern Nevada found that women veterans prefer "one-stop shopping," with 55 percent of VA users reporting that it is very important to them to receive general and women's health care from the same provider or clinic.[57] Forty-four percent of women VA users rated the availability of a women's health clinic very important. In a two-VISN study of women veterans' satisfaction and primary care (PC) quality ratings in Women's Health Clinics (WHCs) and general PC clinics,[58] Dr. Bean-Mayberry and colleagues found that women veterans attending WHCs reported significantly higher rates of excellent patient satisfaction for overall care and for five specific domains of care (OR≥1.6, 95% CI [1.1-2.5][59] for all domains) compared to women attending traditional primary care clinics, even when adjusting for patient demographics, health status, and site of care.[60] Having a female provider, provision of routine gynecological care, and patient involvement in a WHC each had independent positive effects on patient ratings of primary care quality. The combination of all three provider and organizational factors showed a consistent, significant relationship to high ratings for preference for provider (i.e., continuity), communication and comprehensiveness, demonstrating organization of care is strongly associated with patient perceptions of quality.

Breast and Cervical Cancer Screening. Breast and cervical cancer screening rates are the only two gender-specific performance measures unique to women veterans (as opposed to measures such as colorectal cancer screening, which would be considered gender neutral). Earlier primary care organizational data (1999–2000) suggests that mammography rates were better in VA facilities with strong primary care sub-specialty coordination (i.e., consult results were reported in a timely manner) and worse in VA facilities that strictly assigned women veterans to a general primary care provider ($p<.05$).[61] *Again, this puts a premium on coordinated, comprehensive care for women instead of having them in the general pool of veteran patients.*

Cervical cancer screening rates were better in VA facilities with women's clinics that delivered primary care but only in facilities where the women's clinics had a comprehensive staff mix (e.g., integrated gynecologists, other MDs, and social workers) in

56 Ibid.

57 Washington DL, et al. To Use or Not to Use: What Influences Why Women Veterans Choose VA Health Care. JGIM. 2006 Mar; 21: S11-18.

58 Women's Health Clinics are defined as providing women's gender-specific care as distinct from general primary care clinics defined as providing mixed-gender care.

59 Odds Ratio (OR); Confidence Interval (CI)

60 Bean-Mayberry BA, Chang CC, McNeil MA, Whittle J, Hayes PM, Scholle SH. Patient satisfaction in women's clinics versus traditional primary care clinics in the Veterans Administration. JGIM. 2003; 18(3):175-181.

61 Goldzweig CL, Parkerton PH, Washington DL, Lanto AB, Yano EM. Primary care practice and facility quality orientation: influence on breast and cervical cancer screening rates. Am J Manag Care. 2004 Apr;10(4):247-8.

contrast to the women's clinics set up to ensure delivery of gender-specific exams. Thus, women's clinics that provided only gender-specific care did not show higher rates of cervical cancer screening. Women's clinics needed to have comprehensive services beyond gender-specific care. Women's clinics were established in an effort to increase Pap smear rates among eligible women veterans. While rates have improved, further improvement can be gained through comprehensive primary care delivery.

"Gender-Neutral" Quality-of-Care Measures. Neither care model recommended by VHA Handbook 1330.1 (a separate women's clinic or a designated women's health provider within a general primary care team) has yet to show any performance advantage over general primary care models. This may be a result, at least in part, of the gender-specific exam focus of many women's health clinics, where there is likely little or no expectation of delivering comprehensive primary care services. Use of designated providers within general primary care clinics also may result in a focus on reproductive health and/or gender-specific exams; however, no data currently exist about the details of their training/qualifications, whether they take responsibility for the breadth of primary care needs or split those duties with non-designated providers, etc. Research is ongoing to understand the various models of care and their impact on gender-neutral outcomes.

Subsequent analyses are planned for FY2009 in a partnership between the Office of Quality and Safety, the Women Veterans Health Strategic Health Care Group (WVHSHG), and researchers at the VA Greater Los Angeles HSR&D CoE. These analyses will combine a broader set of organizational measures that span primary care programs, specialty care programs, and women's health programs in addition to more detailed patient characteristics and in the context of area characteristics (e.g., urban/rural location, Health Resources and Services Administration (HRSA) primary care shortage area), on-site utilization data, and relative utilization.

EVIDENCE FROM PRIVATE SECTOR RESEARCH

Recent studies compared the quality of care for women served in two different primary care settings: primary care women's health centers and primary care internal medicine practices. Controlling for patient characteristics, these studies found that women who were cared for at primary care women's health centers were more likely to receive preventive care services and have higher patient satisfaction. Moreover, providers at primary care women's health centers were more likely than those at internal medicine practices to deliver the preventive services themselves, obviating the need for patients to see other providers, such as gynecologists, for their routine preventive health services. This finding suggests that women's health centers might be an efficient alternative health care delivery model for women, as patients could receive their general medical and gender-specific preventive health services from one provider at one visit.[62,63]

62 Harpole LH, Mort EA, Freund KM, Orav J, Brennan TA. A comparison of the preventive health care provided by women's health centers and general internal medicine practices. JGIM. 2000;15(1):1-7.

63 Phelan EA, Burke W, Deyo RA, Koepsell TD, LaCroix AZ. Delivery of primary care to women. Do women's health centers do it better? JGIM. 2000;15(1):8-15.

Additional data on quality of care and patient satisfaction are found in studies of HHS-designated CoEs in Comprehensive Primary Care Women's Health. Adjusting for patient characteristics and geographic setting, results showed that women served in the CoEs—ranging from "one-stop shops" to "clinic without walls" care models—were significantly more likely than women in national and community comparison samples to receive a range of age-appropriate screening services (Pap tests, breast exams, mammograms, cholesterol tests, and colon cancer screening) and counseling on health topics (smoking cessation, exercise, alcohol/drug use, domestic violence, and STDs). Patients served in the CoEs also reported significantly higher patient satisfaction levels than women served in the community.[64]

Quality of care, especially when relevant to psychosocial aspects of illness, may be further enhanced by offering familiar surroundings and tangible evidence of collaboration among multiple caregivers in the same physical setting. In addition to quality benefits, "co-location of core women's health services has great potential for decreasing inefficiency, improving access, and lowering costs."[65]

64 Anderson RT, Weisman CS, Scholle SH, Henderson JT, Oldendick R, Camacho F. Evaluation of the quality of care in the clinical care centers of the National Centers of Excellence in Women's Health. Women's Health Issues. 2002; 12(6):309-326.

65 Carlson, K. Multidisciplinary Women's Health Care and Quality of Care. Women's Health Issues 10(5) Sept/Oct 2000; 219-225; 222.

USH WORKGROUP REQUIREMENTS FOR THE DELIVERY OF WOMEN'S PRIMARY HEALTH CARE

The USH Workgroup learned from the current state of primary care delivery that the number of women veterans is growing rapidly; women have a higher amount of mental health and chronic disease burdens; and women veterans are more likely to need two or more visits to get the same basic primary care services that a male veteran gets in one visit. The USH Workgroup also learned that the current primary care delivery models are highly variable, with few facilities offering the full range of primary care services for women in one location with one provider. Further, research showed that access, wait times, and care coordination levels were better in sites where only one visit or one appointment was needed to provide the entire spectrum of primary care services (gender-specific and acute and chronic care). Studies also showed that women who were cared for at primary care women's health centers were more likely to receive preventive care services and have higher patient satisfaction.

In light of these findings, the USH Workgroup supports the goal **to deliver coordinated, comprehensive primary care for women veterans where every woman has access to a VA primary care provider who can meet all her primary care needs, including gender-specific, acute and chronic illness, preventive, and mental health care in the context of a longitudinal relationship with that primary care provider**.

In most health care settings when describing primary care, it is not necessary to specifically cite women's health; women are assumed to be a significant part of the panels of most primary care providers. In the VHA environment however, significant consideration of women's health issues in the primary care setting is a relatively new concept, and thus it is helpful to define the dimensions and scope of that care when it is referred to as Comprehensive Primary Care for Women Veterans. Therefore, the USH Workgroup created a new consensus definition of comprehensive care for women veterans based upon the concepts of patient-centered primary care and existing VA policies.

PATIENT-CENTERED PRIMARY CARE

The concepts for the comprehensive, coordinated model of primary care for women veterans are drawn from the patient-centered care delivery model. Patient-Centered Care has been recognized as the predominant model for delivery of care for all veterans. Patient Care Services recommended to the National Leadership Board/Health Systems Committee concepts of patient-centered delivery of primary care that include:

- Integrated and comprehensive health care team providing seamless coordination of care across the continuum
- Superb access to care
- Patient engagement in care—"Patient-Driven Care"—meeting the individual's needs and preferences
- Dignity and respect for the perspectives and choices of the patient and family
- Treating individuals as holistic beings (interconnected body, mind, and spirit) by

offering complementary therapies and social support, i.e., "nutrition for body and soul"
- Empowering patients through information and education
- Creating an environment conducive to health and healing
- Integrated clinical information systems to support care, education and learning, and quality improvement

These patient-centered concepts overlap with the growing body of work on the Patient-Centered Medical Home (PCMH). The PCMH is a team-based model of care that provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The model puts a premium on whole-person orientation, where the primary care physician is responsible for providing all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all life stages as well as acute care, chronic care, preventive services, and end-of-life care.

A new Commonwealth Fund report shows that a PCMH can reduce or even eliminate disparities among special populations in access and quality. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.[66]

A study conducted by RAND researchers at the University of California Berkeley undertook a rigorous evaluation of care provided according to PCMH principles. For almost 4,000 patients with diabetes, congestive heart failure (CHF), asthma, and depression, they found that patients with diabetes had significant reductions in cardiovascular risk; CHF patients had 35 percent fewer hospital days; asthma and diabetes patients were more likely to receive appropriate therapy.[67]

Care delivered by primary care physicians in a PCMH is associated consistently with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization, improved patient compliance with recommended care, and lower spending. ***These core principles of patient-centered care—comprehensive provision of seamless, high-quality, safe, coordinated care across the health care continuum and a whole-person orientation—are exactly the kind of care that women veterans deserve.***

EXISTING VA POLICIES REGARDING PRIMARY CARE

Redefining comprehensive primary care for women veterans starts with understanding existing VA primary care policies. Primary care offers eligible veterans easy access to health care professionals familiar with their needs. It provides long-term patient-provider relationships, coordinates care across a spectrum of health services, educates, and offers disease prevention programs.

66 Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey. The Commonwealth Fund. June 2007.

67 Higashi T, Wenger NS, Adams JL, Fung C, Roland M, McGlynn EA, Reeves D, Asch SM, Kerr EA, Shekelle PG. Relationship between Number of Medical Conditions and Quality of Care. N Engl J Med 2007 356: 2496-2504.

VHA Directive 2006-031, Primary Care Standards, states:

> Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

To that statement should be added that primary health care for women includes not just general medical care and management of chronic conditions but also gender-specific, mental health, and reproductive health care. While those are areas of concern in the male population as well, their inclusion should be emphasized for the female veteran population because of the significance they may assume at certain stages in a woman's life.

VHA Directive 2006-031 also directs each facility to provide **continuity,** stating that:

> Primary care programs place a premium on sustaining the personal relationships between patients and their providers. This therapeutic alliance improves the likelihood that patients will participate in preventive health screenings, take active and educated roles in decisions affecting their health, and ultimately become more independent in managing their own health.

To address the needs of women veterans—a population with higher mental health and chronic disease burdens—it is crucial for each woman to have continuity of care with one primary care provider who can meet all her primary care needs. Delivering primary care in multiple visits with multiple providers works against the advantages of the continuity of care concept and the creation of therapeutic alliances.

VHA Directive 2006-031 also describes **comprehensiveness:**

> Primary care providers must take responsibility for meeting the health care needs of the individuals assigned to them; if not through their own scopes of practice, then by referral to specialty services. Primary care providers and their health care team manage common chronic diseases prevalent in the veteran population and treat acute illnesses.
>
> The primary care team is responsible for:
> (1) Providing or arranging for appropriate preventive health services, including breast and cervical cancer screenings
> (2) Screening for mood disorders and substance abuse and promptly treating uncomplicated anxiety and depression
> (3) Offering continual education to patients about diseases, medications, and healthy lifestyles, thereby helping patients become more independent, knowledgeable, and confident in maintaining their health. This remains a fundamental goal of primary care.

Breast and cervical cancer screenings are within the scope of practice of primary care providers. It is understandable that cervical and breast cancer screening skills may be out of practice due to the small numbers of women seen within the VA in the past. However,

because the number of women veterans will increase significantly in the next several years, the USH Workgroup finds that this barrier must not be a permanent barrier. Providers can relearn these skills as well as others that focus on primary care delivery to women. Further, retraining in a women's health knowledge base will aid primary care physicians in meeting the requirement to continually educate their female patients on topics such as vaginitis, contraception counseling, osteoporosis, menopause management, and others. The primary care policy clearly states that all primary care providers should already be doing basic screening and treatment of uncomplicated anxiety and depression.

CONSENSUS DEFINITION: COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS

The changing demographics of the women veteran population, the historically fragmented delivery of primary care to women veterans, and the ongoing quality disparities have led the USH Workgroup to examine current policy as it relates to provision of primary care. In light of this policy review and all aforementioned factors, the USH Workgroup concludes that a new definition of Comprehensive Primary Care for Women Veterans is warranted.

The USH Workgroup endorses the following consensus definition of Comprehensive Primary Care for Women Veterans:

Comprehensive primary care for women veterans is defined as the 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. The full range of primary care needs for women veterans is described below.

- Care for acute and chronic illness includes routine detection and management of disease such as acute upper respiratory illness, cardiovascular disorders, cancer of the breast, cervix, colon, and lung, diabetes mellitus, osteoporosis, thyroid disease, COPD, etc.
- Gender-specific primary care, delivered by the same provider, encompasses sexuality, contraception counseling, pharmacologic issues related to pregnancy and lactation, management of menopause-related concerns, and the initial evaluation and treatment of gender-specific conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, etc.
- Preventive care includes services such as age-appropriate cancer screening, weight management counseling, smoking cessation, immunizations, etc.
- The same primary care provider should screen and appropriately refer patients for military sexual trauma as well as evaluate and treat uncomplicated mental health disorders and substance use disorders.
- When specialty care is necessary, the primary care provider will coordinate this care and communicate with the specialty provider regarding the evaluation and treatment plan to ensure continuity of care.

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 new consensus definition for comprehensive primary care given above.

IMPORTANT CONSIDERATIONS IN THE PROVISION OF COMPREHENSIVE WOMEN'S PRIMARY CARE

Of utmost importance to the provision of comprehensive women's primary care within VHA is the existence of proficient, interested, and engaged primary care providers and integrated mental health providers as well as an ongoing mechanism for staff and provider education to promote, improve, and maintain skills and competency. Establishing and maintaining competency in gender-specific women's primary care at all facilities and CBOCs is a complex issue. Clinician interest, experience, proficiency, and knowledge vary across the system and the number of treated women veterans within a panel or site is inconsistent. Specific guidelines need to be developed regarding:

- The number of women within a panel of patients that are sufficient to maintain competency;
- How to educate, train, and maintain provider competency, proficiency, and expertise;
- How to recruit and retain providers, especially those who have trained at VA and have been sensitized to the veterans' military experience; and
- Panel size adjustments and appropriate staff support.

Systems and support elements necessary for comprehensive primary care include space availability and configuration to meet privacy considerations; integrated mental health services, including MST team support; social work services; gynecology and related services such as colposcopy; accessible emergency care; and thorough and accurate mammography tracking. Staffing adequate to provide gender-appropriate chaperones as well as clinical support with availability of same-gender providers on request is essential. Equipment such as privacy curtains, exam tables with stirrups and lights, adjacent bathrooms where pelvic exams are conducted, speculums, supplies, and equipment to perform Pap smears and pregnancy testing should be on hand in the clinic area.

The physical plant at VA facilities, primary care clinics, and CBOCs has played a major role in the way gender-specific care has been provided in the past and may have a significant impact upon implementation plans. Recognizing and addressing the costs necessary to deal with physical plant deficiencies, supply and equipment needs, point-of-care testing changes, and contractual requirements will be important in advancing the current state of women's health care within VA.

While the provision of comprehensive primary care to women veterans at every facility is the foundation of women health care delivery, the USH Workgroup recognizes the importance of a close connection between primary care services and specialty services. Appropriate referral to necessary specialists is needed to assure complete care of women veterans. Individual facilities and VISNs will need to examine their own population of

women and determine the best structure to foster these close relationships in order to provide high-quality, timely, and well-coordinated specialty care.

COMPREHENSIVE WOMEN'S PRIMARY CARE AT FACILITIES AFFILIATED WITH HEALTH PROFESSIONAL SCHOOLS

Systems of care have an inextricable relationship to the learning environment and educational experiences. Because health professional education is a central mission of VA, educational needs must be factored into plans for changes in the delivery of care for women veterans. The USH Workgroup emphasizes that the impact of delivery model changes on VA's training programs must be considered carefully in the design and implementation of such programs.

Still, the USH Workgroup believes that improving primary care delivery standards for women veterans presents an important opportunity for enhancing the education of future health professionals. Implementing comprehensive primary care for women veterans requires interested, engaged, and proficient primary care providers and inter-professional delivery models. Work already has begun to enhance VA primary care providers' knowledge of women's health issues, their clinical skills in dealing with women patients, and continuity- and team-based models of care delivery. Collectively, these changes will create a learning environment ideal for training students in primary and systems-based care. The USH Workgroup encourages facility leadership to explore such new training opportunities with their academic affiliates.

Joint planning will be necessary to avoid any unintended consequences of this initiative. The USH Workgroup recommends that appropriate faculty leaders in the academic community be involved early in planning optimal practice configurations for delivering coordinated, comprehensive primary care to women. Working together will ensure both enhanced care for our women veterans and enhanced education for our health professional trainees.

THE BUSINESS CASE FOR INVESTING IN COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS

Research has shown that within the United States, adults with a primary care physician rather than a specialist have 33 percent lower costs of care and are 19 percent less likely to die, after adjusting for demographic and health characteristics.[68] Primary care physician supply is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care.

By consolidating all primary care services into one visit with one provider in one setting, VA can decrease the costs for a second visit with a specialty provider (such as a women's health nurse practitioner) for routine gender-specific primary care. VHA sites with a "multi-visit, multi-provider" model have incurred significant costs for supporting both

68 Starfield B, Shi L, Grover A, Macinko J. The Effects of Specialist Supply on Populations' Health: Assessing The Evidence. Health Affairs Web Journal, Project Hope, 2005.

primary care visits and women's gender-specific visits. The additional costs are even greater when a gynecologist is utilized for provision of such services as cervical cancer screening and management of birth control. Utilization of fee-basis arrangements increases costs by additional factors of administrative overlays. Currently, women veteran users are three times as likely as their male counterparts to use fee-basis care.[69]

Expecting primary care providers to take on the full range of primary care for women will require some adjustments in appointment times and panel size for those providers. Even after these adjustments, cost savings will be realized by moving to a comprehensive model of care.

Costs associated with missed appointments also should be taken into account. While no-show rates for general primary care have a target of 13 percent, the no-show rates for women's gender-specific prevention clinics have ranged from 14 percent to well over 28 percent at most facilities.[70] Factors related to no-show rates for women's clinics differ from those for men, e.g., not missing work and childcare and eldercare responsibilities. The USH Workgroup concludes that examination of business factors will support the comprehensive "one-visit, one-provider" primary care model for women veterans.

69 Frayne SM, Yu W, Yano EM, Ananth L, Iqbal S, Thrailkill A, Phibbs CS. Gender and use of care: planning for tomorrow's Veterans Health Administration. J Womens Health. 2007 Oct;16(8):1188-99.

70 FY2007 ECF Performance Report, Office of Quality and Performance.

BUILDING BLOCKS OF COMPREHENSIVE WOMEN'S HEALTH

The USH Workgroup endorses the work that has begun in order to meet the Under Secretary for Health's charge that every woman veteran have access to a VA primary care provider who can meet all her primary care needs, including gender-specific care, in the context of an ongoing patient-clinician relationship. This work includes:

- Developing an implementation planning tool
- Creating a full-time WVPM position at every facility
- Offering mini-residency programs in Women's Health
- Defining a women's health research agenda

WOMEN'S COMPREHENSIVE HEALTH IMPLEMENTATION PLANNING TOOL

To aid the implementation of comprehensive primary health care for women veterans at every VA facility, the Women Veterans Health Strategic Health Care Group (WVHSHG) has developed a Women's Comprehensive Health Implementation Planning (WCHIP) tool. By using the planning template, individual facilities, and in turn each VISN, will be able to assess and make decisions about which services need to be developed, in what sequence, and what resources will be required to make it possible. The WCHIP tool outlines a care gap analysis, a market analysis, and a needs assessment. The tool includes supplemental guidance regarding the provision of women's health to support full consideration of the range of possibilities. Once a baseline analysis is complete, this information can be used for the development of goals, timelines, budgets, training needs, and more. The complete WCHIP tool is given in Appendix C.

The WCHIP complements the new VHA Health Care Planning Model's 10-step approach for identifying the comprehensive health care needs of veterans in VISN markets in order to conduct strategic planning. The Health Care Planning Model provides a standard study methodology to proactively evaluate strategic health care planning issues. It allows for the consideration of local market issues, such as compliance with access guidelines in planning solutions. The WVPMs will work directly with the strategic planners at their facility to incorporate the results of the WCHIP into the Health Care Planning Model.

WOMEN VETERANS PROGRAM MANAGERS

In order to assure improved advocacy for our women veterans at the facility and VISN level, the WVPM position was made full time (Appendix D gives the Memorandum to the field indicating the change). This role also will allow for increased outreach to women veterans, improvement in quality of care provision, and the development of best practices in organizational delivery of women's health care.

New mini-residency program in clinical skills for women's health care

Participants report significantly improved skills and knowledge in women's health care after training in a new mini-residency designed to retrain or refresh VA providers interested in gaining proficiency in women's health care.

Program highlights:

- **Three residencies completed: Madison, WI; Palo Alto, CA; and Baltimore, MD**
- **Series of two-and-a-half-day programs planned across the continental U.S.**
- **Skills-based curriculum guided by 2007 EES needs assessment for women's health training**
- **Presented by women's health experts to field-based providers**
- **Includes quality improvement, organizational change, and development of action plans to improve women veterans health care at local facilities**
- **Long-term training infrastructure under development to meet ongoing increased need for women veterans health care.**

PRIMARY CARE PROVIDERS AND STAFF EDUCATION

Many VA primary care sites have dedicated staff whose clinical skills in women's health require updating. Proficiency in women's heath for all providers is necessary to meet the needs of increasing numbers of women veterans. Many sites, particularly those in rural areas, will need additional providers with proficiency in women's health care. Rather than devoting resources to hiring new staff, interested providers are being retrained as a cost-efficient means for delivering appropriate care to the women veteran population.

Mini-Residency Program in Clinical Skills for Women's Health Care. Through collaboration between EES, PCS, and the WVHSHG, mini-residencies, focused on basic skills development in women's health, are being offered in geographically dispersed locations across the VA. The curriculum is guided by an EES-developed needs assessment for women's health training completed by primary care providers in 2007.

The two-and-a-half-day program utilizes a skills-based curriculum presented by women's health experts to field-based providers in local settings. Lectures are interspersed with small group discussions of case studies covering contraception, Pap smears, STDs, abnormal uterine bleeding, chronic pelvic pain, breast masses, and post-deployment issues specific to women veterans. The program also includes hands-on training for breast and pelvic exams with live models. In addition to clinical skills, mini-residency participants receive training in quality improvement and organizational change. Each participant is asked to develop an institution-specific action plan to improve care for women veterans.

All mini-residency participants complete a baseline evaluation of their knowledge, skills, and comfort level in the area of women's health care and organizational improvement. They also complete a similar evaluation at the end of the mini-residency and again in six months, at which time they report on the progress on their action plans. These data allow assessment of the mini-residency structure and content.

Participants return to their home institutions to train colleagues and serve as local resources for women's health care. The mini-residency training slides, pre- and post-training evaluations, and facilitator copies of the case studies are made available on a web site. The need for updated training in women's health will extend beyond these initial

Initial evaluations show significant improvements in skills and knowledge levels

Preliminary results comparing pre- and post-training knowledge scores from the first three mini-residencies (Madison, WI; Palo Alto, CA; and Baltimore, MD) are impressive. After training, participants felt significantly more comfortable in the following categories:

- **Initiating oral contraception (p<.0.001)**
- **Triaging an atypical Pap smear (p<0.001)**
- **Managing abnormal uterine bleeding (p<0.001)**
- **Initiating a workup for chronic pelvic pain (p<0.001)**
- **Performing a pelvic exam (p<0.001)**
- **Identifying post-deployment readjustment issues specific to women veterans (p<0.001)**
- **Teaching other colleagues about women's health topics (p<0.001).**

mini-residency offerings; thus, this program is developing the infrastructure to provide long-term training.

Given the VA interest in linking educational endeavors to patient outcomes, the logical next step would be to assess patient outcomes in participating institutions.

WOMEN VETERANS: A RESEARCH PRIORITY AT VA

The VA clearly has established women's health as a research priority. This focus has intensified in the last decade with VA's Office of Research and Development (ORD) leadership supporting a comprehensive women's health research agenda.

In 2004, in recognition of the changing demographics and special health care needs of women veterans, VA's ORD directed development of the first comprehensive VA women's health research agenda spanning biomedical, clinical, rehabilitation, and health services research. The goal was to position VA as a national leader in women's health research with a focus on mapping research priorities to the needs of women veterans and capitalizing on VA's substantial and productive research enterprise. As part of the agenda-setting process, the evidence base on the health and health care needs of women veterans was developed and included a systematic literature review on health care research related to women veterans and women in the military. Recommendations also were made regarding VA research priorities as well as building infrastructure to foster future VA women's health research.

Currently, ORD supports a broad research portfolio focused on women's health issues, including studies on diseases prevalent solely or predominantly in women, e.g., certain types of cancer, including breast, cervical, and ovarian, lupus, human papillomavirus (HPV), and hormonal effects on diseases in post-menopausal women; research focusing on women subjects, e.g., PTSD in women, osteoporosis in women, and multiple sclerosis in women; and research on the health needs and health care of women veterans.

VA's Health Services Research and Development (HSR&D) in ORD is at the forefront of directing research focused on understanding and improving the health and health care of women veterans. Reflecting the diversity and breadth of VA research related to women veterans, HSR&D is currently funding 27 research projects examining the health and health care of women veterans:

- Six address the health consequences of sexual assault, MST, and other military traumas on women veterans in different cohorts, including OEF/OIF populations.
- Five focus on PTSD, including in OEF/OIF populations.

- Six studies assess screening, health care needs and utilization, and other post-deployment access and reintegration issues of OEF/OIF veterans.
- Eight studies examine access, health care needs, health care utilization, outcomes and quality of care for women veterans related to ambulatory care, chronic mental and physical illness, alcohol misuse, breast cancer, and pregnancy outcomes.
- A second phase study is continuing to examine VA's approaches for delivering care to women veterans as well as the relationship of practice structure and quality of care, while another is assessing the implementation and sustainability of VA women's mental health clinics.

VA Research Focuses on Women Veterans Health Care

For the last several years, VA research has been informing all elements of women veterans' health and health care, as well as VA policy and programs, to serve the needs of women veterans and improve their health and health care.

Current research should further elucidate the health needs and health care of women veterans, particularly for the newest veterans of the OEF/OIF conflict, and provide evidence on access, continuity, and quality of care of VA health care services for women veterans as well as determination of whether VA treatment approaches and service delivery should be tailored differently for female veterans. VA research has a key role in documenting the health care needs and utilization of women veterans, as well as access and quality of care. VA research will continue to be critical in developing the evidence base regarding the performance of the VA health care system serving women veterans and will be instrumental in assessing the impacts of organizational and other system changes on improving the health and health care of women veterans.

HOW VA WILL DELIVER COMPREHENSIVE PRIMARY CARE TO WOMEN VETERANS

As this USH Workgroup report elucidates, veteran demographics are changing, many existing clinic structures limit continuity of care, and there are not enough trained women's health providers to provide the necessary care. Despite higher performance on quality measures in the VA in comparison to the private sector, results indicate that there exists consistent gender disparity in quality measures. It is time for a strategic shift in which women's health primary care can be designed to deliver highest-quality yet cost-effective and comprehensive care to the emerging population of women veterans.

RECOMMENDATIONS, RATIONALE, AND ACTIONS

Recommendation 1

Deliver coordinated, comprehensive primary women's health care at every VA facility. Recognizing models of best practice, develop systems and structures for care delivery that ensure that every woman has access to a VA primary care provider who can meet all her primary care needs, including gender-specific, acute and chronic illness, preventive, and mental health care.

Rationale

The recent influx in the number of women veterans, coupled with the ongoing issues of fragmentation of care delivery and disparities in clinical quality performance issues underscore the requirement for implementation of enhanced primary care for women veterans. Primary care, which includes gender-specific care, is delineated by policy in VHA Handbook 1330.1 and Standards of Primary Care Directive 2006-031. Research evidence, clinical data, and the adoption of models of patient-centered care support the advance of comprehensive women's primary care delivery.

Actions

1.1 Assess current status of care delivery and resources at each facility. Use the WCHIP tool to identify steps needed to achieve coordinated, comprehensive primary care for women, including gender-specific health care by the same provider. Implement the optimal practice configuration for delivering coordinated, comprehensive primary care fitted to a facility's particular configuration and women veteran population.

1.2 As indicated by each facility's WCHIP resource assessment, provide recurring funds to build adequate infrastructure and program capacity (facilities, equipment, and staff).

1.3 To increase relative utilization for women, provide resources and staff time to conduct outreach/education to women veterans.

1.4 Collect data and analyze and report regularly on issues of access, panel size, clinic staffing flexibility, and cost and on the implementation of women's comprehensive health care to the National Leadership Board, the VISN CMOs, the Health Systems Committee, and to the USH annually.

1.5 Ensure academic leaders at affiliated facilities are involved early in planning optimal

practice configuration for delivering coordinated, comprehensive primary care in order to successfully fulfill the VA's educational mission for health professional trainees.

Recommendation 2

Ensure integration of women's mental health care as part of primary care, including co-locating mental health providers.

Rationale

Women veterans who utilize VA clinical services carry a heavy burden of mental illness diagnoses. Depression was the most frequent medical diagnosis for women presenting for care in FY2007, three times more frequent than hypertension. PTSD was the fourth most frequent diagnosis above both diabetes and hypertension. In addition, women veterans, at an average age of 48 years, have complex lives as employees and caregivers of children and elderly parents. Adoption of provision of care in a combined mental health and primary care setting will enable this population to overcome barriers to access mental health care.

Actions

2.1 Assign mental health providers who can provide assessment and psychosocial treatment as needed for a variety of mental health problems, including depression and problem drinking per VHA Handbook 1160.1, to participate in women's health delivery.

2.2 Facilitate collaboration by behavioral health with primary care to provide ancillary services, including pain management, weight management, and smoking cessation programs designed to meet the needs of women veterans.

Recommendation 3

Promote and incentivize innovation in care delivery by supporting local best practices fitted to the particular configuration and women veteran population.

Rationale

VA facilities are best positioned to develop innovative programs to meet the needs of women veterans, especially sub-populations of minority and rural women. Because women veterans have unique needs, best practices can address variations across geographic areas and demographic cohorts. In an atmosphere of competing priorities, awarding clinical grants and finding ways to reward developmental projects will enhance success. With the proliferation of new information technology and the increasing population of younger veterans adept in its use, VA needs to be on the cutting edge of technologically enhanced delivery of health care.

Actions

3.1 Share best practice models and accomplishments in comprehensive women's health care through an improved web portal, interdepartmental and interagency conferences, and other methods of information transfer and collaboration.

3.2 Develop and issue ongoing Requests for Proposals for innovative pilot efforts using

new technology and/or novel delivery models in the provision of health care to women.

3.3 Explore, with the Office of Care Coordination and the Office of Information, new ventures in telehealth inclusive of women veterans.

3.4 Recognize and promote local achievements in creating environments of care that support privacy, safety, and comfort for women veterans.

> To care for him who shall have borne the battle, and for his widow, and his orphan.
>
> *~ Abraham Lincoln*

Recommendation 4

Cultivate and enhance capabilities of all VA staff—medical providers, clinical support, non-clinical, and administrative—to meet the comprehensive health care needs of women veterans.

Rationale

Many VA employees have long been conditioned through their experience to think of veterans as the "men who served." Women veterans have been and continue to be relatively invisible despite their increasing numbers. The core principles of patient-centered care—comprehensive provision of seamless, high-quality, safe, coordinated care across the health care continuum and a whole-person orientation—are key to redesigning care for women veterans as well. Many VA providers may have acquired skills during internships or residency but have lost proficiency in the intervening years. A coordinated training and cultural sensitivity program will be essential to creating an atmosphere of equity and welcome for women veterans.

Actions

4.1 Aggressively recruit and train practitioners to be proficient, knowledgeable, engaged providers of women's health.

- Fund additional and ongoing mini-residency programs in Women's Primary Care for current VA providers. This will require recurring budget for training and travel support.
- Develop recruitment and retention strategies to increase numbers of trained women's health providers.
- Improve career path for primary care practitioners and other women's health providers by developing and promoting VA primary care.

4.2 Train and sensitize all VA staff on issues specific to women's health care.

Recommendation 5

Achieve gender equity in provision of clinical care.

Rationale

Historic, long-standing clinical quality performance disparities exist in provision of care to men and women. A goal of VA is to provide the highest quality care—"the best care anywhere"—as well as to be a national model for women's health care. Highest quality ensures gender parity in the delivery of health care.

Actions

5.1 Work with Associate Deputy Under Secretary for Health for Quality and Safety (10G) to assure continual measurement of women veterans' health outcomes for both gender-specific and gender-neutral parameters. In collaboration with the Deputy Under Secretary for Health for Operations and Management, VISN CMOs, and the Office of PCS, this work must address the systemic reasons for the identified disparities in quality in order to effect change in clinical practice.

5.2 Work with ORD to foster continued research that addresses best practice models for delivery of care to women veterans. Collaborate closely with ORD to better understand the health concerns of post-deployed women veterans in terms of reproductive health, urinary tract infections, STDs, contraceptive use, sexual violence, injuries, exposures, prosthetics needs, etc.

5.3 Develop and implement a validated tool for assessment of sexual activity, sexual risk behaviors, and anticipation of pregnancy as a routine part of all clinical encounters.

THE PATH FORWARD

As we look to the future, there are many exciting opportunities to meet the evolving needs of women veterans. VHA must continue to leverage technology to serve the needs of the emerging population of women veterans. Recognizing that more women utilizing VA services will be of child-bearing age, VA will focus on implementation of electronic oversight of administration of teratogenic medications and utilization of emerging technology to deliver care remotely through "e-clinics." This will minimize travel and number of visits for a population that is often caring for children. VA also must utilize the latest advances in medical science and technology to address the often overlooked burden of cardiovascular disease among women veterans.

> **"We are reinventing ourselves by expanding our women-centric focus to initiate new programs that meet the needs of women veterans."**
>
> ***~ James B. Peake, MD***
> ***Secretary, Department of Veterans Affairs,***
> ***Women Veterans Summit, July, 2008***

Internal and inter-agency collaboration also will be a central component of the path forward. A strong partnership between the Deputy Under Secretary for Health for Operations and Management, VISN and Facility Leadership, VA Office of Patient Care Services, Office of Nursing Services, Office of Academic Affiliation, Office of Quality and Safety, Health and Human Services, and the Women Veterans Health Strategic Health Care Group will ensure comprehensive primary care for all women veterans in every VA facility.

VA also must continue to support research efforts that address the changing needs of women veterans. Ongoing research should provide evidence on access, continuity, and quality of care of VA health care services for women veterans as well as evidence to inform on how VA treatment approaches and service delivery should be tailored differently for female veterans.

Although this report focuses on VA facilities, an obvious next step is extension to the CBOCs. In order to reach all corners of the country and truly provide a portal for women veterans no matter where they reside and get their care, VA also must address how to bring comprehensive care to CBOCs and to more rural areas. There are opportunities for education and care delivery to women through telehealth.

While there are new challenges to face in providing care to women veterans, VHA is positioned to be a national leader in the delivery of care to women, drawing upon evidence from VA research, patient-centered principles, and best practices. Imagine a VA where a woman can walk into any VA facility and find a portal where she can get all her health needs met in a coordinated, comprehensive, safe, and timely manner. Ultimately this goal can be met by renewed efforts to strategically meet the needs of this emerging population of young, involved veterans and their aging counterparts—all women who served their country. VA will continue to provide "The Best Care Anywhere" to all veterans.

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

In Reply Refer To: 13E

Date: 03/10/08

From: Under Secretary for Health

Subject: Proposal Women Veterans Health Care Delivery Responsibilities

To: Chief Consultant, Women Veterans Health SHG (13E)

Thru: Public Health and Environmental Hazards Officer (13)

With women comprising 16% of active duty service members, with full integration in all branches including combat units, women are changing the face not only of our military, but of our veteran population as well. Women make up a larger share of the veteran population, add to its diversity, and require veteran services geared to their specific needs. Unfortunately, we have not kept up with development of the best services for our women veterans at each VHA facility. The debt owed to all our veterans and to women veterans in particular demands nothing less than our full attention and action.

VHA Vision and Goals:

- Provide highest quality primary care to every women veteran
- Each woman veteran presenting at VA will be assured that her gender-specific primary care needs will be met by a proficient and interested primary care provider
- Highest quality includes privacy, dignity, and sensitivity to gender-specific needs
- Highest quality ensures that health care equipment and technology is state-of-the-art
- Highest quality ensures gender parity in performance measures
- Highest quality is providing the right care in the right place and time

Despite the fact that specific provision of care to women has been authorized by legislation since 1992, and that VHA policy has defined minimum women's health care primary care delivery in Handbook 1330.1, many facilities offer fragmented primary care for women veterans, and some facilities remain non-compliant with policy for on-site women's health care delivery to women veterans.

Page 2

Proposal Women Veterans Health Care Delivery Responsibilities

Charge:
This workgroup will define actions necessary to ensure that every women veteran has access to a VA Primary care provider who can meet all her primary care needs, including gender-specific care, in the context of an ongoing patient-clinician relationship. The workgroup will review the current organization and structure of VHA's women's health care delivery, current and expected future needs, and propose recommendations to me on the most appropriate organizational initiatives.

Please convene this workgroup to advise you, including both VHA staff with leadership responsibilities in these areas as well as experts external to VHA who have knowledge and experience which may inform you on how best to serve the health care needs of women veterans who use our health care system. Please provide a status report on your progress by May 15, 2008 and your final recommendations to me no later than July 15, 2008.

Michael J. Kussman, MD, MS, MACP

Department of Veterans Affairs

Memorandum

Date: July 17, 2008

From: Chief Consultant, Women Veterans Health Strategic Health Care Group (WVHSHG)

Subj: Interim Report: USH Workgroup and Provision of Primary Care to Women Veterans

To: Under Secretary for Health (10)
Thru: Principal Deputy USH (10A)
Thru: Chief Officer, OPHEH (13)

1. This memo is to provide you with an interim report on the progress of the USH Workgroup on Provision of Primary Care to Women Veterans and on the provision of primary care within VA to women veterans. The USH Workgroup has met regularly and
   a. Reviewed women veterans enrollee and utilization data from ADUSH for Policy and Planning;
   b. Collected and reviewed data on delivery of care by women's health practice model, and reviewed research on VHA provision of primary care to women veterans;
   c. Examined clinical quality issues in provision of care to women veterans
   d. Arrived at a consensus decision on the definition of primary care for women veterans, including the minimum aspects of care necessary as women's health care delivery model for each site; and
   e. Defined component building blocks necessary to organize comprehensive women's health care at the facility level.

2. The WVHSHG held a face-to face meeting of VISN Lead Women Veteran Program Managers to update on changes in delivery of care to women, define needs at the VISN level, and initiate implementation plan process. The WVHSHG also initiated evaluation and implementation plans at the VISN and facility levels, including assessment of the numbers of women served, current numbers of women's health providers and time allotted to the Women Veteran Program Manager position.

3. In conjunction with EES, the WVHSHG held the first Women Veterans Health Primary Care Mini-Residency at Madison, Wisconsin, June 24-26, during which 40 providers received training in clinical updates in women's health, including pelvic exams and cervical cancer screening, contraception management, abdominal pain, menstrual issues, and post-deployment care of women veterans. The participants developed action plans for their VISN as part of the curriculum. Two additional sessions will be conducted this fiscal year, including Palo Alto in August, and Baltimore in September. A total of 120 providers will complete the Women Veterans Health Primary Care Mini-Residency by EOY FY 2008. Arrangements are ongoing for next year as well, with a goal of six more sessions delivered in FY 2009.

VA FORM MAR 1989 2105

4. The WVHSHG will host a face-to-face business meeting for all 143 facility Women Veteran Program Managers on July 29, 2008. The purpose of the meeting is to orient to programmatic expansions and refine implementation action plans at the facility level.

5. Meetings were held with Mr. Feeley, 10N to address the leadership role in development of primary care women's health at every facility. A memorandum from 10N for full-time Women Veteran Program Managers was distributed July 8, 2008 with a deadline for implementation of these full-time positions by December 1, 2008. Metric -based quarterly reports on implementation status will be required. Appointments for these positions will be reported to 10N and to Women Veteran Health SHG (13E).

6. The USH charge to the Workgroup included final recommendations on how best to serve the health care needs of women veterans, with a delivery date of July 15, 2008. While many aspects of the provision of care to women veterans have been initiated, the complexities of this work have delayed the formation of final recommendations. Each VISN and Facility is currently working on an assessment, and developing plans to establish women's health services where gaps exist. A full report on Recommendations and Implementation Plan will be delivered by October 31, 2008.

We are positioning ourselves to organizationally support the dynamic shifts underway in women veterans health care delivery. We appreciate your demonstrated support in championing these efforts.

Patty Hayes, Ph.D.

Department of Veterans Affairs

Memorandum

Date:

From: Chief Consultant Women Veterans Health Strategic Health Care Group (13E)

Subj: Final Report - USH Workgroup on Provision of Primary Care to Women

To: Under Secretary for Health (10)
Thru: Principal Deputy Under Secretary for Health (10A)
Thru: Chief Public Health and Environmental Hazards Officer (13)

1. I am pleased to provide you with the Final Report from the Under Secretary for Health Workgroup on Provision of Primary Care to Women Veterans. The workgroup members, comprised of a cross-section of VHA's key stakeholders responsible for the delivery of quality care to women veterans, developed a strategic roadmap for delivering comprehensive primary care. The group addressed the current impediments to delivering women's health care; identified the positive systemic impacts of providing coordinated patient-centered comprehensive care for this fastest growing cohort of veterans; and outlined a set of supporting recommendations and actions with assigned owners (Attachment).

2. The USH Workgroup strongly endorses the use of a *consensus definition of comprehensive primary care*, which is a key element of this report. This consensus definition provides a clear explanation of what constitutes comprehensive primary care, without proscribing a structured approach to its delivery. The definition ties the recommendations together and sets a universal direction for the provision of comprehensive primary care to women across VA.

3. I am grateful to have been afforded the opportunity to lead this workgroup knowing that its full impact can greatly improve the health care delivery for our women veterans, a group who so deserve to be equitably served. Thank you for your unwavering commitment to our nation's veterans.

Patricia M. Hayes, Ph.D.

I approve / do not approve the *consensus definition of comprehensive primary care* and the five supporting recommendations and actions in the Attachment.

Michael J. Kussman 11/25/08

Michael J. Kussman, MD, MS, MACP Date

VA FORM MAR 1989 2105

APPENDIX B

VISN	Model For Delivery of Clinical Service to Women Veterans 2007				
	Separate women's health center providing comprehensive, multi-disciplinary care that includes primary care, gender-specific care, mental health services and surgical services within dedicated space.	Separate women's health center providing primary care and gender-specific care within designated space.	Separate gender-specific and/or gynecology clinic, primary care provided in a designated women's primary care team within the facility.	Separate gender-specific and/or gynecology clinic, primary care provided in mixed gender PC teams within the facility.	Integrated, gender-specific and/or gynecology services and primary care provided by primary care providers within the facility.
	Location (Code)				
1	Togus (402) VA Boston HCS (523) West Haven (689)		Bedford (518) Providence (650)	Northampton (631) White River Junction (405) Manchester (608)	
2		Syracuse (528A7)		Albany (528A8) Buffalo (528)	Bath (528A6) Canandaigua (528A5) Has 2 Primary Care Providers who provide PC and gender care to women—755 unique women
3	Brooklyn (630A4)	Northport (632)	VA New Jersey HCS (561)	Bronx (526) Manhattan (630) Castle Point (620A4) Montrose (620)	
4	Philadelphia (642)	Altoona (503) Coatesville (542)	Pittsburgh (646) Wilkes-Barre (693)	Wilmington (460) Clarksburg (540) Lebanon (595)	Erie (562) Hired 7 mid-levels to achieve integration into Primary Care. 699 unique women Butler (529) Uses Fee Basis for all gender care. 484 unique women
5				Baltimore (512) Washington, DC (688) Martinsburg (613) Perry Point (512A5)	
6	Durham (558)	Asheville (637) Fayetteville (565)		Richmond (652) Hampton (590) Beckley (517) Salisbury (659) Salem (658)	
7		Atlanta (508) Dublin (557)	Tuscaloosa (679) Charleston (534)	Columbia (544) Birmingham (521) Augusta (509) Montgomery (619) Tuskegee (619A4)	

VISN	Model For Delivery of Clinical Service to Women Veterans 2007 (*continued*)				
	Separate women's health center providing comprehensive, multi-disciplinary care that includes primary care, gender-specific care, mental health services and surgical services within dedicated space.	Separate women's health center providing primary care and gender-specific care within designated space.	Separate gender-specific and/or gynecology clinic, primary care provided in a designated women's primary care team within the facility.	Separate gender-specific and/or gynecology clinic, primary care provided in mixed gender PC teams within the facility.	Integrated, gender-specific and/or gynecology services and primary care provided by primary care providers within the facility.
	Location (Code)				
8	Tampa (673) Bay Pines (516)	Orlando (675) W. Palm Beach (548) Gainesville (573)		San Juan (672) Miami (546)	
9	Memphis (614)	Mountain Home (621)	Lexington (596)	Murfreesboro (626A4) Louisville (603) Huntington (581)	Nashville (626) Gender-specific care is provided by the PC providers. 4257 unique women
10			Cincinnati (539)	Columbus (757) Cleveland (541) Chillicothe (538) Dayton (552)	
11		Detroit (553)		VA Ann Arbor HCS (605) Saginaw (655) Indianapolis (583) Battle Creek (515) VA Illiana HCS (550) Northern Indiana (Ft. Wayne) (610A4) Northern Indiana (Marion) (610)	
12	Chicago (Jesse Brown) (537) Madison (607)	North Chicago (556)	Milwaukee (695) Chicago (Hines) (578)	Tomah (676) Iron Mountain (585)	
15		Kansas City (589) St. Louis (657)		Marion (657A5) Wichita (589A7) Poplar Bluff (657A4) Topeka (589A5) Leavenworth (589A6)	Columbia (Truman) (589A4) one NP has full panel of women + provides gender care for a few women belonging to other providers. 1277 unique women
16	Little Rock (598)	Houston (580) Oklahoma City (635) Biloxi (520) Alexandria (50)2	Muskogee (623)	Fayetteville (564) Shreveport (667)	New Orleans (629) gender-specific care is provided in each of the 5 clinics that currently comprise New Orleans. 1735 unique women Jackson (586) gender-specific care is provided by Primary Care providers. 2055 unique women

VISN	Model For Delivery of Clinical Service to Women Veterans 2007 (*continued*)				
	Separate women's health center providing comprehensive, multi-disciplinary care that includes primary care, gender-specific care, mental health services and surgical services within dedicated space.	Separate women's health center providing primary care and gender-specific care within designated space.	Separate gender-specific and/or gynecology clinic, primary care provided in a designated women's primary care team within the facility.	Separate gender-specific and/or gynecology clinic, primary care provided in mixed gender PC teams within the facility.	Integrated, gender-specific and/or gynecology services and primary care provided by primary care providers within the facility.
	Location (Code)				
17		Temple (674) Kerrville (671A4) Dallas (549)		San Antonio (671) Bonham (549A4)	
18		Tucson (678) Amarillo (504) El Paso (756)		Phoenix (644) Albuquerque (501) Prescott (649) Big Spring (519)	
19	Salt Lake City (660)	Cheyenne (442)		Denver (554) Ft. Harrison (436) Sheridan (666)	Grand Junction (575) NP has majority of women on her panel and provides gender care + few referrals from other providers. 575 unique women
20	Puget Sound (Seattle) (663)	White City (692)	Puget Sound (American Lake) (663)	Walla Walla (687) Roseburg (653) Anchorage (463) Boise (531) Portland (648)	Spokane (668) 4 NPs provide all PC and gender care + rare referral. 1313 unique women
21	San Francisco (662)	Palo Alto (640)	Fresno (570)	Martinez (612) Honolulu (459) Reno (654)	
22	GLA (West Los Angeles) (691) GLA (Sepulveda) (691A4)	Las Vegas (593) Long Beach (600)		San Diego (664) Loma Linda (605)	
23	Minneapolis (618) Iowa City (638A8)		CIH (Des Moines) (636A6)	NWIHCS (Omaha) (636) Fargo (437) Sioux Falls (438) St. Cloud (656) NWIHCS (Grand Island) (636A4) CIH (Knoxville) (636A7)	Black Hills HCS (Ft. Meade) (568) Black Hills HCS (Hot Springs) (568A4) 1 NP @ each site provides care to most women + few referrals from other providers. 932 unique women
Total					
153	19 (12.4%)	31 (20.3%)	15 (9.8%)	76 (49.7%)	12 (7.8%)

APPENDIX C

W-CHIP (Women's Comprehensive Health Care Implementation Plan) Planning Tool for the Development of Comprehensive Primary Care Services for Women Veterans

The goal of the Department of Veterans Affairs is to offer Comprehensive Primary Care for Women Veterans at every VA facility. Comprehensive primary care for women veterans is defined as the availability of complete primary care from one primary care provider. The primary care provider must, in the context of a longitudinal relationship, fulfill all primary care needs, including acute and chronic illness, gender-specific, preventive, and mental health care. Please see Appendix A for the complete definition of comprehensive primary care for women veterans.

By using this W-CHIP planning tool, individual facilities (CBOCs and Medical Centers) and in turn each VISN, will be able to assess their care gaps, understand their needs for planning, developing and implementing necessary services and the timeline and resources required to achieve the goal of providing comprehensive primary care for all women seen in VA.

Consider the following for planning efforts:

1. **What will be your general approach to planning for Comprehensive Primary Care for Women Veterans?** Whose help do you need during the planning process? How will you collaborate with primary care? Will you utilize a local women's health advisory group, a Women's Health champion and/or WH team to guide the planning process? Can your site benefit from a VHA consultant team visit? Will you build a bottom-up coalition, a top-down coalition, or other model?

2. **How will you brief the leadership on your plans? What products do you need to brief your leadership?** (e.g., define a set of goals, develop an outline of your plan, develop a Power Point presentation for the leadership.)

3. **Assessing the Need**

3a. Market Analysis by Facility and by CBOC. Refer to your "2008 Plan-Of-Care Survey" results (vaww.va.gov/wvhp/apps/survey) for your market penetration and other supporting data. Use and update your "Snapshot Spreadsheet" that you provided to WVHSHG for some of this information. Additional data-specific questions to consider can include VISN and facility data based on enrollees, new and existing patients, and other related data that will come from the VSSC Women's Health Briefing Book.

3b. Other local assessments can be done by looking at the number of women veterans by:

Different Service Connection status
Different Eligibility categories
Physical disabilities, e.g., SCI, Blinded Veterans, MS

Ethnicity
OEF/OIF Status

3c. Care Gap Analysis

The Care Gap Analysis is a tool intended to help you assess your current model for delivering primary care—the staff assigned and the resources allocated —to deliver primary care to women veterans. A completed Care Gap Analysis should help identify those areas within your organization that need to be established, changed or improved in order to provide comprehensive primary health care for female veterans.

The Care Gap Analysis is your opportunity to identify your organization's needs and to support a request for resources. Use the embedded "Supplemental Questions" as a guide to help you complete the Current Primary Care Delivery Model Analysis and the Care Gap Analysis Chart below. Your Plan of Care Survey Data for 2008 will also be helpful in answering the supplemental questions and in completing the Care Gap Analysis.

Definitions:

Comprehensive Primary Care for Women Veterans or a "One-Provider Model" refers to the provision of both general primary care (urgent care, chronic disease management, preventive care, etc.) and gender-specific care (PAP, breast exam, contraception counseling, menopause treatment, etc.) by one provider in one visit.

A Split Model for delivery of Primary Care or a "Two-Provider Model" refers to general primary care delivered at one visit by one primary care provider and gender-specific care delivered by a different provider at a second visit. This would include referring to gynecology or the PAP/prevention clinic for any routine care needs of a woman veteran. This type of model will no longer meet the minimum standards for the delivery of comprehensive primary care to women veterans.

Designated Women's Health Primary Care Provider refers to a primary care provider who is interested and proficient in women's health. A designated Women's Health Provider is preferentially assigned women veterans within their primary care patient panels.

Current Model of Primary Care Delivery Analysis Chart

	Comprehensive	Split Model	Other (Please Define)	Not available
# pts seen in each type of delivery model				
# of Primary Care Providers (by FTEs) offering each model of care (if offering split visits, please list separately the total FTE of those in general primary care providing split-care and those in the PAP clinic, women center, gyn clinic, doing only pap/ breast care)				
For each model, what is the average wait time for a new primary care appointment?				

For each model, how many panel openings on average does each provider have?				
Do you have Designated Women's Health Primary Care Providers? If so, how many are there and in what models do they deliver care?				
If your site has a Women's Health Center: # of pts seen in each model (Note: if a female pt is seen in the women's center for PAP/ prevention clinic only, that is a split visit)				
If your site has a Women's Health Center: Is the space shared or exclusive? If exclusive, does it have its own entrance and waiting room?				

Care Gap Analysis Chart

BUILDING BLOCKS	Fully Available Currently, Meeting Patient Demand	Available, but Not Meeting Patient Demand	Not Yet Available
WVPM time allocation			
Primary Care Collaboration and Leadership Support			
Financial Resources			
Champions for Women's Health Program Development at Site (other than the Women Veterans Program Manager)			
Active Women's Veterans Advisory Committee			
Mental Health Providers Co-Located with Primary Care			
Support & Collaboration (pharmacology, radiology, IT, etc.)			
Maintenance of Provider Knowledge and Skills in Women's Health			
Gender Specific Patient Education			
Access to Data Necessary for Change			

BUILDING BLOCKS	Fully Available Currently, Meeting Patient Demand	Available, but Not Meeting Patient Demand	Not Yet Available
Active WH Quality Improvement Program			

4. Timeline. With the information you obtained from the Care Gap Analysis, utilize the chart below to identify the objectives needed to meet the ultimate goal of delivering Comprehensive Primary Care to Women Veterans. Specify your steps in the planning process based on the needs of your facility, including the needs of the CBOCs. Clearly state the objectives you plan to establish or develop at your facility. Include in your plan the time frame for initiating and implementing each objective. Please use a separate table for each objective.

Steps in the Planning Process	Date
Identify local champions	
Assemble a Facility Task Team/Advisory Committee	
Gather usage data and performance measures needed for planning	
Discuss plan with Primary Care Management	
Develop draft strategies	
Develop draft plans	
Outline Pros/Cons of plans	
Develop a Presentation	
Present to Advisory Committee/Task Team	
Talk with Field Leaders/VISN Lead	
Finalize implementation plan, including budget request	
Present to Facility Leadership/get concurrence	
Revise	
Implementation (phased approaches)	
Evaluation and Measurement	

5. Resource Analysis and Budget Development. For each program to be developed, determine your projected needs in each of the following areas. Use the following table to document your needs for each program area. (A new chart will be needed for each program to be developed.)

Program Name	
Leaders to be engaged	

Staff needed –identify position and FTEs (Physician, Nurse Practitioner, Nurses II and III, Physician's Assistant, Clerks, Pharmacist, Mental Health Provider)	
Space requirements	
Major equipment needs	
Data needs	
IT resource needs	
Ancillary service needs – e.g., pharmacy, medical records, billing, marketing	
Potential partners – medical, community, etc.	

6. Budget. Developing a budget will be critical to address the resource needs defined above. In addition to the actual dollar amounts necessary to meet your resource needs, what process will you use to develop your budget and identify resources that can assist you? Make sure you justify costs, explain possible efficiencies and look for potential cost savings for the veterans and for VA. Also consider returns on investment such as improved patient satisfaction, streamlining, service contact points, differences between buying and outsourcing, etc.

7. Staff Development: Training and Hiring. To help meet the staffing needs defined above, and to further the integration of women's primary health into your facility, what do you need to do in each of the following areas?

Leadership development
Assessment / integration of current staff competencies
Resident training
Selection of new hires/orientation/inreach activities
(To be determined)

8. Risks. What risks and barriers do you need to consider as you establish women's comprehensive primary care as the model at each facility? What are the risks to the WVPM and women veterans if women's comprehensive primary care is **not** established?

9. Culture Change

What will you need to do internally in terms of outreach and marketing to promote culture change in support of the full integration of women's comprehensive primary care into your system?

Supplemental Questions for Care Gap Analysis (W-CHIP 3c)

Answering these questions to the best of your knowledge will help you decide how to appropriately assess the level of care for women veterans.

I. Current Model of Primary Care Delivery Analysis

Women's Health Primary Care Providers

- How many providers offer care to women?
- How many provide comprehensive care?
- How many provide split-model care?
- What is the scope of their practice? (MD, NP, etc.)
- Who else is on your primary care team?(SW, RN)
- How many FTEs support WH care?
- Is there a medical director for WH?
- Is there a Senior Clinician in WH at the site? Is this person trained in internal medicine, gynecology, family medicine, or another discipline?
- Is there a WH team? Who is on the team?
- Who do you consider the WH Champions at your site?
- Who has the authority over service availability and arrangements? (WVPM, the Medical Director, the Champion, etc.)
- What is the average panel size of providers in WH?
- How many patients/appointments per day?
- What is the wait time for new appointments?
- What is the wait time for return appointments?
- Number of panel openings in each clinic?

Clinic Space

- Do you have a separate, designated clinical workspace for WH?
- Is the space exclusively for Women's Health or is it shared space?
- If shared, whom do you share it with?
- If exclusive space, does it have its own entrance? Does it have its own waiting room?
- If you have a separate Women's Health Center with exclusive space, which services do you offer:
    - General Primary Care (Cardiovascular prevention, DM management)
    - Urgent visits
    - Cervical and Breast cancer screening
    - PAP/breast exam
    - Contraception counseling and prescribing
    - Management of menopause
    - General reproductive health care services
    - Treatment of uncomplicated vulvovaginitis
    - Osteoporosis diagnosis and treatment
    - Hormone replacement therapy

  - Mental Health Services
  - Social Work Services

- If you do not have a separate Women's Health Center Space with exclusive space, where do you offer:
  - General Primary Care (Cardiovascular prevention, DM management)
  - Urgent visits
  - PAP/breast exam
  - Contraception counseling and prescribing
  - Management of menopause
  - General reproductive health care services
  - Treatment of uncomplicated vulvovaginitis
  - Osteoporosis diagnosis and treatment
  - Hormone replacement therapy
  - Mental Health Services
  - Social Work Services

- Regardless of your current model of care, do you have:
  - Gyn exam tables (how many)?
  - Privacy curtains, gowns, drapes?
  - Speculums? (disposable or metal)
  - Thin prep available?
  - GC/chlamydia probes?
  - Table lights? Speculum lights?
  - CPRS workstation within the exam room?
  - Chaperones available for MDs, NPs, and PAs?
  - Restrooms in proximity to WH exam rooms?

- Where is the gender-specific equipment stored? (Speculums, thin prep containers, etc.) In the primary care clinical area? In the WH center area?
- Who orders gender-specific supplies?

II. Care Gap Analysis

WVPM Time Allocation

- How many hours are currently dedicated to this role?
- How many hours are spent in patient care responsibilities?
- Who do you report to? (i.e., chief of staff, chief of nursing, chief of primary care, etc.)
- What department funds your salary?
- Do you have a WH Advisory Committee?
- If you are a VISN-lead WVPM, are you on the VISN Executive Leadership Committee (ELC)?

WH Budget

- Is there a separate budget for Women's Health? If yes, then:
- Who controls that budget?
- What mechanisms exist for you to seek additional funds?

Women Veterans Advisory Committee

- Do you have a committee? If yes, then:
- Who sits on this committee? What is their background? (e.g., veteran, MD, RN, SW)
- How often do they meet? (e.g., quarterly, monthly)
- Do they have a charter (or guidelines describing their advisory role)?
- Who do they report to? How often do they report?
- Do they offer recommendations?
- Who is the chair of the committee? Is this a rotating position?
- Do you have members of other departments on your WH advisory committee?

Mental Health Providers

- Do you have Mental health providers in Primary care clinic or in a separate Women Health Center?
- Do MH providers see women on the same day or, do women have to return for a separate appointment?
- What is the wait time for a mental health visit with a provider? With a female provider?
- Do you have an MST program coordinator -- is the WVPM doing a dual role or is it a separate position? If it is a separate position, how do you collaborate? What is your screening mechanism?

Support & Collaboration (pharmacology, radiology, IT, SW, etc.)

- Are there formal guidelines and procedures for tracking non-VA healthcare delivery?
- Are there formal guidelines on when a referral to gynecology is appropriate and when Gyn care should be done within primary care?
- Do you have a mammogram coordinator?
- How do you track abnormal PAPs?
- Are you able to stock gender-specific medications in your pharmacy? (Contraceptive pills, emergency contraception, vaginal cream, etc.)
- Do you have a specific CPRS template for well women exams?

Provider Education in Women's Health

- Do you have staff capable of training other staff members in WH?
- Do you have funds to send staff to women's health training programs?
- Have you funded your own local conference or workshop on WH?

Gender-specific Patient Education

- Do you have staff capable of training patients in gender-specific self-directed care?
- Do you have posters, pamphlets, handouts, etc., for patient education in WH?

Access to Data

- Do you have the necessary data to justify the planned care delivery changes?
- Is the data easily accessible?
- Is the data organized into a PowerPoint presentation for facility leadership?

Active WH QI Program

- Do your providers receive individual feedback?Are female patients included as part of the feedback. Are there incentives by gender?
- Do you have a formal tracking mechanism to demonstrate follow-up and outcomes of performance measures?
- Are you a member of the facility's Quality Assurance Committee?
- How do you track abnormal PAPs? Abnormal mammograms? Abnormal DEXAs?
- How do you track medications that have teratogenic effects in reproductive-age women?

APPENDIX D

Department of Veterans Affairs

Memorandum

July 8, 2008

Deputy Under Secretary for Health for Operations & Management (10N)

Subj: Women Veteran Program Managers Full-time FTEE Positions

To: VISN Directors 10N (1-23)

1. Serving the needs of women veterans is a vital part of our mission. The number of women serving in active duty military has grown steadily since 1990 with 42% of all OEF/OIF females utilizing VHA services. Of these returning women, 86% are under age 40 and of child bearing age. This fact alone requires a revisiting of our programs and support services for women veterans.

2. The position of the Women Veteran Program Manager (WVPM) has been required in VHA since 1992. I am now requesting that the WVPM be made a full-time position and filled as soon as possible, but no later than 12/1/08. I appreciate the dedicated WVPM employees and their advocacy for our veterans and know that this request for full-time status is long overdue. I anticipate that supporting this role will allow for increased outreach to women veterans, improvement in quality of care provision, and the development of best-practices in organizational delivery of women's health care.

3. Please ensure that the WVPM has full access to facility leadership in reporting and collaboration of care for women veterans. The role of the WVPM is to strategically plan, coordinate quality care, evaluate delivery of care including timeliness, and to outreach to women veterans that need our services. VHA Handbook 1330.02 provides a description of program duties and responsibilities, with sample Position Description and Functional Statement: http://vaww1.va.gov/wvhp/docs/VA-Handbook-133.02.pdf. I urge you to take this opportunity to make certain that the defined WVPM position has the support and reporting chain necessary to effectively carry out the rapid changes required at the facility level.

4. I also understand that it is important for many clinicians to maintain their practice skills, and for these WVPMs, a minimum amount of patient direct clinical work may be available to maintain competencies and licensure. This can be accomplished with employees on a case-by-case basis. However, the maximum time allotted for clinical work must not exceed the minimum requirement for licensure, certification, or privileges, usually not more than 1/8 time.

5. Internet-based training for the position of WVPM is available through EES. Employees must be individually granted access by contacting the Women Veterans Health Strategic Health Care Group (WVHSHG) at VHA CO 13E Staff@va.Gov

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6. In order to track the implementation of this position, quarterly facility reports will be required to document the number of unique women veterans accessing VA services (including CBOCs), the progress of filling this WVPM position and the hours devoted to the position. In addition, names and contact information of the WVPM and any vacancies and new appointments must be reported to the Women Veterans Health Strategic Health Care Group and your VISN Lead WVPM on an ongoing basis.

7. For questions, please contact Patricia Hayes, Chief Consultant, Women Health Strategic Health Care Group at (202) 461-7174.

William F. Feeley

William F. Feeley, MSW, FACHE

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APPENDIX E

CURRENT AND FUTURE VA RESEARCH ON WOMEN'S HEALTH

The multitude and diversity of VA research studies are mirrored in recent research findings on the health of women veterans, further evidence of the expanding landscape of VA women's health research. Examples in the area of PTSD include a number of biomedical and clinical research studies examining the neurobiology of severe psychological trauma in women, ERP abnormalities in female nurse and male combat Vietnam veterans with PTSD, structural brain MR and neurocognitive function in female nurse Vietnam veterans, and HPA axis reactivity in men and women with chronic PTSD. A recently completed VA clinical trial—the first cooperative study focused on women, which also included DoD partnership—determined that prolonged exposure, a type of cognitive behavioral therapy, is an effective treatment for PTSD in female veterans and active duty military personnel and is feasible to implement in a variety of clinical settings in VA. As a result of this research, VA's Office of Mental Health is supporting a national rollout of training in prolonged exposure.

Research also points to the prevalence of comorbid conditions in women veterans. For example, a study of the prevalence and associated risks of health and problem drinking in women veterans found that 24 percent of the study population reported binge drinking in the past year; associated risks (smoking, alcohol-related diseases, psychiatric conditions, injuries, and multiple sexual encounters) were higher among women reporting binge drinking. Other research found that women veterans receiving care at the VA with a history of sexual assault were more likely to have associated physical symptoms and medical conditions.

Gender disparities in care have been analyzed and highlighted. Possible disparities in some types of preventive care among women veterans with spinal cord injuries and disorders (SCI&D) have been suggested in research comparing women veterans in general and those with SCI&D. While only 5 percent of veterans with SCI&D who use VA each year are women, their unique health issues may create additional complexities and challenges to their care, particularly when special equipment and body adjustments are needed to perform care. VA investigators also have documented the substantial burden of obesity among women veterans using VA medical facilities (in 2000, 68 percent were overweight and 37 percent were considered obese); obesity prevalence was somewhat lower than in male veterans and was highest among the 60- and 70-year age groups. Researchers also have found gender differences in VA use and costs, with women having more outpatient visits and fewer inpatient days, lower costs compared to men, and three times more likely to use fee-basis care. Greater outpatient use of medical and mental health care suggests the need for integrating physical and mental health care for women veterans.

An early-stage evaluation of VA's mandated military sexual trauma screening program demonstrates the feasibility of universal screening, which provides clinically important information that can inform mental health and behavioral health treatment and suggests that screening can promote both detection of sexual trauma and access to mental

health care, potentially reducing the burden of psychiatric illness for veterans who have experienced military sexual trauma. An evaluation of the screening nationwide in VA in 2003 indicated that more than 70 percent of all patients completed military sexual trauma screening, a rate similar to other screening-related performance measures in the VHA for that year. In FY2007 more than 90 percent of all patients completed military sexual trauma screening. Research indicates that veterans with a positive screen were more likely to have a mental health diagnosis and mental health comorbidities, including PTSD, as well as medical comorbidities. In addition, veterans with a positive screen had significantly increased rates of mental health treatment in the three months after screening, compared to negative screens, particularly among patients without previous use of mental health treatment.

VA researchers have developed and evaluated an interactive educational program to enhance VHA employees' awareness of women veterans and their health care needs.

Current research should further elucidate the health needs and health care of women veterans, particularly for the newest veterans of the OEF/OIF conflict, and provide evidence on access, continuity, and quality of care of VA health care services for women veterans as well as determination of whether VA treatment approaches and service delivery should be tailored differently for female veterans.

Expected findings of ongoing VA studies of women veterans (in the next 1-4 years) include:

- Impact of practice structure for VA care of women veterans (e.g., women's clinics) on accessibility, continuity, coordination, quality, satisfaction, and performance measures.
- Documentation of changes in VA women's health care delivery and relationship to quality.
- Analysis of the principal health conditions and diagnoses in women veterans; prevalence and association of comorbid chronic disease and mental illness, including diabetes, depressive disorders, and cardiovascular conditions; and gender differences in health care use and costs.
- PTSD prevalence and treatment (i.e., association of PTSD positive screening test and mental health care use for VA users and non-users).
- Predictors of mental health care use among women veterans with PTSD, in OEF/OIF and non-OEF/OIF populations (e.g., race, anxiety disorder, income, VA utilization, service-connected disability).
- Determination of MST in veterans returning form Iraq and Afghanistan and the association with mental health diagnoses and risk of depression, PTSD, and substance use disorders.
- Examination of the role of health behaviors in the association between MST exposure and physical health in both men and women.
- Association of general health care needs and VA health care utilization with MST, combat trauma, PTSD, and traumatic brain injury (TBI) in OEF/OIF populations.

- Assessment of gender differences in health care utilization, costs, and satisfaction of OEF/OIF veterans.
- Examination of gender differences in individual, institutional, and stigma-related barriers to health care use among OEF/OIF veterans, and possibly different barriers related to PTSD and sexual assault.
- Assessment of gender differences related to treatment preferences and community reintegration problems among OEF/OIF veterans, including mothers with dependent children, as well as barriers to utilizing care and support services.
- Determination of the efficacy of an internet-based intervention to improve psychological health and functioning among OEF/OIF veterans with reintegration problems, including examination of gender differences.
- Assessment and validation of screening and risk measurement tools and treatments for PTSD and intimate partner violence.

Future Plans

- An update of the evidence synthesis of the published research related to the health and health care of women veterans is being conducted, to be completed in FY 2009.
- VA's QUERI program will be conducting a session at its 10th anniversary national meeting in December on implementation of quality health care services for women veterans.
- VA co-sponsored, along with NIH, the DoD-directed conference on trauma spectrum disorders and the role of gender, race, and other socioeconomic factors, held October 2008. This conference addressed PTSD, traumatic brain injury, psychological health, and family functioning.
- VA participated as one of the sponsors of a PTSD roundtable on women (with DoD, the National Institute of Mental Health, and others), directed by the Society for Women's Health Research in late 2008.
- VA and DoD research collaboration is being expanded.
- VA research dissemination is being updated and expanded on VA's web site.

APPENDIX F

GLOSSARY OF ACRONYMS

ACEI	Angiotensin Converting Enzyme Inhibitor
ADUSH	Assistant Deputy Under Secretary for Health
AHRQ	Agency for Healthcare Research and Quality
AMI	Acute Myocardial Infarction
ARB	Angiotensin Receptor Blocker
ASA	Aspirin
BP	Blood Pressure
CBOC	Community-based Outpatient Clinic
CHF	Congestive Heart Failure
CI	Clinical Inventory
CoE	Center of Excellence
DoD	Department of Defense
EES	Employee Education Services
EPRP	External Peer Review Program
FY	Fiscal Year
GLA	Greater Los Angeles
GYN	Gynecology
HbA1C	Hemoglobin A1c
HEDIS	Healthcare Effectiveness Data and Information Set
HMG CoA	Hydroxymethylgutaryl-coenzyme A
HPV	Human Papillomavirus
HHS	Health and Human Services
HRSA	Health Resources and Services Administration
HSR&D	Health Services Research and Development
HTN Dx	Hypertension Diagnosis
ICD	International Statistical Classification of Diseases
IUD	Inter-uterine Device
JGIM	Journal of General Internal Medicine
LDL	Low-density Lipoprotein
LVEF	Left Ventricular Ejection Fraction
MD	Medical Doctor
MH	Mental Health

MR	Mitral Regurgitation
MST	Military Sexual Trauma
NIH	National Institutes of Health
OEF/OIF	Operation Enduring Freedom and Operation Iraqi Freedom
OQP	Office of Quality and Performance
ORD	Office of Research and Development
PCMH	Patient-Centered Medical Home
PC	Primary Care
PCS	Patient Care Services
POC	Plan of Care
PTSD	Post Traumatic Stress Disorder
QI	Quality Improvement
QUERI	Quality Enhancement Research Initiative
RCD	Research Career Development Program
SHEP	Survey of Health Care Experiences of Patients
SCI&D	Spinal Cord Injuries and Disorders
SMI	Serious Mental Illness
STD	Sexually Transmitted Disease
TBI	Traumatic Brain Injury
USH	Under Secretary for Health
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Services Network
WCHIP	Women's Comprehensive Health Care Implementation Plan
WHC	Women's Health Clinic
WVHSHG	Women Veterans Health Strategic Health Care Group
WVPM	Women Veterans Program Manager

Women Veterans Health
Strategic Health Care Group

Department of Veterans Affairs
Veterans Health Administration
810 Vermont Avenue, NW
Washington, DC 20420

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