Interpersonal Violence

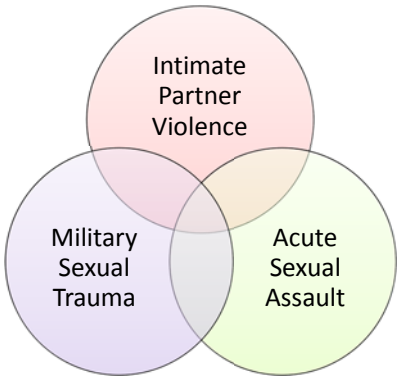
VETERANS HEALTH ADMINISTRATION

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

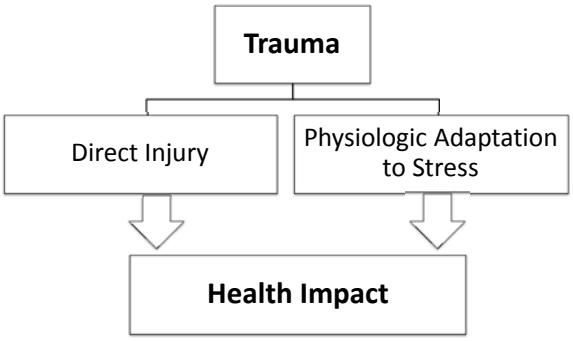
Objectives

- Discuss three types of interpersonal trauma
- Review VHA policies and screening recommendations
- Describe optimal management
- Emphasize a patient-centered, team-based approach

Interpersonal Trauma



Trauma Can Manifest in Multiple Ways



Interpersonal Trauma Affects **Physical Health**

Headaches	Abdominal and pelvic pain	Chest pain and palpitations
Irritable bowel syndrome or GI problems	Sexually transmitted infections	Fibromyalgia or chronic pain syndromes
	Medically unexplained symptoms	

Interpersonal Trauma Affects **Reproductive** Health

In women, increased prevalence of…

- Pelvic inflammatory disease
- Irregular menses, premenstrual symptoms
- Perinatal and neonatal issues
- Miscarriage

Interpersonal Trauma Affects **Mental Health**

- Post-Traumatic Stress Disorder (PTSD)
- Depression
- Anxiety
- Substance abuse
- Suicidality

Patient-Provider Relationship

*can resemble **some** aspects of the*

TRAUMATIC RELATIONSHIP/EXPERIENCE

- Power differential
- Physical pain and exposure
- Touching of intimate body parts
- Lack of situational control

Practice Trauma-Informed Care

- Like universal precautions… we don't always know who has had an exposure
- Disrobing, invasive exams can be especially difficult for trauma-exposed women Veterans
- Be prepared to let the patient direct the exam, and to stop if evidence of distress or dissociation
- Be attentive to privacy needs, personnel in the room

She may be having a trauma-related reaction…

- Anxious, agitated, jumpy or withdrawn, quiet, frozen
- Tearful with no obvious cause; strong emotional reactions
- Difficulty concentrating, distractible, disoriented
- Experiences flashbacks, dissociates
- Minimizes symptoms that require intimate exams
- Refuses care/cancels appointments

Women with multiple presenting problems may have abuse histories…

- Greater abuse severity along with varied forms of abuse → more physical symptoms
- Ongoing abuse may → more somatic symptoms over time
- ALWAYS validate her physical symptoms and pain

Nicolaidis et al., 2004; Gerber et al., 2008.

MST Definition: US Code (1720D of Title 38)

Psychological trauma that resulted from

- Assault of a sexual nature
- Battery of a sexual nature
- Sexual harassment

that occurred while the Veteran was on

- Active duty
- Active duty for training
- Inactive duty training

What is MST?

Sexual assault or battery	Repeated, threatening sexual harassment	While on duty or off duty
Occurs on base or off base	Perpetrated by man or woman; military or civilian	Reported from all eras

Other MST experiences many include…

- Unwanted sexual touching or grabbing
- Threatening offensive remarks about the body
- Threatening, unwelcome sexual advances
- Threats for refusing sex
- Coercing sex by implying it will result in promotions or better treatment

An authority figure is often involved

VA MST screening rate is 74%

Annual incidence:

- Active duty women
  - 3% sexual assault
  - 54% sexual harassment
- Users of VHA
  - 23% sexual assault
  - 55% sexual harassment

1 in 5 women (20%) report MST

MST in deployed OEF/OIF women Veterans is 15%

MST is associated with…

• Depression, suicide risk	• Asthma
• PTSD	• Breast cancer
• Alcohol/drug abuse	• Heart attacks
• Disrupted social networks	• Obesity
• Occupational difficulties	• Menstrual/pelvic pain
• Sexual dysfunction	• Somatization

Suris & Lind, 2008; Murdoch et al., 2006; Stein & Barrett-Connor, 2000; Frayne et al., 1999; Kimerling et al., 2010.

VA Policy: all Veterans must be screened for MST using the one-time clinical reminder in CPRS

Universal screening is good clinical practice…

- Many patients do not spontaneously disclose
- MST awareness provides a context for presenting problems and helps teams adapt care

MST Screening Questions

When you were in the military…

Did you receive unwanted sexual attention?

Did anyone force you to have sex?

Who Should Screen for MST?

- Licensed professional or others ***trained on how to screen and how to respond to disclosure***
- Providers must always review Veterans' responses and initiate follow-up if needed

Training is critical so responses are clinically appropriate and referrals and follow-up treatment occur.

What if she says "yes"… ?

Listen attentively

Validate and empathize
I'm sorry this happened to you while you were serving your country.

Educate and normalize
Many Veterans have had experiences like yours. It has affected some of them for years. People can recover, however.

Assess current difficulties
How much does this continue to affect your daily life today? In what ways?

VHA Directive 2010-33
Military Sexual Trauma Programming

- All Veterans seen in VHA must be screened for MST
- Free treatment – *with no limit on* duration – for all MST-related physical and mental conditions
- Designated MST Coordinator at every VHA facility

VA must provide staff with MST training and engage in outreach to inform Veterans about services

Intimate Partner Violence (IPV)

CDC definition of IPV

- Actual or threatened physical, sexual, or psychological harm

Person using violence can be partner, ex partner, or acquaintance

Men or women can experience or use IPV

- Women more likely to experience multiple forms, suffer psychological/physical consequences, or die

Occurs among heterosexual or same-sex couples; does not require sexual intimacy or cohabitation

Epidemiology Differs by Population & Methods

DOJ statistics	Self-reported data
Women = 85% of those affected	CDC: 35.6% of women report IPV
Young women 18-34 = highest rates	BRFSS: 28% of women, 33% of women Veterans

Catalano S, 2012; Black et al., *2011*; Dichter et al., 2011.

IPV as a Women's Health Issue

Women who experience IPV are more likely to…

Have injuries and fear for their safety

↓

Report poor mental and physical health

↓

Use aggression in relationships when experiencing IPV

Black et al., *2011*; Coker et al., 2002; Hellmuth et al.; Gerber et al., 2014.

VHA IPV Assistance Programming

Plan for Implementation of the Domestic Violence/ Intimate Partner Violence Assistance Program

Recommended

- Psychological rehabilitation framework
- Veteran-specific guidelines
- DV/IPV Coordinator at each facility
- Use of E-HITS screen

Subgroup Differences

No racial differences

Higher education is a *protective* factor

Lower household income is *risk* factor

IPV understudied for LGBT groups

Abusive Relationship Dynamics

- Can occur in a relationship with very little physical violence
- Women may be isolated from others
- Partners can interfere with healthcare
- Poorly compliant patients may be suffering abuse

McCloskey et al., 2007.

IPV and Pregnancy

- Higher risk of IPV
- IPV escalation (e.g., from emotional to physical abuse)
- Leading cause of maternal mortality and mortality
- Contraceptive coercion is a form of IPV

Chambliss LR, 2008; Miller & Silverman, 2010; Miller et al., 2010.

IPV and PTSD

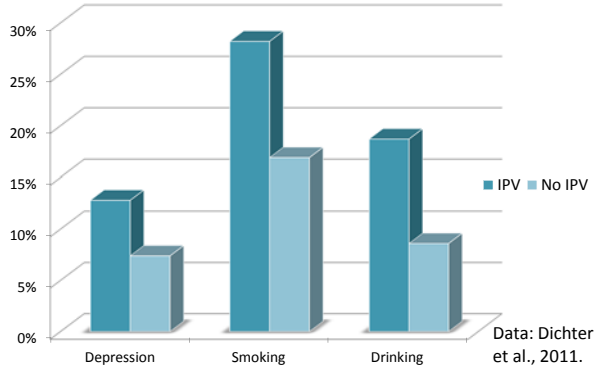
31-84% of women who experience IPV have PTSD

PTSD symptoms increase risk of future *IPV* (decreased capacity to detect danger; vulnerability attracts controlling, aggressive individuals)

CPT can reduce risk of experiencing future IPV

Iverson et al., 2011.

IPV is associated with depression, smoking, and drinking among women Veterans



Data: Dichter et al., 2011.

IPV <u>is</u> a Medical Issue

2001 study of femicides…

- 41% had health care provider contact prior to death
- Yet only 3% accessed advocacy or shelter programs

It's common for women not to seek medical assistance after an injury from IPV

Sharps et al., 2001; National Coalition Against Domestic Violence Report 2001.

IPV and the Military

<u>Users of IPV</u>

- Active duty personnel at much higher risk of using IPV (58%)
- No difference by branch of service

<u>Experience of IPV</u>

- Active duty women…
  - 30% IPV in lifetime
  - 22% IPV during active duty
- Recently returned Veterans:
  - 75% family readjustment issues
  - 60% IPV
  - 25% guns at home

Sayers et al., 2009.

Higher rates of pre-military trauma and child abuse

Many women enlist to leave violent/unstable homes

- *VA primary care population*: 50% of OEF/OIF women and 46% of all women Veterans report current or past IPV
- *VA mental health population*: 70% report IPV in lifetime
- *National Behavioral Risk Factor Survey*: ⅓ of Veterans report IPV in lifetime (vs. < ¼ of non-Veterans)

Campbell et al., 2003; Sadler et al., 2004; O'Campo et al., 2006; Dichter et al., 2011.

Risk Factors for Experience of IPV

Veteran and Active Duty Women

- Younger age
- Less education
- Enlisted
- Army branch of service
- High stress associated with service
- Fewer years of service

Campbell et al., 2003.

Issues that commonly co-occur with IPV in Women Veterans

TBI
- Risk factor for, and sequale of, IPV
- May be unrecognized; symptoms similar to PTSD, anxiety, depression

Homelessness
- IPV worsens PTSD and substance abuse, which increases risk

PTSD
- Present in 31-84% of women who report IPV
- Symptoms increase risk of future IPV

IPV Screening

US Preventive Services Task Force
Level B Recommendation:

"Screen women of childbearing age and provide or refer women who screen positive to intervention services"

AHRQ pub no. 12-05167-EF-2; Nelson et al, 2012; Tjaden & Thoennes, 2000.

Where to ask about IPV?

- No family, friends, or children over age 3 present
- Invite partner to "*sit in the waiting room where it is more comfortable*"

comfortable & private setting

When to ask about IPV?

- Routinely as part of social hx
- Injuries don't fit the story
- Chronic pain/somatic issues
- Depression, anxiety, PTSD
- Substance abuse
- Pregnancy (first prenatal visit, once per trimester, post-partum visit

HOW to ask about IPV?

Introduce/normalize questions

Because violence is so common in the lives of women, we have begun asking all patients about it

Consider both current and past IPV

Be aware that feelings of isolation, coercion, or fear may signify emotional IPV

In the past year…

1. Has your partner physically hurt you?
   - o Never
   - o Rarely
   - o Sometimes
   - o Often
   - o Frequently

E-HITS scoring:
- Range 5-25
- Positive ≥7

2. Has your partner insulted you?
3. Has your partner threatened to harm you?
4. Has your partner screamed or cursed at you?
5. Has your partner forced you to have sexual activities?

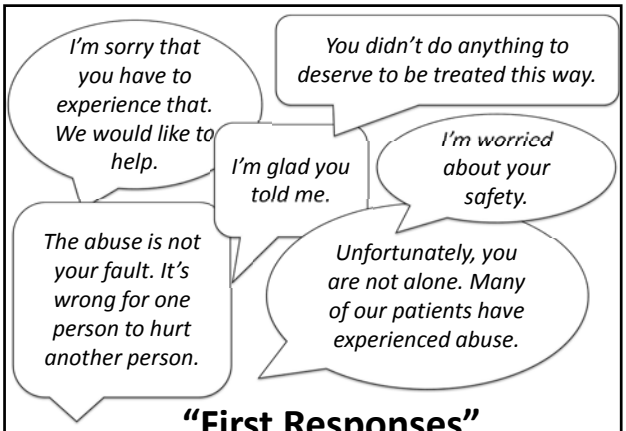
Iverson et al., 2013.

Benefits of Routine IPV Inquiry

- Increases comfort in talking about IPV
- Normalizes discussion of IPV; reduces stigma
- Fosters trust which may make disclosure more likely
- Women want to be asked; believe providers can help
- Opportunity to reduce patients' exposure to IPV (USPSTF)

What to do if she says "YES"

- Stop, make eye contact
- Respond with empathy and compassion
- Be non-judgmental, supportive, concerned
- Evaluate for danger ('warm hand-off' to MH/SW?)
- Use PACT team approach for referrals and services
- Consider resources in VA and community



"First Responses"

How Can You Help?
It is not your role to "fix it"

Document encounter	Treat health problems and injuries	Assess safety
Offer support	Provide education and resources	Coordinate follow-up

After Disclosure

Meta-analysis of women's expectations of clinicians:

- Be non-judgmental and individualized
- Let her direct the conversation; don't force her to talk about the abuse or leaving the relationship
- Trust her judgment regarding legal involvement

Feder et al., 2006.

Risk Assessment

She may not realize she's in imminent danger

Danger increases if:

- Abuser access to weapons
- Abuser uses substances
- Abuser unemployed
- Recent abuse escalation
- History of severe abuse
- History of stalking
- Attempted strangulation

Campbell et al., 2002; Johns Hopkins School of Nursing, www.dangerassessment.org

Suggested Documentation

1. IPV assessment in social history
1. Specify details of IPV incident (user's name, actions, date and time)
2. Document physical exam findings, injuries, health effects
3. Code for resulting condition (ex. contusion, laceration)

Good documentation can help in court, with child custody, or with state victims' compensation

Reporting IPV

Some states have mandatory reporting. Most do not.
Women fear children will be placed in protective custody.

Ask: ***"Are there children in the home?"*** If yes:

- May need to enter a consult for VA social services
- Know your facility's protocol/state reporting laws

She may not leave the situation…

Understand the barriers to this behavior change

View as a chronic disease; work on it slowly over frequent visits

She may have lost her sense of free will and autonomy

Help her regain self-esteem; validate her actions while being honest about your safety concerns

Respect her timetable; never tell her what to do!

Exiting Violent Relationships

- Women who are separated from a violent partner are 25x more likely to be assaulted by that partner
- Women are most likely to be killed while leaving
- Up to a third who leave will continue to be harmed by their partner

This is a time of risk.
Be supportive and help connect her to resources.

Safety Plan

- Tailor to her specific situation
- Identify ways to stay safe
- Back-up plan for escalating violence
- Pack a bag, keep in a secure place
- Copy documents
- Code word for others to call police

National Coalition Against Domestic Violence Safety Plan
http://www.ncadv.org/protectyourself/SafetyPlan_130.html

VHA Domestic Violence/Intimate Partner Violence plan
http://vaww.infoshare.va.gov/sites/cmsws/DPIPV2/SitePages/Home.aspx

Be Alert for IPV and MST Co-occurrence

- IPV 2.5x more common in women who have experienced MST
- Multiple forms of trauma increases adverse health impact
- Prior experience of IPV is a risk factor for future violence

Dichter & Marcus, 2013; Latta et al., in press.

http://vaww.infoshare.va.gov/sites/cmsws/DPIPV2/Shared%20Documents/October%20DV%20Awareness%20Month/IPVBrochure_Web.pdf

Acute Sexual Assault

Definitions (Safe @ UNC. ©2013)

Acute sexual assault	Sexual contact with alleged perpetrator occurring in last 72 hours
Sexual assault	Any sex act or sexual contact against someone's will, without consent, or when someone is unable to freely give consent
Force	Includes verbal, physical or emotional pressure or manipulation, threats, coercion and/or use of alcohol or other drugs

No weapon except force is used in most assault situations

VHA Directive 2010-014

Assessment and Management of Veterans Who Have Been Victims of Alleged Acute Sexual Assault

All facilities must have plans to manage Veterans, male and female, who are victims of acute sexual assault

- Trained on-site examiner, examiner on-call to come to site, or transfer to Rape Crisis Center or a site with trained examiner

Veteran should be offered

- Evaluation and treatment of medical and MH needs
- Forensic exam to obtain historical/physical evidence for possible future use by law enforcement for investigation or prosecution

The Forensic Exam

- Performed by trained examiners (e.g., Sexual Assault Nurse Examiners - SANE)
- Historical and physical evidence collected
- Written consent obtained by the trained examiner

When forensic exam is OFF site…

- Document verbal consent to evaluate and treat medical and MH needs
- Provide care so it doesn't impact physical evidence (e.g., collecting urine specimens, disrobing for exam)
- Offer forensic exam, follow local transfer policy
- Offer STI/pregnancy prophylaxis if indicated

When forensic exam is ON site…

- Offer immediate consult to MH; initial contact from MH must occur within 24 hours
- Use language that gives patient control ("I am going to ask you questions about your health, is that ok?")
- Minimize having patient repeat story multiple times
- Primary Care may seek assistance from VA ED

Possible Sequelae of Sexual Assault

Direct health effects	Indirect mechanism	Physiologic mechanisms	Somatization
• 4 - 30% STI • 4% injured • 5% become pregnant	High-risk behaviors (substance abuse, risky sex, unsafe driving)	Hypothalamic-pituitary-adrenal axis dysregulation	

Reduce Distress

Reduce power differential between the provider and patient…

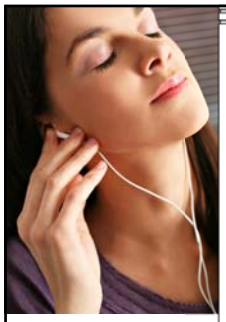
- Converse while she is fully dressed
- Sit at the same level
- Make eye contact
- Provide options and choices
- Be transparent; explain reasons for certain courses of action
- View her as an expert on her body

Reduce Distress

Anticipate and Prepare

- Attend carefully to her concerns
- Explain it is not unusual for assault survivors to have strong reactions to certain procedures
- Describe procedures and ask what she anticipates will be most difficult part
- Brainstorm coping strategies

Reduce Distress



Employ Distractions

Ensure she feels in control
- Explain chaperone role
- Ask permission to touch
- Tell her exam stops if she asks
- Running dialogue of actions
- Periodically ask how she's doing

Respect her subjective experience, even if it seems extreme

Never ignore her requests or dismiss her expression of distress

Next Steps…

- Connect with mental health, if desired
- Provide written info on local resources (shelters, hotlines, support groups)
- Work closely with the assigned social worker
- Maintain list of services and support staff in ED

Summary: How You Can Help

PACT team model approach for positive healing environment

Screen to identify and connect to appropriate care and resources

Recognize when care is violence-related and document appropriately

Adapt care when necessary

Important Points to Remember

- Maintain awareness for interpersonal violence
- Display a compassionate attitude
- Treat with respect; don't make value judgments
- Provide a safe and supportive environment of care
- Follow VHA and local policies
- Remember facility DV/IPV Coordinators

Key Referral Resources

Women Veterans Program Manager	Social Work Services Department	VA Homeless Coordinator
MST/IPV Coordinators	Mental Health	Community resources Safe shelter, financial support, legal advocacy, parenting & custody issues

Authors	**Megan Gerber, MD, MPH** VA Boston Healthcare System **Rachel Latta, PhD** Edith Nourse Rogers Memorial Veterans Hospital **Sarina Schrager, MD, MS** Univ of Wis School of Medicine & Public Health
Contributors	**Linda Baier, MS** Univ of Wis School of Medicine & Public Health **Lisa Nocera, MD** New York Harbor VA Healthcare System

Innovation Diffusion and Organizational Change

May, 2015

Overview/Objectives

- Additional Educational Opportunities
- Implementing Change:
  - Discuss why change is needed/important
  - Review an approach to organizational change
  - Introduce an action plan template
  - Describe examples of program innovation

Training Opportunities

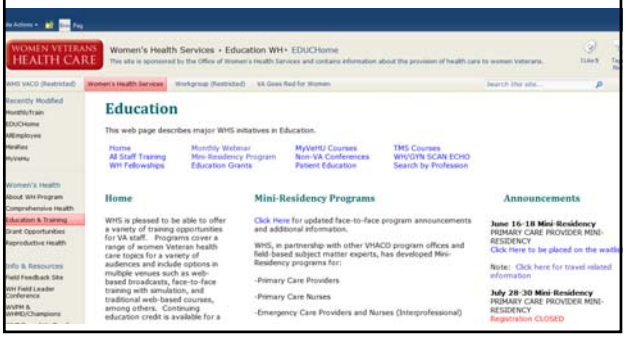
Mini-Residencies

PCP Mini-Residency
- Launched 2008
- >2100 trained
- Goal: Minimum one trained provider per site

Additional Mini-Residencies
- Primary Care Nurses
- Primary Care Providers and Nurses
- Emergency Care Providers and Nurses

Provider Training Opportunities

WH Education Intranet: http://vaww.infoshare.va.gov/sites/womenshealth/whsra/educ/EDUCHome.aspx



50+ Accredited, On-Demand Programs on MyVeHU and TMS

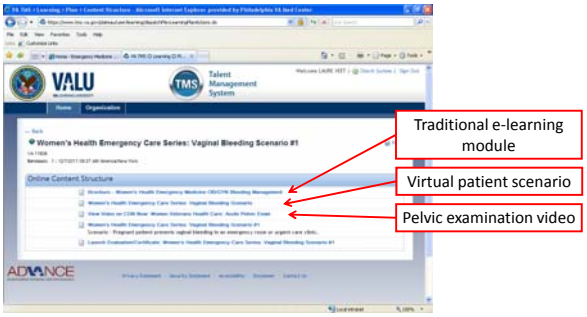
Osteoporosis	Urinary tract infections/ Incontinence	Cardiovascular	Sexual dysfunction
Preconception/ Prescribing	Reproductive Mental Health Topics	Dementia	Musculoskeletal pain/ Fibromyalgia
	Breast and Pelvic Exam	Infertility	

Women's Health Topics on MyVeHU Campus

Monthly Audio-Conferences

- Third Tuesday, 12PM EST and 3PM EST
- Audience: Primary Care Providers, Nurses, Pharmacists, Social Workers, RNs, Psychologists

Women's Health Emergency Medicine Course



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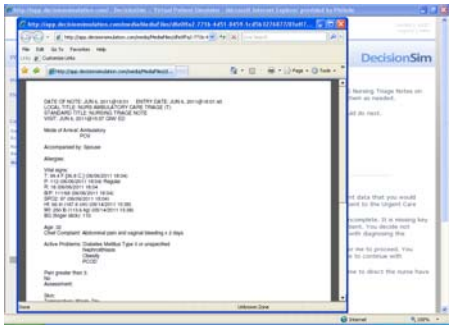

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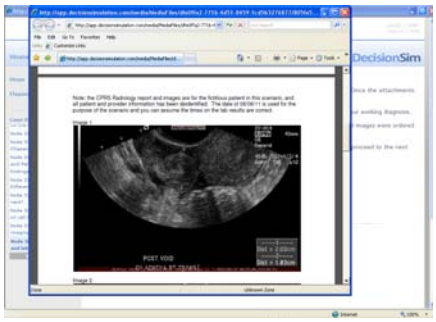

Implementing Change

Are You Ready?

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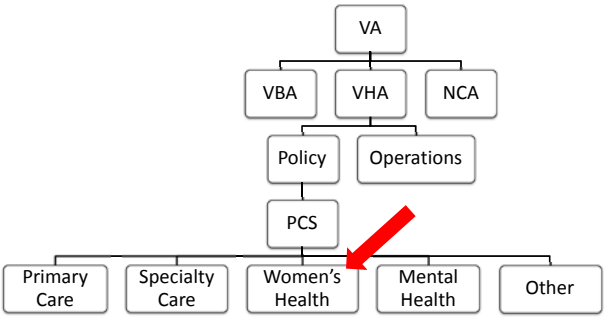
Women's Health Services



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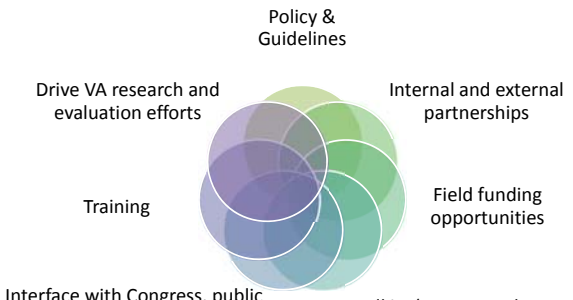
Women's Health Services



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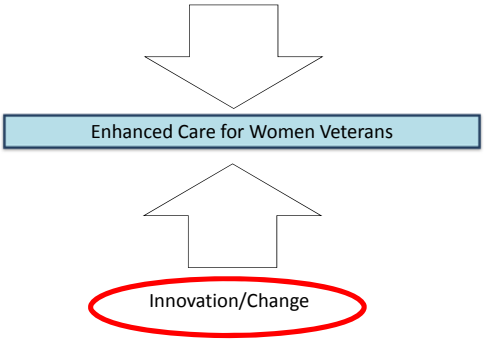
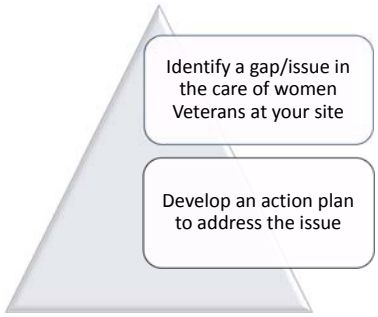
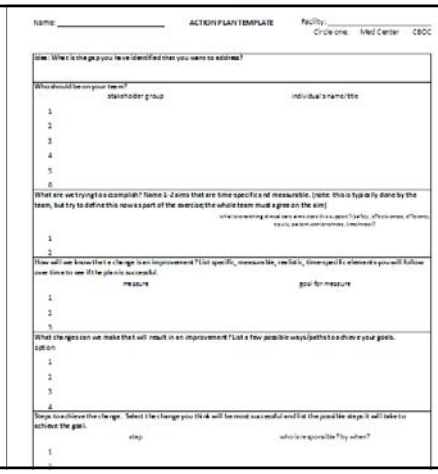
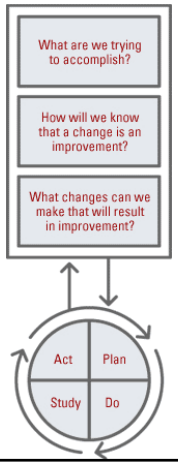


The Challenge



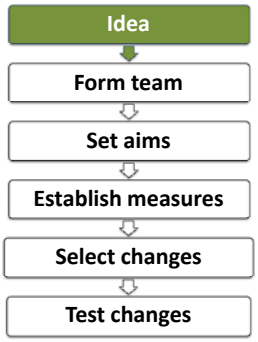


How To Improve

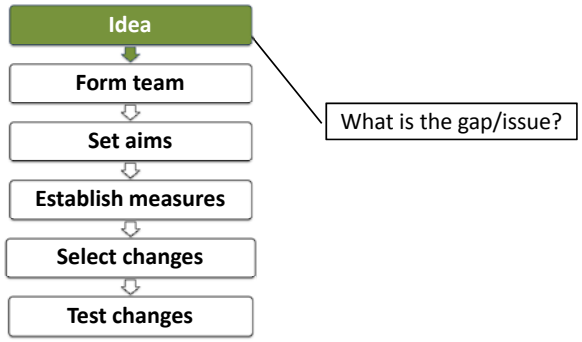


*Source: Institute for Healthcare Improvement (www.IHI.org); Langley et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed). San Francisco: Jossey-Bass, 2009.

How to Improve



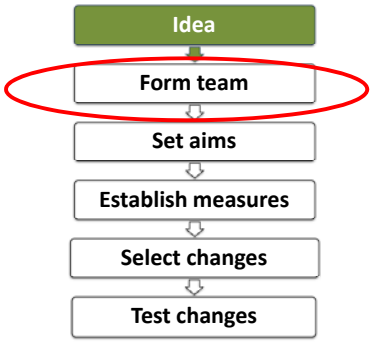
How to Improve: Idea



Idea/Issue/Gap: Examples from Prior Participants

- Breast MRI reports are not coming back from the affiliate
- Performance measures show a gender gap in lipid management
- No pelvic exam tables in my CBOC
- No-show rate is greater in women's health
- "Can't get" certain OCPs in CBOCs

How to Improve: Form a Team



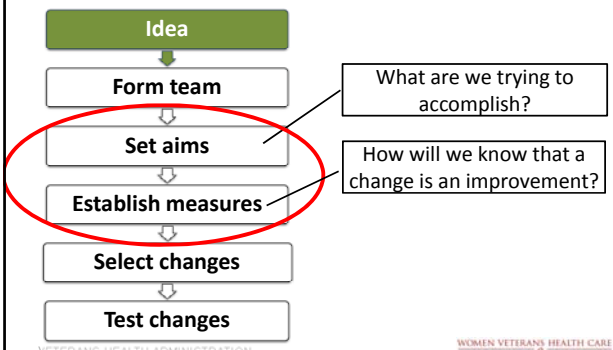
Who Can Be On Your Team?

- Women Veterans Program Manager
- Medical Director Women's Health
- CBOC-Site Liaisons
- Women's Health Clinical Team/PACT
- Nurse Manager
- Other Providers
- Facility Director
- Chief of Staff
- Chief of Primary Care
- Chief of Clinical Support
- Chief of Nursing
- Chief of Pharmacy
- Chief of Prosthetics
- Chief of SPD
- Chief of Mental Health

Team Roles

- Identify team leader (s)
- Project manager/coordinator?
- All team members are active, should have action items and follow up at subsequent visits

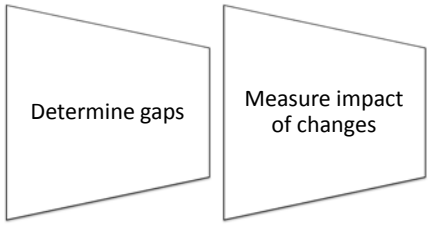
How to Improve: Set Aims and Establish Measures



SMART Aims

- Specific
- Measurable
- Attainable
- Realistic
- Timely
- Tangible

You Need Data To:



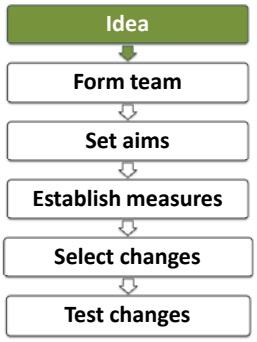
Data: Do You Know……

- No-show rates?
- Wait times?
- Patient satisfaction scores?
- Staff satisfaction?
- Quality measures?
- Gender gaps?

Sources of Data

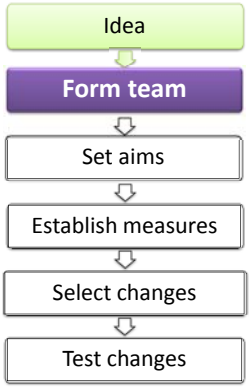
- Business office
- Facility planners
- Brief chart review
- Quality office
- Clinical reminders
- WVPM
- VSSC

Example



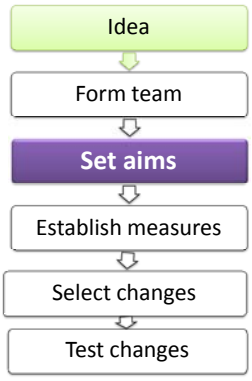
"When a patient comes in with vaginitis, we have no microscope on site, so we treat the patient with multiple empiric antibiotics and never get a diagnosis."

Example (cont.)



1. PCP
2. Chief, Primary Care
3. CBOC Nurse Manager
4. Lab
5. SPD (supply)
6. Woman Veteran Program Manager

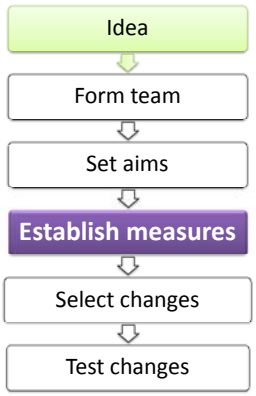
Example (cont.)



Possible aims:

- Be able to diagnose the cause of vaginitis in the next 3 months
- Decrease use of empiric antibiotics

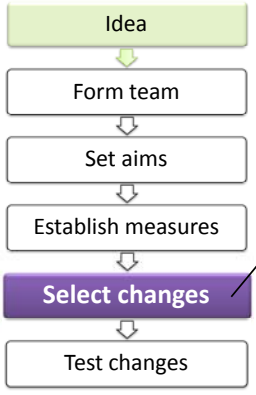
Example (cont.)



Measure: Testing available at our site (goal: within 3 months)

Measure: Decrease use of an empiric multi-drug regimen (goal: 50% reduction in 6 months)

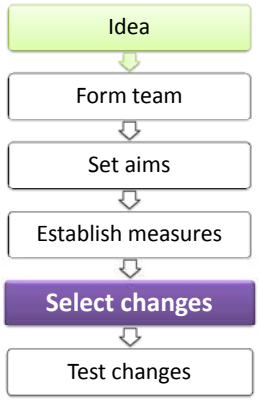
How to Improve: Select Changes



What changes can we make that will result in an improvement?

1) List possible changes
2) Select the best change to implement
3) List steps to achieve the change

Example (cont.)



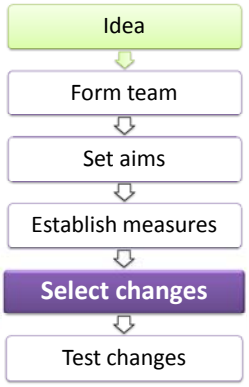
Is there more than one way to achieve your goals?

Possible changes

- Microscope
- Vaginitis testing kits ★

★ = selected change

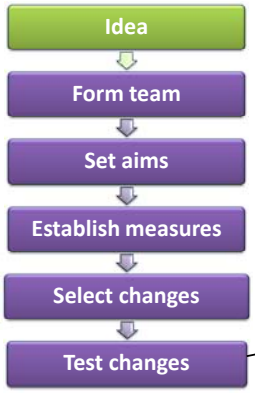
Example (cont.)



Steps to achieve the change:

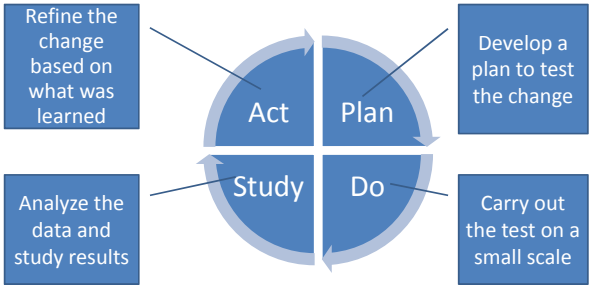
- Identify team and hold meeting #1
- Agree on aims
- Review various kits
- Determine means to order, monitor stock, etc.
- Purchase, plan in-service, etc.

How to Improve: Test Changes

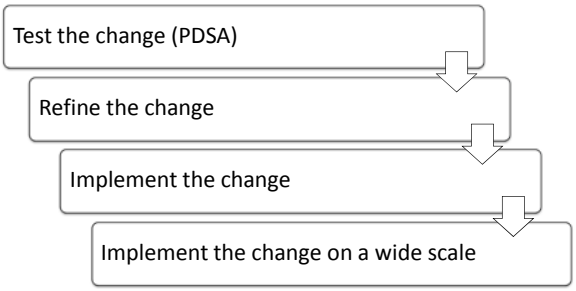


PDSA; Plan-Do-Study-Act

Test Changes



Test and Refine the Change



Name: _____ **ACTION PLAN TEMPLATE** Facility: _____
SAMPLE 1 Circle one: Med Center CBOC

Idea: What issue have you identified that you want to address?
When a patient comes in with vaginitis, we have no microscope on site, so we treat the patient with multiple empiric antibiotics and never get a diagnosis

Who should be on our team?

	Stakeholder group (e.g., provider, nurse manager, lab)	*Individual's name/title (note: indicate team leader with '*')*
1	Provider	LV
2	Nurse Manager (clinic budget)	AAA
3	Chief Physician (medical expertise)	BBB
4	Lab	CCC
5	SPD	DDD
6		

What are we trying to accomplish? Name 1-2 aims that are time-specific and measurable. (Note: this is typically done by the team, but try to define this now as part of the exercise; the whole team must agree on the aim)

	Aim	*What overarching clinical care aims does this support? (safety, effectiveness, efficiency, equity, patient-centeredness, timeliness)?*
1	Be able to diagnose cause of vaginitis within the next 3 months	Efficiency, timeliness
2	Decrease use of empiric antibiotics	

How will we know that a change is an improvement? List specific, measurable, realistic, time-specific elements you will follow over time to see if the plan is successful.

	Measure	*Goal for measure*
1	Testing available at our site	Within 3 months
2	decrease in use of a multi-drug empiric regimen for vaginitis	50% reduction in 6 months; 80% reduction in one year
3		

What changes can we make that will result in an improvement? List a few possible ways/paths to achieve your goals.
Option:
1 purchase microscope (need a way to maintain, ensure proficiency, meet Joint Commission lab standards, etc.)

Name: _____ **ACTION PLAN TEMPLATE** Facility: _____
SAMPLE 2 Circle one: Med Center CBOC

Idea: What issue have you identified that you want to address?
There is only one PCP at a CBOC who cares for women patients. There is no one to provide comprehensive primary care to women if this provider goes on prolonged leave or leaves/changes clinics, etc.

Who should be on our team?

	Stakeholder group (e.g., provider, nurse manager, lab)	*Individual's name/title (note: indicate team leader with '*')*
1	PCP	LV
2	Women Veteran Program Manager	AAA
3	Chief, Primary Care (scheduling, hiring, etc)	BBB
4	CBOC Nurse Manager (scheduling, hiring)	CCC
5	Facility Education Department	DDD
6		

What are we trying to accomplish? Name 1-2 aims that are time-specific and measurable. (Note: this is typically done by the team, but try to define this now as part of the exercise; the whole team must agree on the aim)

	Aim	*What overarching clinical care aims does this support? (safety, effectiveness, efficiency, equity, patient-centeredness, timeliness)?*
1	At least one additional Women's health PCP available at that CBOC All Women's Health PCPs who care for women patients have enough	Equity, patient-centeredness, timeliness
2	patients and training to remain competent	SAME

How will we know that a change is an improvement? List specific, measurable, realistic, time-specific elements you will follow over time to see if the plan is successful.

	Measure	*Goal for measure*
1	Number of designated women's health comprehensive primary care providers Number of women seen by a designated women's health comprehensive primary care provider	minimum of 2 within 6 moths 80% in 6 months
2		
3	Number of providers trained or hired	at least one in 6 months

What changes can we make that will result in an improvement? List a few possible ways/paths to achieve your goals.
Option:
1 train one provider currently in the CBOC

Implementing Institutional Change - Large-Scale Examples

- Identified gap: Low rates of mammogram screening, poor reporting and follow-up
- Multiple changes considered and implemented
  - Worked with vendors
  - Addressed patient factors (bills, awareness)
  - Addressed provider factors (education, performance measures)
  - Addressed all sites (CBOC liaisons, site visits)
  - Worked across system (simplify authorization/payment)
- Outcome: Improved timeliness of reporting and patient satisfaction

Implementing Institutional Change - Large-Scale Examples

- Identified Issue: Large numbers of young women with issues new for VA staff
- Deployment issues (combat exposure, heavy gear, ceramic vests, extreme temperatures)
- Musculoskeletal problems
- Gender-specific concerns
- Mental health concerns

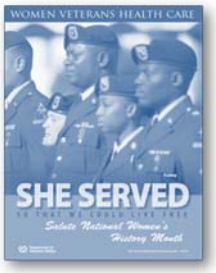
Implementing Institutional Change - Large-Scale Examples

- Selected change: Interdisciplinary Returning Women's Clinic
  - Primary Care
  - Social Work
  - Psychology
  - Gynecology
- Outcome:
  - Increased enrollment
  - Improved patient satisfaction
  - Clinical outcome measures pending

Key Points

- The face of VA is changing
- The system needs to adapt
- Small changes make a big difference
- You can help

Thank you



Authors

Laure Veet, MD
Director, Women's Health Education, Women Veterans SHG, VHACO
Adjunct Associate Professor of Medicine, University of Pennsylvania
Staff Physician, Philadelphia VAMC

Samina Iqbal, MD
Medical Director Women's Health, VA Palo-Alto Health Care System
Senior Consultant, Women Veterans SHG, VHACO

Post-Deployment Care for OEF/OIF/OND Women Veterans

VETERANS HEALTH ADMINISTRATION

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Objectives

- Describe the characteristics of OEF/OIF/OND women Veterans using VA health care
- Address care for deployed women Veterans
- Identify common post-deployment medical and mental health conditions
- Explore methods to assess and facilitate mental and physical health care

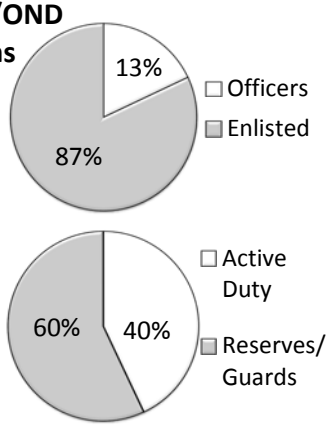
Who are OEF/OIF/OND women Veterans?

OEF/OIF/OND Women Veterans

- Over 324,474 women have served FY02-FY14
- 221,031 have separated from the military
- 137,440 have used VA health care
- 56% < age 34
  82% < age 44

Separated OEF/OIF/OND Women Veterans

Service branch	Percent of women
Army	52%
Air Force	24%
Navy	20%
Marine Corps	4%



Addressing Care for Deployed Veterans

Case Example 1
Jessica

- 24-year-old Marine veteran
- Severe low back and foot pain that developed during deployment
- Boots didn't fit; carried heavy equipment
- Recent episodes of heart pounding, feeling hot and dizzy
- Joined the military after finishing high school
- Raised by her mother

Jessica
(continued)

- Gunner in the military
- Removed bodies of soldiers from rivers
- Exposed to fumes
- Diagnosed with thyroid cancer; medically discharged
- Suppressive doses of levothyroxine

How Does Combat Affect Health?

All wars have similar post-combat health problems

- Physical injuries with residual pain
- Diagnosable mental health conditions
- Unexplained symptoms with general health decline
- Psychosocial distress: marriage/work/social disruption

A good history helps!

- Medical history
- Gynecological history
- Mental and psychosocial health
- Family history
  - Medical conditions
  - Mental health conditions

Pre-Military Life:
Ask about Psychosocial Risk Factors

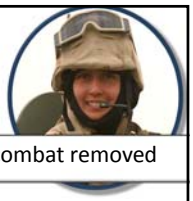
- Living environment
- Supportive relationships
- Significant life events
- Mental health history

Why is It Important to Ask?

Psychologic trauma may impact:

- Psychologic and psychosocial functioning
- Psychiatric morbidity/substance use/self-injury
- Response to psychophysiological disorders (pain)
- Health services utilization
- Long-term physical health

Changing Roles & Exposures



Jan 24, 2013: ban on women serving in combat removed

- Gunners, police, pilots, truck drivers, fuel suppliers
- Exposures
  - IEDs, RPGs, mortars, extreme temperatures
  - Daily operations
    - Equipment, gear, physical activities
    - Facilities, hygiene, health care issues
  - MST

Military History: What to Ask?

Tell me about your experience...

- When and where did you serve?
- What were your duties?
- How has the service affected you?
- Were you exposed to chemicals, fumes, or blasts?

Military History: Follow-up

If yes, ask…*"Would you like to tell me more?"*

- Did you see combat, enemy fire, or casualties?
- Were you or a colleague injured or hospitalized?
- Did you become ill during service?
- Were you a prisoner of war?

Why is It Important to Ask?

- Acknowledge service as part of her life
- Show interest and appreciation of service
- Assess how military service might affect current or future health

You may well break down barriers and reduce stigma to prevent…

- Family breakdown
- Social withdrawal, isolation
- Employment problems
- Alcohol and drug abuse
- Suicide

Common Health Issues for OEF/OIF/OND Women Veterans

Post-Deployment Evaluation Screens

1) GI
2) Fever
3) Skin rashes
4) TBI
5) Embedded fragments

1) PTSD
2) Depression
3) Alcohol use
4) MST
5) Tobacco use

Traumatic Brain Injury (TBI)
The Invisible War Wound

12-20 % of OEF/OIF/OND Veterans	Symptoms	Women
• Women = 5% of cases	• Cognition: *memory, concentration* • Neurological: *Headache, loss of balance, dizziness* • Neurobehavioral: *Sleep, fatigue, irritability*	• Present at higher rate • Symptoms more severe

TBI: *The Invisible War Wound*

Women:

- 30% more likely to have PTSD
- 4x more likely to have substance abuse
- 2.7x more likely to be unemployed
- 7x more likely to be homeless
- Co-morbidities , depression, anxiety, chronic pain complicate diagnosis and treatment

Toxic Embedded Fragments

Exposure to bullet, blast, or explosion	ASK:
• Retained metal or plastic fragments? • Not inert • May be absorbed into blood stream • Local or systemic effects	• Exposed to bullet, blast, explosion? • Embedded fragments? • Documented by radiograph? • Removed? • Remains?

Medical Diagnoses: 132,448 Female OEF/OIF/OND Veterans Seen in VA (2002Q1-2014Q4)

• Musculoskeletal (MSK)	60%
• Mental Disorders	55%
• Nervous System/Sense Organs	49%
• Genitourinary System	44%
• Digestive System	40%
• Respiratory	37%
• Endocrine System	38%
• Skin Diseases	30%
• Injury/Poisoning	30%
• Infectious/Parasitic Diseases	22%

Neurological Conditions in OEF/OIF Women Veterans
2002Q1-2014Q4

Disorders of refraction/ accommodation	25,958
Migraine headaches	23,117
Disorders of ear Hearing loss	16,237 11,969

Digestive System Conditions in OEF/OIF Women Veterans
2002Q1-2014Q4

Dental	21,345
Disorders of the esophagus	18,184
Functional digestive disorders	12,791

Genitourinary Conditions in OEF/OIF Women Veterans
2002Q1-2014Q4

Disorders of menstruation, abn bleeding	21,347
Inflammatory dz of cervix, vagina, vulva	18,620
Other disorders of urethra, urinary tract	17,342
Pain/other symptoms with female genital organs	16,698
Disorders of the breast	9,638

Military Musculoskeletal Injuries

British military study…

- 70-82% of injuries are MSK
  - Most are NON-COMBAT related
  - For women, highest rate during basic training

Geary et al. *Occup Med (London)*, 2002.

Women are 57% more likely to return to duty after an injury than men!

Cohen et al. *Arch Intern Med,* 2009.

Joint disorders	54,866
Back disorders	46,627
Soft tissue disorders	22,864
Cervical region disorders	18,339
Peripheral enthesopathies	14,621
Osteoarthrosis	13,038
Muscle, ligament and fascia	12,127
Synovium, tendon, bursa	10,107
Intervertebral disc disorders	8,423
Internal derangement knee	6,463

Common MSK Injuries in OEF/OIF Women Veterans

(2002Q1 - 2014Q4)

Knee is Most Commonly Injured Joint

1. ACL
2. Meniscus tear
3. Sprains and fractures

9.5% of ACL injuries → permanent disability discharge

Risks for receiving disability discharge due to ACL injury:

- Lower job status, satisfaction, pay grade/rank
- Shorter length of service
- Less education, cigarette smoking, mental stress
- >age 30 at injury (think reservists)

Dunn et al. *J Bone Joint Surg Am,* 2003.

Females Have Higher Risk of ACL Injury

- Environmental: boots not made for women
- Anatomic: increased Q angle
- Possible hormonal influences
- Women land with knee pivot; men like a hinge

Zazulak et al. *Sports Med,* 2006.

When you see a women 10 years post-deployment and she says, "I hurt my knee in training", she probably did

51% of women have radiographic changes of OA **12 years** after an ACL injury

Pain in OEF/OIF/OND Veterans

47% report chronic pain after deployment
- 28% moderate to severe pain

Increasing rates of disability cases in military
- Pain is the primary physical problem affecting soldiers

Chronic pain often begins in basic training
- 25% males and 50% female recruits have at least one injury during basic training

Zambraski A. US Army Research Institute of Environmental Medicine, 2006

Case Example 2
Jenny

- 27-year-old Army reservist
- Concerned about anger
- Grew up in a violent neighborhood
- Saw close friend die in a drive-by shooting days before deployment
- Left husband and 2-yo son for 13-month deployment
- **Upon return from deployment, she and her husband argue frequently**

Common Mental Health Disorders in Female OEF/OIF/OND Veterans: 2002Q1-2014q4

Adjustment reaction (includes PTSD) 48,764	Depressive disorders 42,826
Anxiety, dissociative, mood, somatoform disorders 38,910	Non-dependent substance abuse 26,030

Adjustment Process versus Disorder

Adjustment	Adjustment Disorder
• May be a normal process • Expected and transient stress reaction	• Debilitating reaction to stressor • Distress ≤6 months • Anxiety and/or depression • Disruption in employment, school, relationships • May develop into depression/anxiety disorder

PTSD Rates and Risk Factors Among Women

- 15-17% of OEF/OIF Veterans
- Women 2x as likely to be diagnosed
- Co-morbid substance use, especially binge drinking
- Risky behaviors, suicidal ideation
- Re-victimization
- Presents as medical complaint/psychosocial stressor

Depression and Anxiety in Women

Women 2x as likely be diagnosed with depression

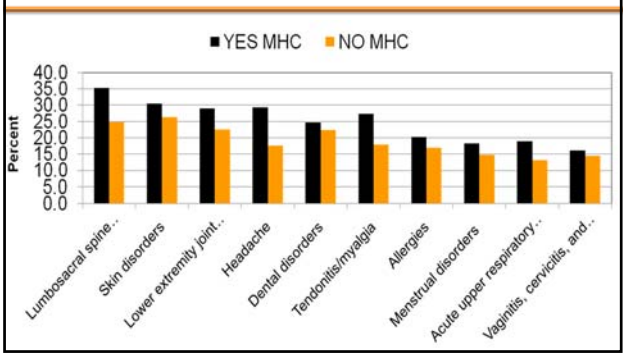
2/3 of patients with GAD are female

Women 2x as likely to be diagnosed with a panic disorder

Eating Disorders (ED)

- 2-3% of men, 5% of women
  - Of 107 women in a VA clinic, 25% binging and 7% purging
- Not primary complaint
- No signs on exam
- Develops at weigh-ins
- Causes dental/GI conditions

Top 10 Medical Conditions in OEF/OIF Women Veterans: By Mental Health Condition (MHC) Status, FY2006-2007



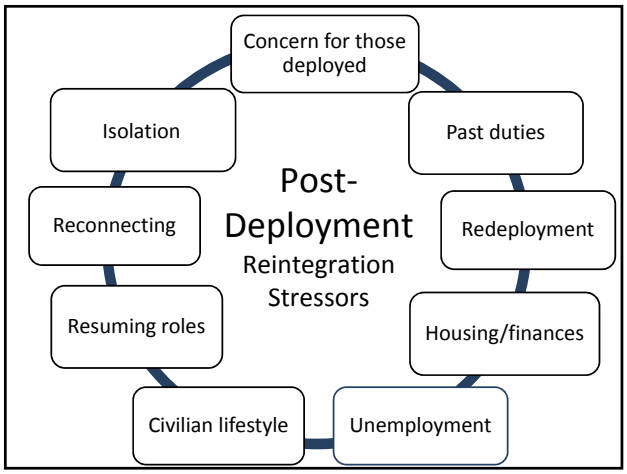
Military Sexual Trauma
FY2014 Data

Of veterans seen at a VA facility and screened for MST by a VA provider…	• 85,003 (25.0%) of women reported MST • 60,599 (1.3%) of men reported MST
Of VA OEF/OIF/OND outpatients screened for MST by a VA provider…	• 16,440 (23.0%) of women reported MST • 4,850 (1.0%) of men reported MST

MST is associated with…

- Increased suicide risk
- Major depression
- PTSD
- Alcohol/drug abuse
- Disrupted social networks
- Occupational difficulties
- Sexual dysfunction
- Asthma
- Breast cancer
- Heart attacks
- Obesity
- Menstrual & pelvic pain
- Somatization

Murdoch et al. *J Gen Intern Med* 2006; Stein & Barrett-Connor. *Psychosom Med* 2000; Frayne et al. *J Womens Health Gend Based Med* 1999; Kimerling et al. *Am J Public Health* 2010.



Addressing Post-Deployment Issues in Primary Care

Patients may first present in primary care.
An important opportunity for…

- Early detection
- Addressing mind and body health
- Risk reduction
- Facilitating referrals

Addressing Mind & Body Health

- Assess for physical symptoms
- Assess for stress-related symptoms
- Discuss risky behaviors & risk reduction
- Include multiple disciplines in care

Skilled and Caring Evaluation

Environment	Undivided attention
Validate concerns	Respect boundaries
Instill hope	Provide next steps

Facilitating a Specialty Care Referral

PACT members can facilitate care coordination

- Follow up on referrals for timely scheduling
- Provide Veterans with VA and non-VA resources
- Keep close follow-up with Veterans
- Keep Veterans informed

Facilitating a Mental Health Referral

1. Patients with MH issues hesitate to seek care
2. Address health behaviors
3. Early treatment before co-morbidities develop
4. Refer to specific provider
5. Arrange specific appointment time
6. Educate on empirically-supported treatment

Addressing Physical Concerns

Musculoskeletal	Headaches	Hearing loss
Skin	Vision	Dental
Respiratory		
Genitourinary	Fatigue /sleep	Gastrointestinal

Addressing Mental Health Concerns

Adjustment disorder	PTSD	Depression
Anxiety	Eating disorder	Opioid dependence/ Coping with pain
Tobacco use	Binge drinking/ Substance abuse	

Addressing Reintegration Concerns

Adjusting to civilian lifestyle	Resuming family roles and responsibilities	Reconnecting
Unemployment	Housing and Finances	Redeployment
Feeling responsible for past duties	Unable to share experiences; feeling alone	Concern for those still deployed

Resources Within VA

OEF/OIF Case Manager	WVPM
MST Coordinator	National Center for PTSD
Vet Centers	Suicide Prevention Coordinator

OEF/OIF/OND Care Management

For transitioning veterans, spouses and eligible family members

Assist	Coordinate	Support
• Planning and problem-solving • Housing, legal, employment, health issues	• Assistance from VA and other agencies • Information and agency referrals	• Attain goals • Regain and maintain self-sufficiency

Authors

Samina Iqbal, MD
VA Palo Alto Health Care System
Palo Alto, CA

Natara Garovoy, PhD, MPH
VA Palo Alto Health Care System, Palo Alto, CA

Barbara Polak, MS, RN
VA Central Office, Washington, DC

Linda Baier Manwell, MS
Univ of Wisconsin General Internal Medicine Madison, WI