INCREASING ACCESS TO CARE AND KNOWLEDGE OF SERVICES FOR WOMEN VETERANS IN THE VETERANS AFFIARS HEALTHCARE SYSTEM

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ABSTRACT

Dakar S. Howell: Increasing Access to Care and Knowledge of Services for Women Veterans in the Veterans Affairs Healthcare System
(Under the Direction of Elaine Brooks Harwood)

Background: Women are the fastest growing population of patients who access the Veterans Health Administration (VHA), within the U.S. Department of Veteran Affairs (VA) for healthcare. The magnitude of this population growth poses several challenges for the historically male-dominated VA healthcare system.

A major barrier to care is WV's lack of knowledge of about gender-specific services available to them within the VHA. This knowledge gap has led to disjointed care and attrition from the Durham Veterans Administration Medical Center (DVAMC). Therefore, a tool that combines and presents all of the resources available to WV is vital in order to improve WV's health and access to VA care.

Objectives: The objectives of this evidence based practice (EBP) quality improvement project was to evaluate the effects of a women's health resource manual (WHRM) for inpatient WV in the DVAMC about the policies and services that are available to meet their needs and increase their access to VA care.

Method: Women Veterans admitted into an inpatient setting were provided with a WHRM, a cover letter with intent to participate form, and two randomly coded questionnaires (pre-intervention and post-intervention). The data sets included responses to the questionnaires. The WV's completed the pre-intervention questionnaire and were allowed adequate time to read the resource manual. Prior to discharge, the WV completed the post intervention questionnaire.

Results: The outcomes of this EBP project improved WV knowledge of gender-specific-services and provided evidence that supports the need to strengthen healthcare providers ability to inform WV about gender-specific services in the VHA system. Evidence also supported increasing the dissemination of the WHRM to increase the WV sense of inclusion in the VA and satisfaction with the gender-specific resources provided it the DVAMC. Descriptive statistics that utilize McNemar's analysis were employed to compare the pre- and post-intervention measures.

Conclusions: The study showed statistical significance in post-questionnaire results about how WV's rate the VA, and the quality of gender-specific services offered by the DVAMC. These results support the need for further research to improve resources for WV and to improve providers ability to inform WV about gender-specific resources offered in through the VA.

To my family. Thank you for your unconditional love and support of my dreams and for staying on the rollercoaster with me. I love you all.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

DNP	Doctor of Nursing Practice
DWHP	Designated Women's Health Provider
DVAMC	Durham Veteran's Administration Medical Center
EBP	Evidence Based Practice
LGBT	Lesbian Gay Bisexual Transgender
OEF/OIF/OND	Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
PI	Primary Investigator
SCT	Social Cognitive Theory
US	United States
VA	US Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WHPC	Women's Health Primary Care
WHRM	Women's Health Resource Manual
WV	Women Veterans

CHAPTER 1: INTRODUCTION

Introduction

Increasing numbers of women are serving in the United States (US) military in the 21st century. Research conducted in July 2016 revealed a total of 214,098 women serving as active duty personnel, with an additional 589,632 serving in the Reserves and National Guard (Statistics Brain, 2016). Women are the fastest growing population of patients who access the Veterans Health Administration (VHA) for healthcare, and these women veterans (WV) have a distinct set of healthcare needs. Since 2009, the average age and numbers of WV who access the VHA for healthcare have increased dramatically and women are projected to comprise 18 percent of the VHA population by 2040 (Brooks, Dailey, Bair, & Shore, J., 2016; deKleijn, M., Largo-Janssen, Canelo, & Yano, 2015).

The rising numbers of women serving in the US armed forces poses several challenges for the historically male-dominated VHA system. The VHA healthcare system must adequately address the increasing numbers of WV who are eligible to access care through the US Department of Veterans Affairs (VA) hospitals and clinics, the shifting age distribution of WV, and ethnically diverse population of WV, and to increase efforts to promote inclusion and culture change in the care of these women (Yano, Haskell, & Hayes, 2014). In 2011 the Women Veterans Task Force was created to assess the needs of WV and develop a plan of action to study the disparities and barriers that impede the care of WV within the VHA system (US Department of Veteran Affairs [USDVA], 2015).

As of 2015, 80 percent of WV are under the age of 65, and 39 percent of them received care in the civilian sector by non-VA providers (Bastian, Mattocks, Rosen, Hamilton, Bean-Mayberry, Sadler, Klap, & Yano, 2015). This dual care system, which was created due to healthcare services being sought outside the VA, causes fragmentation in the delivery of care and contributes to poorer health outcomes for WV (Mattocks, 2015).

The Durham Veterans Administration Medical Center (DVAMC) is a large medical center located in Durham, North Carolina and is a part of the Mid Atlantic Care Network of the Veterans Integrated Service Network (VISN) 6. The VISN coordinates healthcare within a specific region to minimize travel time and cost to veterans. Circa 2005, the DVAMC opened a Women's Health Clinic that had Designated Women's Healthcare (DWHP's) providers on site. Even with the availability of this clinic, barriers that impede WV access to care at the DVAMC are still present. The problem for the DVAMC is the lack of WV's knowledge about the breadth of gender-specific services that are available to them. A cross sectional population-based survey of WV showed that 68 percent of the WV who were surveyed had unmet healthcare needs and that WV attributed this shortfall in healthcare to a lack of knowledge of services and eligibility requirements (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). This knowledge deficit impedes WV's ability to access gender-specific care. A possible cause of this knowledge gap is that women use the VHA based on communication from friends and family instead of from healthcare providers, which leads to inadequate information regarding eligibility requirements and lack of understanding of available services (Wagner, Dichter, & Mattocks, 2015). The significance and impact of this problem on WV who access the VHA nationwide for care have led to decreased inpatient satisfaction rates, decreased use of preventative services, increased

cost to WV, and poor care coordination (Bastian, Tentanlnge, Murphy, Brandt, Bean-Mayberry, Maisel, & Wright, et al. 2014).

Problem Statement

The problem is the lack of WV's knowledge about the breadth of gender-specific services available to them in the DVAMC. A cross-sectional population-based survey of WV showed that 68 percent of the WV who were surveyed had unmet healthcare needs and that WV attributed this shortfall in care to a lack of knowledge about services and eligibility requirements (Washington, Bean-Mayberry, Riopelle, & Yano, 2011).

Outreach efforts to address women's health services have not adequately improved WV's knowledge about services and access to care at the DVMAC and within the VHA system. Women veterans who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) report dissatisfaction with services and little knowledge about available services.

Purpose Statement

The purpose of this project is to provide WV with a resource manual that contains information about eligibility requirements and the gender-specific policies and services available to them within the VISN6 of the Mid-Atlantic Health Care Network Region (Morehead City, Fayetteville, Durham, Salisbury and Greenville, North Carolina) in the VHA system. The expected outcomes of this project are increased WV knowledge about resources and services, increased patient satisfaction, and increased utilization of gender-specific services in the VHA system, specifically at the DVAMC.

Practice Question

Will a Women's Health Resource Manual (WHRM) that is disseminated in the inpatient setting increase WV's knowledge about services, access to care, satisfaction in the VA, sense of inclusion in VA culture, and satisfaction with quality of gender-specific information in the DVAMC?

CHAPTER 2: REVIEW OF LITERATURE

Changing Demographics

In 1865, President Abraham Lincoln established the first National Soldiers and Sailors Asylum to "…care for Him who shall have bore the battle, and for His widow and orphan" (USDVA, 2015). In 1946, the VHA was founded with the purpose of delivering care to the nation's veteran population (USDVA, 2015). At the time, US military veterans were a predominantly male military population, although women had served in the armed forces in roles ranging from nurses to combat service members since the inception of the US military (Planning, 2017).

The current face of military service members represents a dramatic change, with increasing numbers of women enlisting and joining officer ranks. The military's transition to an all volunteer force in 1973 also resulted in a sharp increase in women joining the military (Ganzer, 2016). Currently, the numbers of female active duty and veteran service members is higher than at any point in US history. As new occupational and educational opportunities develop for female service members their numbers will steadily increase, making today's WV population markedly different than its predecessors (Ganzer, 2016).

As OEF/OIF/OND evolve into the longest military conflict sin US history, the influx of WV who have served in these conflicts places great demands on the male-centric VHA healthcare system. Utilization rates for WV age 43 or younger during the 2013 fiscal year stood at 81.3 percent. These younger WV require access to gender-specific services (Office of Public Health, VHA 2014 & Frayne, Phibbs, Saechao, Maisel, Friedman, Finlay, Berg, &

Balasubramanian, et al. 2014). Furthermore, WV seeking healthcare within the VA require specialized care that acknowledges their service, respects their need for privacy, and delivers comprehensive gender-specific care (Frayne, et al. 2014).

The VHA's efforts are focused on implementing and improving gender-specific data collection and improving Health Effectiveness Data and Information Set scores (Frayne et al. 2014). A study initiated by the VHA that relates to gender and utilization of services by WV showed that WV are more likely than male veterans to have a service-connected disability and that they require 11.8 percent more outpatient healthcare visits than men (Frayne, et. al 2014).

Standards of Care

The Women Veterans Health Program was created in 1988 and renamed the Women's Health Services in 2012 to highlight the VA's efforts to implement comprehensive gender-specific primary care and continuity of care and between VA and non-VA healthcare providers (Ganzer, 2016). The previous model of VHA women's healthcare outsourced reproductive – related care to non-VA providers, which resulted in disjointed care (Ganzer, 2016). The current model of care includes Patient Aligned Care Teams to deliver interdisciplinary care and provide communication among providers within the VA and the private sector (Ganzer, 2016).

As the VHA began increasingly acknowledging the demographic trends that pointed to the need for gender-specific utilization and the provision of the VA healthcare system, concurrent national policy changes emerged that mandated each VA facility to designate a Women's Health Program Manager. The roles of the Women's Health Program Manager are to coordinate high quality, comprehensive care and work to improve gender-specific care, resources, facilities, and workforce to make healthcare more accessible for WV (Washington, Farmer, Mor, Canning, & Yano, 2015). Furthermore, WV enrolled in the VHA must be assigned

to a Designated Women's Health Primary Care Provider who is proficient in women's health, engaged in health promotion and maintenance, and focused on dignity and gender-specific needs (Washington et al, 2015).

The VHA is striving to surpass gold standards of care for all veterans and continues to implement national policies and initiatives specifically to promote culture change and inclusion for WV. The VHA's mission is to provide comprehensive care and customer service that exceeds private sector care by maintaining a healthcare environment where staff members are courteous, patient preferences are respected, and care is coordinated, accessible, and convenient. The VHA culture change campaign strives to promote an environment of care where WV feel acknowledged and entitled to receive the same care and benefits as their male counterparts receive (Ganzer, 2014). In 2013, the VHA launched a Women Veterans Call Center Hotline to increase enrollment of WV in the VHA and to increase access to benefits provided to all veterans (United States Department of Veterans Affairs, 2010). The VHA's women's healthcare policy places an emphasis on more accessible clinic hours, maternity care coordination, trauma-informed care competency, telehealth, reproductive health, mental health, and homeless veteran services (VHA Handbook 1330.01, 2010). The Health Effectiveness Data and Information Set measures indicate the VA is equipped and striving to improve the privacy, safety, dignity and sensitivity to gender-specific needs of this rapidly growing population (Frayne et al., 2014).

Barriers to Care at the System Level

Women have not been afforded the same status as men in the US military, which manifests in gender disparities in healthcare, promotions, sexual assault, and transitioning to civilian employment. In 1980, WV who served in World War II were granted veteran status by the US Congress. In 1983, Public Law 98-160 mandated that the VHA establish an Advisory

Committee on Women Veterans, as they were not adequately educated about benefits for which they were eligible for according to the law (Veterans 2010). Prior to the enactment of this legislation, WV did not have equal access to benefits and care. The VHA system did not have the infrastructure to manage the increased burden of WV and their specific healthcare needs. Despite the new law, the VHA system lacked providers who were educated in women's health and gender-specific care. This deficiency resulted in unmet healthcare needs for WV throughout the system (United States Department of Veterans Affairs, 2010). In 1992, the Veterans Health Care Act (Public Law 103-585 Title I) authorized the VHA to administer gender-specific care, reproductive services, and to treat sexual trauma that occurred while serving in during active duty (VHA Handbook 1330.01, 2010).

In recent years, there have been multiple stories have appeared in national and local media regarding the lack of access to care, organizational, and demographic barriers, and negative perceptions of the VA healthcare system that impede WV's access to care. For example, in September 2017, the DVAMC was highlighted on a local news station, WRAL in Raleigh, North Carolina, a regarding a veteran who refused to leave the VA facility after being discharged from the inpatient setting to an assisted living facility. The veteran wanted to remain at the DVAMC and receive care in the Community Living Center. He refused to leave the medical campus due to financial concerns, stating "They had the right to send me to Vietnam to screw me up and then they're going to have the right to throw me out of here too…" (Browder, 2017). Such negative perceptions of care delivered to WV in the VHA system directly impact levels of utilization and satisfaction with services. Factors associated with negative perceptions and low satisfaction scores include systems, organizational, and demographic barriers.

Organizational Barriers

Organizational barriers include lack of knowledge about DWHP's, comprehensive women's health preventative services, and privacy and safety within clinic and hospital spaces (Bastian et al., 2015). VA facilities that have gender-specific care provided by DWHP's yielded higher rates of patient satisfaction and positive perceptions of VA care compared with those VA facilities that did not (Wagner et al. 2015 & Bastian et al. 2014). These findings support the need for the VHA system to expand its outreach, education, and methods to enroll more WV in the healthcare system. The VA has initiatives underway to increase access to care and remove barriers to care for WV, including after-hour clinic availability, childcare services, pharmacy services by mail-order or online, gender-specific training sessions, mini-residency education for staff, and state-of-the-art healthcare equipment and technology.

Studies conducted across the VHA system suggest several areas for future research to highlight knowledge gaps related to women's healthcare and to improve WV's experiences at VA facilities (Carter, Borrero, Wessel, Washington, Bean-Mayberry, & Corbeli, 2016). Research findings suggest that the VA should implement outreach campaigns for WV with a focus on education, training, policy, and EBP interventions for healthcare teams. Also, a health system culture change plan needs to be implemented to educate providers to be more receptive to the unique needs of the WV population and to dispel assumptions/prejudices about women in the military. For example, sometimes WV are reluctant to self-identify as veterans and report that their service is considered 'less valuable' than that of their male counterparts (Frances, & Hans, 2016). Healthcare providers unconscious biases may lead them to that assume women in waiting rooms are the spouses of the veteran. These unconscious biases within the VHA system reinforce feelings of isolation and devalue the sacrifices and contributions of WV. Unconscious

perception biases lead providers to make decisions based on stereotypes and cultural norms that disenfranchise certain groups (McCormick, 2015). Addressing these actions with awareness training and cultural change campaigns can increase enrollment and increase inclusion among WV and decrease WV attrition rates and use of non-VA services.

Barriers to Care at the Provider Level

Prior to 2008, healthcare providers at all levels who worked in the VA system did not receive any continuing education in women's health (Frayne et al., 2015). In the VHA Barriers to Care study, WV indicated in the VHA Barriers to Care study that providers were not knowledgeable about their needs as veterans or as women. The study also found that healthcare providers did not receive respect from staff, or adequate information regarding services were not provided, and did not have adequate time to discuss concerns when seeing patients in the VA system (Frayne et al., 2015). The study also showed that, among WV aged 18to 44 years, satisfaction with healthcare providers decreased, but the inverse was found among WV aged 60 to 80 years (Frayne et al., 2015). The results of the Frayne et al. (2015) study suggest that the needs of younger WV were not being met and is led WV to seek care in the civilian sector.

In addition, military and VA culture can lead nurses and providers to assume that veterans are men (Wagner et al., 2015). Providers' stereotypical attitudes and perceptions can lead to disregard for women's sacrifices and military service. Women veterans need to feel welcomed at the VHA and their service must be acknowledged within VA healthcare facilities. If healthcare providers cannot address problems adequately or suggest possible interventions, then their impact on WV's health outcomes can cause downstream effects in the health of WV.

Nurses are the largest group of healthcare providers that interact with WV and they should be equipped with the education and resources to serve as advocates for WV and actively

participate in their healthcare. Nurses need to be proficient in in delivering women's health education and promoting positive relationships between WV and the healthcare system. Nurses need to support the development of a welcoming environment using resources, greetings, and images with which WV can identify.

Barriers to Care at the Patient Level

Despite legislation and advancements in healthcare services, barriers to healthcare for WV are evident at every level. According to the Women's Health Services Study of Barriers for Women Veterans to VA Health Care Final Report (2015), the nine patient-level barriers to healthcare for WV include lack of knowledge and misperceptions about eligibility and available services, inadequate outreach to address women's health services, long driving distances and inadequate hours of operation in medical center clinics, lack of childcare, acceptability of integrated care, lack of gender sensitivity, mental health stigma, and lack of safety and comfort (USDVA, 2015). Patterns of utilization of VHA healthcare also indicate that WV's rely on information from relatives, friends, and the media for their information regarding VA care. Media attention about VHA care does little to dispel the assumptions about healthcare for all veterans throughout the VA system, including WV. Consequently, many WV utilize non-VA healthcare to meet their needs for gender-specific care (Wagner et al. 2015). This lack of utilization due to lack of knowledge regarding availability of services for WV indicates a need for the VA to create a culture change initiative and improve policies to increase WV's knowledge about services, benefits, and programs that are available in the VHA system.

Several studies have identified significant deficits in knowledge about benefits and services offered to WV by the VA. Participants in a cross-sectional population based survey of WV revealed a lack of knowledge about WV's program managers and benefit coordinators

(Washington et al. 2015). The study showed that the major reason for WV did not utilize the VHA for healthcare was their lack of understanding about the process of applying for benefits, the documents that were needed to enroll, and the online or in-person options that were available. The 2015 study from the National Survey of Women Veterans found that 51 percent of WV of reproductive age, ranging from 18 to 44 years, stated that they believed they were ineligible to receive care at the VA (Washington et al., 2015). The study further revealed that WV who did not utilize the VHA for care did not have a primary care physician and had the worst perceptions of the VHA (Washington et al., 2015).

In a study conducted with WV in rural areas, focus group participants in five states voiced their frustration with trying to understanding VA benefits and their inability to navigate the VA healthcare system (Brooks, Dailey, Bair, & Shore, 2016). The same study also showed that medical technology solutions, such as telehealth to access care in more rural areas were not preferred over in-person women's healthcare (Brooks et al., 2016). Rural WV felt isolated from their fellow female service members and lacked peer support and the ability to receive VA-related communications (Brooks et al., 2016).

Social Determinants of health that affect negative perceptions of the care of WV in the VA system include patients of a young age (18-44 years), poor health status, and higher educational levels. Wagner and colleagues (2015) found that younger patients experienced higher levels of dissatisfaction due to long wait times and poor communication with providers regarding healthcare decision making than older patients (Wagner et al. 2015). Younger WV value time with providers and coordinated care, and prefer communication that includes them as partners in care. Additionally, WV's perceptions are guided and shaped by personal experience and contact within the VA system. Women who reported poor gender-sensitive care where

women feel outnumbered and unacknowledged, emphasized a need for a culture change within the VA (Washington, et al., 2015). The negative perceptions of the unavailability of gender-specific care are also determinants in delayed care and unmet medical needs. The VA collects data through the Consumer Assessment of Healthcare Providers and Systems and the Survey of Healthcare Experiences of Patients. The results from these surveys indicate that women scored their experiences low for the measure 'getting needed care' (Bastian et. al 2014).

Current Policy Related to LGBT Care

In 2011, the VHA established policy regarding the delivery of healthcare to transgender and intersex veterans. The policy states that sex reassignment surgery is not funded by the VHA, however, intersex and transgender veterans can receive hormonal therapy, mental healthcare, and medically necessary post-operative care following sex reassignment surgery (VHA Directive 2013-003). Transgender veterans are provided the same care that all veterans receive in the VHA without fear or discrimination. The VHA is a lesbian gay bisexual transgender (LGBT) positive healthcare environment, enforces a zero-tolerance policy for harassment, and mandates annual diversity training for all staff (VHA Directive 2013-003). Women veterans who identify as LGBT receive gender-specific women's health services from DWHPs. Due to the complexities associated with providing healthcare to LGBT patients, each VA hospital has an LGBT coordinator to provide education and information regarding programs, health maintenance, and inclusiveness.

Policies Related to Gender-Specific Care

In 2010 the VHA women's health service implemented an intimate personal violence policy that mandates the use of a routine the extended-hurts/insult/threatens/scream (E-HITS) screening tool for all WV who access the VA for care (VHA Directive 2010-014). VHA

Directive 2010-014 mandates that all settings have action plans to manage the treatment of violence, abuse, and sexual assault.

The VHA Handbook 1330.30 summarizes the maternity healthcare and coordination policy that establishes standards of care including prenatal diagnostics, breastfeeding and lactation support, childbirth and parenting classes, post-partum care, and newborn services (VHA Handbook 1330.30). To further enhance the delivery of reproductive healthcare, each VA hospital has a maternity care coordinator to serve as a liaison between VA and non-VA healthcare providers to ensure community resources and to facilitate continuity of care.

In 2009, the VHA privacy policy mandated that privacy curtains be installed in outpatient areas, all medical unit bathrooms doors have locks, baby changing tables are installed in family bathrooms, and there are pajamas and robes in various sizes are available specifically for WV (VHA Handbook 1330.30). The policy provides the standard operating procedures for protecting the dignity and overall quality of care delivered to WV.

These gender-specific policies are the infrastructure of the WV healthcare services and ensure that care delivered in the VHA system is sensitive to the unique needs of WV; however, these policies do not address WV's knowledge deficit concerning resources and services and the barriers that hamper and delay access to care. A strategic plan that collaborates with community Veteran Service Organizations, addresses outreach, explores new ways to decrease attrition from the VA, and informs WV of their eligibility for services will improve access to care and enrollment in gender-specific services.

Current Efforts to Close the Gap

To determine the effectiveness of legislation, policy changes, research, and quality improvement efforts the Women's Health Strategic Health Care Group is collaborating with the

Department of Defense to develop educational materials to educate VA healthcare providers and staff system-wide about the appropriate care and needs of WV (deKleijn, Largo-Janssen, Canelo, & Yano, 2015). Mini-residencies that consist of comprehensive training in multidisciplinary approaches to reproductive health, maternity and newborn care, healthy aging, mental health, emergency services, contraception and preconception care, and prescribing safe medication are mandatory for DWHP's. This training and these competencies are to essential to providing a high-quality workforce of clinicians that can provide gender-specific care and to increasing provider sensitivity regarding combat informed care (deKlejin et al., 2015). To close the knowledge gap, the VA is building infrastructure to incorporate research conducted in the area of WV healthcare to ensure that the needs of WV are equally represented to reduce healthcare disparities and improve access to care (Carter, et al., 2016).

Summary

Women veterans face challenges and obstacles during military service and during the transition to civilian life that male service members do not experience. According to Frayne et al., (2014), 57 percent of WV had a service-connected disability that occurred during military service. To retain these WV who come to the VHA for care, the organization and providers must value the service and sacrifices of women in the armed forces. Women veterans deserve for the VHA to deliver gender-specific care and mental health services in an environment where dignity, respect, and safety are at the forefront.

In 2013, 12 percent of WV who utilized VHA services were aged 65 or older. As the WV population continues to increase and as WV age, their needs and levels of care continuously evolve and emphasis must be placed on methods to increase WV's knowledge of services, access to care, benefits, and enrollment in women's health services through the VA system. Several

studies support future research into women's health and educational interventions to decrease disparities and barriers to care at the patient, provider, and organizational levels. The VHA must be proactive and prioritize women's healthcare and move toward a care system that educates and empowers WV to optimize their health and to utilize the VA resources and benefits they earned through their service.

CHAPTER THREE: THEORETICAL FRAMEWORK

Plan-Do-Study-Act Framework

The Plan-Do-Study-Act (PDSA) model for quality improvement was developed in the 1920's by physicist Walter Shewart to improve the quality of the Western Electric Company's production of telephone technology (Best & Neuhauser, 2006). Shewart proposed a theory called the 'Shewart Cycle' to integrate the deductive reasoning in the scientific method and inductive reasoning in probabilities and statistics to reduce variation, improve process, and increase efficiency (Crowl, Sharma, Sorge, & Sorensen, 2015). The Shewart cycle was developed further by W. Edwards Deming and reintroduced as 'Plan-Do-Study-Act' and utilized as a method for continuous quality improvement of products, processes, and services. Although the PDSA method was utilized originally in business and manufacturing, it has been adopted into the healthcare setting as a practical framework to improve process and healthcare outcomes (Best & Neuhauser, 2006).

The PDSA cycle is a data-driven process that has been utilized to improve the effectiveness of quality improvement initiatives in healthcare settings by piloting small studies, gathering data to assess the impact of interventions, and rapidly adapting to modify the procedures to optimize goals and outcomes (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2013). This model of quality improvement allows healthcare organizations to understand the variation that occurs within their organizations on a small scale and affords them the opportunity to adapt, reduce risk and harm to patients, and acquire feedback from staff and stakeholders to improve the process (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2013).

Research suggests that the VHA should invest in educational resources to decrease disparities and barriers to care and to optimize the health of WV (Frayne et al., 2014). The PDSA model is an appropriate framework for the implementation of projects to improve the availability of gender-specific resources, reduce attrition of WV from the VA, and improve the culture of care for WV in the VHA healthcare system. The PDSA model can aid in enhancing the content and quality of resources when implementing a WHRM and decrease organizational barriers that impede closing the health equity gap for WV through cyclic analysis of data to reduce waste and improve access to gender-specific care.

Main Constructs of Plan-Do-Study-Act

The PDSA model is a dynamic cyclical process that consists of four steps. During the initial step, 'Plan', a problem is identified, a prediction is made regarding the outcome of an intervention, metrics and benchmarks are established for data collection, stakeholders are identified, and clear roles and responsibilities are defined (Morelli, 2016). This planning phase consists of identifying the setting in which the test will occur in and allocating resources necessary for effective implementation (Morelli, 2016). During the second step, 'Do', the project is implemented on a small scale or with a small sample of participants. The problems, unexpected observations, and variations are identified through continuous monitoring, and data are collected. During the third step in the cycle, 'Study', data are analyzed and compared to the predicted impact in the 'Plan' phase. The results of the 'Study' analysis determine the information that was learned and the data sets that support the plan (Crowl, Sharma, Sorge, & Sorensen, 2015). The data also are used to identify variations that could erode the quality of the change, reveals if the change is sustainable and effective, and reveals unexpected costs or waste. The 'Study' phase also gives the team an opportunity to reflect on information learned in the

process of conducting the improvement effort and allows teams to increase the efficiency of the implementation process (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2014). During the final step in the cycle, 'Act', the observations, variations, and areas of improvement identified in the 'Study' phase are placed into an action plan to begin the next cycle of the PDSA model. Each cycle of the PDSA model links to the next and documents the spread of the change and adaptive strategies used to improve processes (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2014). Thus, the PDSA model is a continual process to determine if an initiative should be continued on a larger scale, removed, or improved (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2014).

Applicability of Plan-Do-Study-Act Model to this Project

The continued lapse in the provision of resources and information to WV regarding gender-specific care at the DVAMC is the focus of the targeted intervention proposed for this project. The practical application of the PDSA model, with the integration of the tools developed for this Doctor of Nursing Practice (DNP) project regarding the spectrum of gender-specific care available at VA facilities, will inform both WV and their healthcare providers and lead to an increase in access to care, inclusion, and enrollment in women's health services.

The PDSA model provides a framework to aid in the successful intervention of the WHRM developed in this project. The model is the foundation to ensure that the information contained in the developed WHRM is relevant and that it meets the needs of the WV. The model supports this intervention with collaborative and action-based learning to ensure that WV receive the education and access to the care they require to improve their health.

CHAPTER FOUR: METHODOLOGY

Project Overview

The VA has initiatives underway to increase WV's access to care and to remove barriers at the organizational level, healthcare system level, and provider level. Studies suggest several areas for future research to highlight knowledge gaps in women's health and improve veterans' experiences (Carter et al., 2016). Research suggests that the VA needs to implement outreach campaigns for WV and focus on education, training, policy, and EBP interventions for providers and staff (Carter et al., 2016).

Currently, no WHRM is available in the Durham, Fayetteville, Salisbury, or Asheville VAMC's. The WHRM developed for this project contains resources and phone numbers for the VISN 6 region of North Carolina and highlights the DVAMC. This manual is intended to help increase enrollment of WV in VHA services and decrease attrition and use of non-VA services.

Project Design

This project was designed to identify and describe gaps in WV's knowledge of available resources in the VHA system and is not original research. The study design for this EBP quality improvement project is descriptive. The project was descriptive to identify and describe the impacts of a patient education tool designed to improve WV's knowledge of the availability of gender-specific care at the DVAMC (Hulley, Cummings, Browder, Grady, & Newman, 2013). The tool that was developed to describe this knowledge gap and identify resources, content, and information that WV desire and need is a WHRM. This manual includes information about the breadth of comprehensive services available to WV, such as, DWHP's, reproductive family

planning services, mental health services, homeless support services, and military sexual trauma services. The developed WHRM can serve as an intervention to address the culture at the VA and to provide tailored resources for patients and nurses about the policies and services available to meet the needs of female veterans. During the implementation period of this study, the developed WHRM was provided to every female veteran who accessed the DVAMC through inpatient hospitalization and who met inclusion criteria.

Recruitment

Subjects recruited for this project consisted of a convenience sample of WV admitted to designated DVAMC inpatient units. The primary investigator (PI) provided a WHRM to each female veteran who was admitted to the designated inpatient unit along with a cover letter, intent to participate form, and two randomly coded questionnaire forms, one for pre-intervention and one for post-intervention, as well as a self-addressed, stamped envelope.

Inclusion criteria

Inclusion criteria were WV who received care in the VISN 6 healthcare network of the DVAMC and who were eligible for VHA healthcare. Women veterans of any age, race, ethnicity, and with any length of military service who were admitted to the inpatient setting were eligible to participate in the study. Participants were required to be alert and oriented and mentally competent to make decisions concerning their medical care.

Exclusion criteria

Exclusion criteria were unconscious patients, WV who were disoriented, patients unable to make their own medical decisions, involuntarily committed and/or admitted to the mental health inpatient setting.

Procedures

A targeted sample size of 20 WV was deemed to be sufficient to inform the project. Project implementation occurred over two weeks. The project PI met each female veteran who was admitted to the inpatient setting, discussed the project with the patient, and obtained a letter of intent from the patient to participate in the project.

The WV were asked to complete a randomly coded pre-intervention questionnaire and then allowed 12 to 24 hours to read the WHRM. The pre-intervention questionnaire was sealed in the VA envelope and collected by the PI. After 24 hours or prior to discharge, each participant completed the randomly coded post-intervention questionnaire, sealed it in the envelope, and returned the envelope to the PI. In the event the veteran did not complete the post-questionnaire at discharge, they were afforded the convenience to return it free of charge via the United States Postal Service (USPS) in the VA postage paid envelope to minimize non-responses.

Data Collection Instruments

Data were collected utilizing two questionnaire forms with responses based on a Likert scale of 1to 5, and close ended questions ranging from 1 to 2, and open-ended questions. The questions assessed WV's knowledge of resources and support programs at the DVAMC and the usefulness of the WHRM. The pre-questionnaire included four questions on a 5-point Likert scale (not knowledgeable, slightly knowledgeable, somewhat knowledgeable, moderately knowledgeable, and extremely knowledgeable) and nine close-ended questions that assessed the avenues that WV utilized to access services at the DVAMC. Potential total scores for the pre-questionnaire ranged from 12 to 33 (highest rating). The post- questionnaire consisted of six questions on a Likert scale, seven closed-ended questions, and one open-ended question that assessed potential additional items to include in the WHRM. The potential total scores of the

post-questionnaire ranged from 13 to 44 (highest rating). The cover letter, questionnaires, and WHRM are provided in the Appendices.

Data Collection Strengths and Limitations

The pre- and post-questionnaires contained open-ended questions that gleaned information from the participants and allowed them to described their opinions in their own words (Hulley, Cummings, Browder, Grady, & Newman, 2013). A strength of the data collection process was that these responses provided the PI with valuable information about the content the participants would like in a WHRM. However, a disadvantage of open-ended questions is that they required the PI to utilize subjective methods to analyze responses and required more of the participants' time to answer (Hulley, Cummings, Browder, Grady, & Newman, 2013).

The responses given on a Likert scale, quantified the behavior, attitudes, and quality domains assessed in the study. The close-ended questions were quickly and easily answered by participants, which is a strength of the project. A limitation is that these questions can be leading and not exhaustive of all possibilities (Hulley, Cummings, Browder, Grady, & Newman, 2013).

Other strengths of the data collection process included that the administration of the paper questionnaires was inexpensive, involved limited error, and was efficient for the timeframe of the project implementation. A limitation to the administration of paper questionnaires, however, was the loss of time in manually answering the questions and an increase in error in marking answers or skipped questions (Hulley, Cummings, Browder, Grady, & Newman, 2013). Computer and electronic questionnaires are more efficient and cost less than paper questionnaires. Electronic questionnaires would have limited errors in marking answers and skipped questions and would have reduced the paper and supply costs for the project. Electronic questionnaires also would have increased the ease of use for patients who had difficulty with

dexterity or vision. Electronic questionnaires were not utilized in this project due to time constraints in the implementation phase and waiting for institutional review board approval.

Data Analysis

The data were analyzed to discern themes in the open-ended questions, as presented in the summary tables 1 to 20. The Likert scale and closed-ended responses were analyzed using descriptive statistics, such as means, standard deviations, averages, McNemars $\chi 2$ test, frequency charts, and descriptive survey charts (Bonnel, & Smith, 2014).

McNemar's $\chi 2$ test is a statistical test that compares matched pairs of data and can be utilized with data sets that are repeated in the same experimental test (Eliasziw, & Donner, 1991). McNemar's $\chi 2$ test is sensitive to the proportion of positive and negative cases and, when combined with the chi-square ($\chi 2$) test, the results indicate a test of common performance (Trajman, & Luiz, 2008). A *p*-value that is below .005 is statistically significant, indicating that a variable is significant for that measure (Trajman, & Luiz, 2008).

Human Subjects Consideration

Subjects who agreed to participate in the project were informed about the project and given a letter of intent to participate at the initial encounter. Each subject was a volunteer, and no financial compensation for participation was offered. The PI discussed possible benefits of participation and explained the expected outcomes at the initial encounter. The PI explained that the primary aim of the study was explained to be improve WV's knowledge of resources available to WV within the VA system. The minimal risks to the project participants were the time commitment required to complete the pre- and post-intervention questionnaires and to read the WHRM.

To minimize breaches of confidentiality, the only patient data obtained were age (excluding date of birth), branch of service, and years of service. The data were collected and stored on the PI's computer and kept separate from the VA electronic medical records. No confidential information was requested from, contained in, or recorded from on the pre- or post-questionnaires. Prior to implementation the PI created and assigned random codes that linked the pre- and post-questionnaires for data analysis. The data were stored in a secure location with the project chair at The University of North Carolina at Chapel Hill School of Nursing and will be maintained there for a period of three years.

Setting

The DVAMC is a tertiary care teaching and research facility associated with Duke University School of Medicine. The DVAMC provides general and specialized medical, surgical, and psychiatric inpatient and ambulatory care. The DVAMC has four medical-surgical units, three intensive care units, two psychiatric care units, and an emergency department. Women veterans who are eligible for care in the VA system can be admitted to any of the hospital's inpatient units.

Key Stakeholders

The VISN 6 Women's Health Coordinator and the Women's Health Program Manager at the DVAMC assisted with guiding the content of the intervention and were invested in the process of change. The nurse managers for four inpatient units supported the project and allowed their units to pilot-test the WHRM. In order to promote support for the project intervention, the PI attended monthly meetings with the Women's Health Program Manager and stakeholders in the DVAMC system, including meetings of the Women's Health Committee, Information Technology, Nursing Education, VA Education, Reproductions, and the Nurse Managers.

Cost

The VA Medical Media Department and Reproductions Department provided color printing of all posters that were used to promote this DNP project, the WHRM, and the surveys needed to implement the project. No outside funding or costs, other than for the PI's time and travel, were incurred in the implementation of this DNP project.

Strengths

Currently, the Durham, Fayetteville, Salisbury, and Asheville VAMC do not have a WHRM. The developed WHRM contains resources and phone numbers for the VISN 6 region of North Carolina, highlighting the DVAMC. This resource can be distributed electronically to the community-based outreach clinics within VISN 6 to provide information about access to care to a broad and rural population of WV.

Resources for women's health were difficult to find at the DVAMC and are not readily available in inpatient units, thus contributing to an increased demand for a WHRM. Currently, staff must call Women's Health Services to obtain resources, policy information, and practice guidelines regarding the care and treatment of WV. Women's health information is also inaccessible for those without Internet or computer access, and navigating the VA website has been difficult for some veterans. According to the VA Barriers to Care Study, WV prefer resources to be in the form of brochures and handouts and to be given out very frequently (2015). The developed WHRM serves as an immediate resource that can be used by VA staff to educate WV regarding the available resources while concurrently allowing nurses to maximize their nurse-patient relationships.

Sustainability

The WHRM developed in this DNP project is gender-specific, concise, and formatted in a manner that can be reproduced in and for any VA facility. The WHRM has been added as a document on the VA's VISN6 Intranet on the Women's Health SharePoint website to be accessible to all VISN6 VA hospitals. The WHRM has adaptability and can be tailored to fit the services in any VA setting. The dissemination of the manual can be documented easily by healthcare staff in women's health inpatient assessment and education care plan notes in the electronic medical records.

The developed WHRM also can be utilized at The University of North Carolina at Chapel Hill in the Carolina Veteran Resource Center, which opened on the University's campus in September 2017. This resource manual can serve as a resource to support the University's veteran population and aid in connecting veterans with the local VHA system. The WHRM affirms WV and further reaffirms that their service in the US armed forces matters and they are valuable members of the VA system.

Theoretical Framework that Supports Sustainability of the Project: Social Cognitive Theory

Social cognitive theory (SCT) is rooted in traditional behavioral learning theory and was developed by psychologist Albert Bandura in the 1970's (Luszczynska, & Schwarzer, 2005). Bandura first proposed this theory as 'social learning theory' and it became known as 'social cognitive theory' in the 1980s when the concept of self-efficacy was introduced (LaMorte, 2016). The key concepts of SCT include that learning is a cognitive process that takes place within a social context through observation, interaction with environmental and cultural influences, modeling, reciprocal determinism, self-control, goal setting, and self-efficacy (Bandura, 2001). In addition**,** SCT suggests that its key concepts determine the specific behaviors

a person will engage in, and the reasons for engaging in that behavior. The goals of these concepts are to achieve behaviors that continue over time (LaMorte, 2016). This theory explains ways of changing and altering behavior in response to observation and social modeling (Bandura, 2005).

In nursing practice settings, SCT has been utilized in nursing practice settings to facilitate new learning, change attitudes and behavior, and improve methods of teaching so behaviors are retained (Godin, Bélanger-Gravel, Eccles, & Grimshaw, 2008). The theory's constructs have been utilized in healthcare to change organizational behavior and create a culture that supports diversity and inclusion (Butts, & Rich, 2015). SCT is a dynamic theory that allows the learner to be self-reflective and regulatory. The principles offered in SCT, when applied, help learners increase their level of confidence in their ability to change their behaviors positively and improve outcomes (Bandura, 2001). Thus, for this study, these learned behaviors can significantly impact clinical patient relationships, the education delivered during inpatient stays, and WV's decision-making processes to assess the VA for care.

A significant barrier to effective care of WV in the VHA system that has been identified in the literature is the failure of healthcare providers, both physicians and nurses, to educate WV adequately about their eligibility for comprehensive gender-specific services (Zephyrin, Katon, Hogga, Balasubramanian, Saechao, Frayne, Mattocks, & Feibus et al., 2014). This barrier to care is influenced by the nurses and physicians in terms of gender roles, modeled behaviors by preceptors, more experienced nurses, attending physicians, and the male centric culture of the healthcare organization. These learned behaviors, such as disregarding combat related stress, inadequately addressing treating pain, and not informing WV of gender-specific services,

significantly impact patient relationships, the education delivered during both inpatient and outpatient visits to the VA, and WV's decision- making processes to access the VA for care.

Another barrier to effective gender-specific care in the VHA is WV's lack of knowledge about their eligibility for and availability of services within the VHA (USDVA, 2015). The primary focus of this project is to ensure that all WV who are eligible for care in the DVAMC are knowledgeable about the services and care available at this facility, with hope for future dissemination of the WHRM throughout the VHA. Eligibility for care in the VHA is complex and is not be addressed in this study. Each subject in the study already was determined to be eligible for care in the VHA.

Main Constructs of Social Cognitive Theory

The goal of SCT is to change behavior and reinforce desired behaviors that can be maintained long-term (LaMorte, 2016). The six key constructs of Bandura's current model of SCT are reciprocal determinism, behavioral capability, observational learning, reinforcement, expectations, and self-efficacy (LaMorte, 2016).

The interactions between people, changes in the environment, and observed modeling behavior are referred to as 'reciprocal determinism'. Reciprocal determinism is important in understanding how social environments affect health-related behaviors. This construct explains how individuals adjust their behavior by observing other individuals and society as a whole (Bandura, 2002). When nurses and physicians see role models succeed by exhibiting certain behaviors, they believe they have the capacity to do so as well (Bandura, 2004). Behavioral capability is the actual ability to perform a certain behavior with baseline knowledge about the means to perform that behavior. In order to perform any behavior a person must first know how to perform that behavior (LaMorte, 2016). Observational learning is the basis for modeling

behavior and is based on the assertion that people model the behavior and actions they observe in others. This phenomenon is particularly true of the observation of positive or successful behaviors. Such behaviors allow observers to believe they are capable of performing any behavior once they observe another person successfully engage in a certain behavior (LaMorte, 2016). The reinforcement construct targets how a response to a behavior affects the likelihood of long-term engagement in that particular behavior. The reinforcement can be internal or external responses, negative or positive, and can have a significant impact on a person's perception of their ability to continue any given behavior (LaMorte, 2016). Expectations are a person's perception of the consequences of a behavior. People make decisions about engaging in a behavior by anticipating the consequences, which is based on past experience. Expectations that are based on an individual's personal experience are subjective and place value on the outcome of a behavior (LaMorte, 2016). The construct of self-efficacy is defined as the individuals' belief about their capabilities to influence events in their lives. Self-efficacy influences people's cognitive, motivational, affective, and selective processes (Bandura, 1989). Self-efficacy is the level of resilience a person has in his/her ability to maintain a behavior change, such as following new guidelines, adhering to policies, and adopting practice changes (Bandura, 2004). High levels of self-efficacy lead to long-term change by allowing people to be empowered and have a sense of control (Luszczynska, & Schwarzer, 2005).

Applicability of Social Cognitive Theory to This Project

Social cognitive theory is one of the most common behavioral change theories used in healthcare (Bandura, 2000; Tougas, Hayden, McGrath, Huguet, & Rozario, 2015). Applicability to this DNP project affirms that the theory emphasizes the importance of responsibility of healthcare providers and patients to embrace behavioral change to maximize effective care and

the assumption that patients can be empowered to change their health-related behaviors if given the proper tools and education (Tougas et al., 2015). This framework of care is central to the belief that self-efficacy is the foundation for successful behavior change. Patients and providers have no incentive to change without the belief that change will have a positive impact on care (Bandura, 2000). These learned behaviors significantly impact clinical patient relationships, the education delivered during inpatient stays, and WV's decision-making processes to access the VA for care.

Theoretical Framework that Supports Sustainability of the Project: Interpersonal Relations in Nursing

Survey data collected by the VA through the Consumer Assessment of Healthcare Providers and Systems and the Survey of Healthcare Experiences of Patients indicated that WV rated their experiences in 'getting needed care' lower than men rated their experiences (Bastian et al., 2014 & Women's Health Services of the USDVA, 2016). A possible cause for this discrepancy is that women access the VA based on communications from friends and family instead of from healthcare providers and women have inadequate information regarding eligibility requirements (Wagner et al., 2015).

As providers change their behaviors and attitudes about WV and their need for gender-specific services, interventions can be implemented to close knowledge gaps and eliminate barriers to care. As the male-centered culture in the VA healthcare system begins to evolve, the theory of interpersonal relations can be used to support interventions to sustain this changed behavior. *Theory of Interpersonal Relations in Nursing* was published in 1968 by a psychiatric nurse, Hildegard Peplau (McCarthy, & Aquino-Russell, 2009). Peplau contends that the central purpose of nursing is a caring relationship that helps patients identify their needs in the direction of productive personal and community living (McCarthy, & Aquino-Russell, 2009). The theory

identifies four phases in the nurse-patient relationship and how these phases integrate to provide guidance to meet goals, and knowledge to make changes (Peplau, 1992). Peplau's theory can be widely applied in all areas of nursing and is a leading theory that identifies the nurse-patient relationship as the foundation of nursing practice (McCarthy, & Aquino-Russell, 2009).

Main constructs of the Theory of Interpersonal Relations in Nursing

The core constructs of Peplau's theory describes six nursing roles the phases of the nurse-patient relationship. The nursing roles are stranger, resource, person, teacher, leader, surrogate, and counselor (McCarthy, & Aquino-Russell, 2009). The nurse as a stranger receives the patient for the first time as a stranger and establishes trust. The nurse then becomes the teacher and provides the patient with education and resources to help the patient understand their health needs and set goals (McCarthy, & Aquino-Russell, 2009). The nurse becomes the counselor by providing guidance and encouragement to meet established goals. The nurse acts as a surrogate by advocating for the patient and ensuring their needs are met and coordinating care for the patient. As a leader, the nurse helps the patient reach their maximum potential and gain confidence and independence (McCarthy, & Aquino-Russell, 2009).

The phases of the nurse-patient relationship include pre-orientation, orientation, working, and resolution (Peplau, 1991). The first phase of the nurse patient relationship, is pre-orientation is when the nurse gathers data and reconciles preconceived thoughts about the patient and diagnosis. In the orientation phase, the nurse establishes expectations, limitations, and rapport, and assesses the patient's health (McNaughton, 2005). The working phase consists of the sub-phases of identification and exploitation. In the identification sub-phase, the nurse fulfills the role of counselor to identify problems and create a plan of care based on the patient's goals. In the exploitation sub-phase, the nurse takes on the role of educator, and identifies services to meet

the needs of the patient, and fosters new healthy behaviors in a safe environment (McNaughton, 2005). The final phase is resolution, in which the patient's needs and goals have been met through collaboration, and the relationship is ended with the patient's discharge (McNaughton, D., 2005). Peplau's theory explains that nursing is a healing art and that the symbiotic nurse-patient relationship allows for growth and the exchange of knowledge through the therapeutic relationship process to reach common goals (Peplau, 1992).

Applicability of the Theory of Interpersonal Relations in Nursing to This Project

The nurse-patient relationship is the first interaction between a female veteran and the VA healthcare system. Research has determined this first contact to be the most important and influential interaction that influences a female veteran's decision to access VA services (Washington, et al., 2015). The ability to deliver patient-centered, comprehensive care plays a significant role in increasing the levels of trust and safety in the pre-orientation and orientation phases of the nurse-patient relationship. The theory of interpersonal relations is based on the premise that nurses spend more time with patients than any other healthcare provider. Thus, this interaction supports the interventions in this DNP project to maximize the role of the nurse as a teacher and counselor to provide gender-specific resources and services to WV.

The interventions in the project target the working phase of the nurse-patient relationship. The WHRM created for this project will contains an information packet that can be provided to every female veteran who accesses the VA through inpatient hospitalization. This tool kit includes information about the comprehensive services available to WV at the DVAMC. In addition, the nurse will enter a women's health consult for every female veteran inpatient who does not have access to a DWHP.

The expected outcomes of this intervention are supported by the resolution phase of the theory and go beyond implementing comprehensive care. The expected outcomes focus on improved nurse and provider knowledge and ability to educate WV about health services, improved patient satisfaction rates, and awareness of services among female veterans.

A strength of utilizing Peplau's theory for this project is that the phases of the relationship process proceed regardless of time limitations and length of hospital stay (D'Antonio, Beeber, Sills, & Naegle, 2014). The theory can be effective in inpatient hospitalizations where outcomes will be measured. A limitation of the use of the interpersonal relations theory for this project is its lack of usefulness for patients who have altered mental status, are withdrawn, or refuse to interact (McCarthy, Aquino-Russell, 2009). To address this limitation, a consult will be entered to ensure that a DWHP contacts the patient when their health events resolve or their desire to interact returns. In sum, the theory of interpersonal relations in nursing provides the infrastructure that will aid in sustaining the intervention of the developed WHRM. Peplau's theory allows the nurse and patient to move forward in a partnership to facilitate learning and optimize the health of this unique population.

Limitations to Sustainability

The VA healthcare organizational structure at the DVAMC led to several problems that impacted the implementation of the WHRM into clinical practice. Organizational barriers that negatively affected the DNP project include the historically male centric culture in the VA and misconceptions of stakeholders. An assessment of these issues was vital prior to the implementation of interventions to ensure the success and sustainability of the project.

The VHA was founded with the purpose of delivering care to a predominately male military population. Military and VA culture can cause nurses and other healthcare providers to

assume that veterans are men (Wagner et al., 2015). The stereotypical attitudes and perceptions of VHA staff often disregard the sacrifice of WV and their military service. This negative treatment causes WV to feel isolated and leads them to seek services in the civilian sector (Mirsa-Hebert, Santurri, DeChant, Watts, Rothberg, Sehgal, & Aron, 2015). For this project to be sustainable WV need to feel valued and their service should be acknowledged within VA healthcare facilities.

To combat this problem, an organizational paradigm shift in the male-centric culture needs to be implemented. The proposed paradigm shift will allow for the education of healthcare providers to be more receptive to this unique population's needs and to dispel assumptions about women in the military. Among the ways this idea can be implemented at the DVAMC is by creating a timeline for strategically posting WV's media on the VA news boards throughout the facility and sending out information about gender-specific topics and the care of WV's to staff. These actions can increase enrollment of WV in the VA and decrease attrition and use of non-VA services.

Another organizational issue that impacted the implementation and outcomes of the project was the recruitment and buy-in of significant stakeholders and their accompanying misconceptions. The organizational structure at the VA made it imperative to identify stakeholders, such as medical directors and clinicians, who were in key administrative positions in specialty areas to assist in obtaining buy-in within the organization. Frontline nursing staff members were educated about the project but they were not utilized in the implementation of the project's interventions to avoid increasing their workload. Nursing staff members also had misconceptions that the project implementation would negatively impact the length of time for admission documentation due to the perceived length of time needed for implementation, lack of

knowledge about evidence-based practice, and a perceived increase in workload for staff (Hagedorn, Hogan, Smith, Bowman, Curran, Espadas, & Kimmel et al. 2006). However, lack of buy-in from the stakeholders did not lead to poor implementation of the WHRM (Needham, 2008).

To eliminate possible misconceptions and poor execution, stakeholders and staff were informed of the project and its goals early in the process. Including staff and stakeholders early gave them time to adjust to a new clinical care pathway for WV. The PI conducted two in-service education sessions for nursing staff members to educate them about the research and evidence that led to this to project. The in-service sessions served to engage staff members and gain their support for the project and its expected outcomes.

The current face of military service members is dramatically changing with more women fulfilling active duty roles. The number of female active duty and veteran service members is greater than at any point in history. As OEF/OIF/OND evolve, the increase in the number of WV places great demands on the male-dominated VA healthcare system. Women veterans who seek healthcare in the VA system require specialized care that acknowledges their service, respects their need for privacy and gender-specific care, and effectively meets their needs. The implementation of this project serves as a start toward changing how WV receive care in the VA healthcare system.

Chapter Five: Results

Results

The project data are the results of McNemar's tests, frequency statistics, and descriptive statistical analyses that were employed to determine if the developed WHRM met its expected outcomes to 1) to improve WV's knowledge of gender-specific services, policies, and resources within the VHA and 2) increase WV's sense of inclusion and satisfaction within the VA, and improve the quality of gender-specific resources available in the DVAMC.

Data were collected over a period of two weeks. The sample population consisted of 20 WV who were voluntary participants. Fifty-five percent of the population studied were between the ages of 25 and 54 years (Table 1). The WV who participated in the study had served in the military an average of 8.65 years with 55 percent having served in the Army, 20 percent in the Navy, 15 percent in the Air Force, and 10 percent in the Marines and Army Reserves (Table 2, Table 3, and Table 4).

Table 1. Demographics: Age

Age		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	25-34	3	15.0	15.0	15.0
	35-44	4	20.0	20.0	35.0
	45-54	4	20.0	20.0	55.0
	55-64	5	25.0	25.0	80.0
	65-74	3	15.0	15.0	95.0
	75-84	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Table 2. Demographics: Years of Service

Years of Service		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	5.0	5.0	5.0
	2	5	25.0	25.0	30.0
	4	3	15.0	15.0	45.0
	6	1	5.0	5.0	50.0
	7	1	5.0	5.0	55.0
	8	2	10.0	10.0	65.0
	9	1	5.0	5.0	70.0
	13	1	5.0	5.0	75.0
	14	2	10.0	10.0	85.0
	22	1	5.0	5.0	90.0
	24	1	5.0	5.0	95.0
	25	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Table 3. Demographics: Branch of Service

Branch of Service		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Air Force	3	15.0	15.0	15.0
	Army	11	55.0	55.0	70.0
	Army-Reserves	1	5.0	5.0	75.0
	Marines	1	5.0	5.0	80.0
	Navy	4	20.0	20.0	100.0
	Total	20	100.0	100.0	

Table 4. Demographics: Mean years of Service

Descriptive Statistics for Years of Service	N	Minimum	Maximum	Mean	Std. Deviation
Years	20	1	25	8.65	7.652
Valid N	20				

Frequency Statistics

The frequency data analysis was conducted using IBM SPSS Statistical Software (IBM Corp. released 2013). The variable used to measure the usefulness of the WHRM was answered 'yes' by 100 percent (N=20) of the participants (Table 5). The variable used to test the order of the contents within the WHRM revealed that 90 percent of the participants reported that the order of the table of contents was arranged well (Table 6). In comparison, WV's knowledge of patient escorts that can accompany WV to appointments within VA was 25 percent in the pre-survey and 95 percent in the post-survey (Table 7 and Table 8). Women veterans knowledge of the VA App Store was 20 percent in the pre-survey and 100 percent in the post-survey (Table 9 and Table 10). Prior to the intervention of the WHRM 80 percent of women felt included and acknowledged as veterans, indicating a 20 percent improvement in inclusion (increased to 100 percent) in the post-survey (Table 14 and Table 15). With regards to WV's recommending the VHA to other WV, the pre-survey revealed that 90 percent of WV responded that they would recommend the VHA to other WV (Table 11). The post-survey showed that 100 percent of participants would recommend the VHA (Table 12). Although WV would recommend the VA to others, the data indicated that only 25 percent of the participants were talked to by a provider regarding women's health primary care at the DVAMC, and this data set improved slightly to 30

percent in the post-survey (Table 16 and Table 17). In terms of women's reproductive health services, 50 percent of participants received reproductive care through the VHA and 50 percent received reproductive care in the private sector (Table 13). For most of the variables, the frequency and proportions of WV who answered 'yes' increased in the post-survey.

Table 5. Usefulness of Women's Health Resource Manual

Usefulness of Manual		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	100.0	100.0	100.0

Table 6. Order of Manual Content

Order of Content		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	18	90.0	90.0	90.0
	2	2	10.0	10.0	100.0
	Total	20	100.0	100.0	

Table 7. Pre-Survey: Knowledge of Escorts

Escorts		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	25.0	25.0	25.0
	2	15	75.0	75.0	100.0
	Total	20	100.0	100.0	

Table 8. Post-Survey: Knowledge of Escorts

Escorts2		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	19	95.0	95.0	95.0
	2	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Table 9. Pre-Survey: Knowledge of VA App Store

App store		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	4	20.0	20.0	20.0
	2	16	80.0	80.0	100.0
	Total	20	100.0	100.0	

Table 10. Post-Survey: Knowledge of VA App Store

App store2		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	100.0	100.0	100.0

Table 11. Pre-Survey: Recommend the VA to Women Veterans

Recommend		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	18	90.0	90.0	90.0
	2	2	10.0	10.0	100.0
	Total	20	100.0	100.0	

Table 12. Post-Survey: Recommend the VA to Women Veterans

Recommend2					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	100.0	100.0	100.0

Table 13. Receive Reproductive Health Services at the VA

RWHS					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	10	50.0	50.0	50.0
	2	10	50.0	50.0	100.0
	Total	20	100.0	100.0	

Table 14. Pre-Survey: Included as a Veteran at the DVAMC

Included					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	16	80.0	80.0	80.0
	2	4	20.0	20.0	100.0
	Total	20	100.0	100.0	

Table 15. Post-Survey: Included as a veteran in the DVAMC

Included2					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	20	100.0	100.0	100.0

Table 16. Pre-Survey: Provider Discussed Women's Health Primary Care

WHPC		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	25.0	25.0	25.0
	2	15	75.0	75.0	100.0
	Total	20	100.0	100.0	

Table 17. Post-Survey: Provider Discussed Women's Health Primary Care

WHPC2		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	6	30.0	30.0	30.0
	2	14	70.0	70.0	100.0
	Total	20	100.0	100.0	

Descriptive Statistics

All data analyses were conducted utilizing the IBM SPSS Statistical Software and statistical significance was assessed at $p < 0.05$ (IBM Corp. released 2013). Twenty five percent of WV answered 'yes' to receiving information regarding emergency birth control, healthy aging, sexually transmitted infections, and cervical cancer on the pre-survey questionnaire, whereas 75 percent answered 'no' (Table 20). In comparison, after reading the WHRM 90 percent of WV were extremely satisfied with the quality of the information about emergency birth control, healthy aging, sexually transmitted infections, and cervical cancer (Table 20). This measure was statistically significant with a p value of 0.001^{a} (McNemar's test p value < 0.05).

In terms of participant satisfaction with the VA providing gender-specific resources (*hiGSinfo* in Table 18), 40 percent of WV indicated that they were extremely satisfied and 60 percent rated the variable within a range of 2 to 5 (slightly satisfied to extremely dissatisfied) on

the pre-survey questionnaire (Table 18). In comparison, 85 percent of WV were extremely satisfied with the gender-specific information in the post-survey questionnaire, and the responses in the 2 to 5 range decreased to 15 percent (Table 18). This finding is statistically significant with a p value of 0.002[a] (McNemar's test, p value < 0.05).

Finally, 25 percent of participants responded that they were extremely satisfied with the quality of gender-specific information (*hiGSquality* in Table 19) that the VA provided, and 75 percent responded within a range of 2 to 5 (slightly satisfied to extremely dissatisfied) on the pre-survey questionnaire (Table 19). At post-survey, 85 percent of the participants were extremely satisfied with the quality of the gender-specific resources in the VA, and the responses in the 2 to 5 range decreased to 15 percent (Table 19). The data indicates a significant change across this measure with a p value of 0.002[a] (McNemar's test, p value < 0.05).

Table 18. Comparison of Rating Gender-Specific Information from the VA

hiGSinfo * hiGSinfo2 Cross-tabulation			**hiGSinfo2**		**Total**
			1	**2**	
hiGSinfo	1	Count	6	2	8
		% within hiGSinfo	75.0%	25.0%	100.0%
		% of Total	30.0%	10.0%	40.0%
	2	Count	11	1	12
		% within hiGSinfo	91.7%	8.3%	100.0%
		% of Total	55.0%	5.0%	60.0%
Total		Count	17	3	20
		% within hiGSinfo	85.0%	15.0%	100.0%
		% of Total	85.0%	15.0%	100.0%

Chi-Square Tests		
	Value	**Exact Sig. (2-sided)**
McNemar's Test		.022a
N of Valid Cases	20	

(Binomial distribution used, p value < 0.05)

Table 19. Comparison of the Quality of Gender-Specific Information from the VA

hiGSquality *hiGSquality2 Cross-tabulation					
			hiGSquality2		**Total**
			1	2	
hiGSquality	1	Count	4	1	5
		% within hiGSquality	80.0%	20.0%	100.0%
		% of Total	20.0%	5.0%	25.0%
	2	Count	13	2	15
		% within hiGSquality	86.7%	13.3%	100.0%
		% of Total	65.0%	10.0%	75.0%
Total		Count	17	3	20
		% within hiGSquality	85.0%	15.0%	100.0%
		% of Total	85.0%	15.0%	100.0%

Chi-Square Tests

	Value	**Exact Sig. (2-sided)**
McNemar's Test		.002a
N of Valid Cases	20	

(Binomial distribution used, p value < 0.05)

Table 20. Comparison of Available Services within the VA

avail service * avail service2 Cross-tabulation			**avail service2**		**Total**
			1	2	
avail service	1	Count	4	1	5
		% within avail service	80.0%	20.0%	100.0%
		% of Total	20.0%	5.0%	25.0%
	2	Count	14	1	15
		% within avail service	93.3%	6.7%	100.0%
		% of Total	70.0%	5.0%	75.0%
Total		Count	18	2	20
		% within avail service	90.0%	10.0%	100.0%
		% of Total	90.0%	10.0%	100.0%

Chi-Square Tests

	Value	**Exact Sig. (2-sided)**
McNemar's Test		.001a
N of Valid Cases	20	

(Binomial distribution used., p value < 0.05)

Evaluation of Open-Ended Questions

Formal analysis and coding of open-ended responses were not necessary for this project. The responses delineated essential content that WV requested to be included in the WHRM to ensure that the outcomes of the project were achieved, i.e., to 1) to improve WV's knowledge of gender-specific services, policies, and resources within the VHA and 2) to increase WV satisfaction with the quality of gender-specific resources and sense of inclusion within the VHA.

The open-ended question responses indicated four major themes with regard to additional information that the participants requested to be included in the WHRM: retirement benefits, women's health primary care (WHPC), job recruitment, and mentorship for WV who were adjusting to the civilian sector (Table 21). Other themes noted by participants already were included in the WHRM content (Table 21). According to O'Cathain and Thomas, the themes identified in open-ended questions can corroborate and identify issues that may require further analysis (2004). The themes reassure that

the intervention and survey tool have content validity and they are specific and sensitive in terms of addressing the desired objectives (Hulley, Cummings, Browder, Grady, & Newman, 2013).

Table 21. Open-ended Answers to What Content WV Would Like in a WHRM in the VA

What Information Would You Like Included in WHRM in the VA	Number of Responses
Mentorship for female veterans	2
Proper housing	1
Job recruitment	2
Retiree's information	3
Female Service Connection disabilities	1
Affordable housing	1
Infertility care for spouse of veterans	1
More about cancers	1
Gynecological surgical services	1
Menopause (what to expect)	1
Breast self-exams	1
Women's Health Primary Care	3
Resource phone numbers	1
Re-adjustment information	1
LGBTQI information	1

CHAPTER 6: DISCUSSION

Introduction

The purpose of this project was to provide a WHRM for WV that contains comprehensive information regarding eligibility and the gender-specific policies and services available in the VHA. The Study of Barriers for Women Veterans to VA Health Care identified nine barriers that WV encounter when accessing care (USDVA, 2015). The results of the project address four of the barriers: 1) comprehension of eligibility requirements and scope of services, 2) effect of outreach that specifically addressing women's health services, 3) acceptability of integrated care, and 4) gender sensitivity (USDVA, 2015).

Comprehension of Eligibility and Scope of Services

The WHRM contains information about eligibility for VA services and can provides WV with the preferred hard copy information that they can reference frequently and easily for eligibility instructions, forms, and contact phone numbers. The results of the measures that pertain to scope of services, such as the VA App Store and provision of escorts, indicated an increase in WV's knowledge after reading the WHRM developed for this DNP project. Among participants, knowledge of the App Store increased by 80 percent and knowledge of the provision of escorts increased by 70 percent (Table 7and Table 10). The DVAMC organization can improve WV knowledge of services by strategically placing the WHRM in the exam rooms in the Women's Health Clinic to increase awareness, visualization, and accessibility to resources.

Outreach that Specifically Addresses Women's Health Services and Gender Sensitivity

The quality of the gender-specific information provided at the DVAMC is lacking in

frequency, quality, and breadth of available services. The project results showed that the WHRM was statistically significant in improving WV's satisfaction across these measures (Tables 18, Table 19, and Table20). The WHRM improved feelings of inclusion by 20 percent (Table 14 and Table15). Research suggest that OEF/OIF/OND WV are the least satisfied with gender-specific services (United States Department of Veterans Affairs, 2015). Thus, targeted dissemination of the WHRM to OEF/OIF/OND WV demographic can improve their perceptions of the VA and increase their satisfaction with VHA services. The VHA also should develop collaborative relationships with community partners to identify methods to increase gender-specific outreach through veterans' town hall meetings and healthcare fairs. Effective outreach methods can contribute to a shift in the male–centric veteran culture, thus leading to organizational change and improved feelings of inclusion, specifically among OEF/OIF/OND WV.

Women's Health Primary Care

The developed WHRM has the potential to increase the percentage of WV enrolled in WHPC within the DVAMC. The Barriers to Care Study showed that 75 percent of WV rated care from a DWHP specializing in primary care as highly important (2015). The DVAMC is currently below the VISN 6 target goal of 85 percent enrollment of WV with WHPC providers (DVAMC Women Veterans Health Committee, 2018). The North Carolina VISN 6 facilities featured in the WHRM are below the target, with the exception of the Asheville VA that exceeds the goal at 86.4 percent (DVAMC Women Veterans Health Committee, 2018). For the 2018 fiscal year, the Salisbury VAMC is at 79 percent, Fayetteville VAMC is at 61percent, and DVAMC is at 72 percent (DVAMC Women Veterans Health Committee, 2018).

Increasing healthcare providers' and staff members' understanding of gender sensitivity can increase WV's enrollment in and use of WHPC at the DVAMC. The DVAMC and other the

other VISN 6 facilities can encourage healthcare provider participation in mini-residency training programs in gender-specific primary care to ensure that WV receive the same level of care across sites within the VA. Primary care providers should engage in didactic training to increase their competency in caring for veterans with post-traumatic stress disorder and military sexual trauma, and LGBTQI care. Educational offerings can improve providers with knowledge about women's health services and improve their ability to inform WV about WHPC services at each visit.

Women's health primary care providers can assess and ensure seamless coordination of mental health, post-traumatic stress disorder, and military sexual trauma services that are perceived as a stigma among veterans. Women veterans are more reluctant than male veterans to seek assistance for mental health issues (USDVA, 2015). The developed WHRM was rated 100 percent useful by participants in the study, and it contains resources available at all four North Carolina VA hospital facilities (Table 5). The frequent and widespread distribution of the WHRM in primary care settings can provide a wide range of support for WV with mental health diagnoses. Research efforts can aid in making WV feel welcome and encourage return visits to the WHPC setting.

Organizational Leadership

Leadership within the VHA should increase recruitment and retention strategies to attract providers proficient in women's health. The success of the WHPC program is dependent upon organizational leadership and appropriately staffed clinics to ensure high quality coordinated care. Organizational efforts to increase safety, and privacy can aid in making WV feel welcome and encourage subsequent visits to the VHA for care. For example, the VHA could improve the facilities' environment of care to better accommodate WV and their gender-specific needs by

ensuring that proper curtains are installed in exam rooms, baby changing stations are available in all family and women's bathrooms, and exam rooms have locks installed that can be secured from inside the exam rooms. Women veterans in the OEF/OIF/OND era rate VA facilities as uncomfortable and not secure (USDVA, 2015). Thus, VA leadership should support the improvement of facilities and comfort to increase access to care and improve gender-specific performance measures.

Evaluation of Theoretical Framework

For this project, the PDSA model provided a framework to aid in the successful implementation of the WHRM. Prior to the implementation of the project, a PDSA cycle was conducted with the goal of reducing participant drop-out and streamlining implementation. According to Taylor, McNicholas, Nicolay, Darzi, Bell, and Reed, incremental small-scale interventions provide data that allow the investigator to adapt and adjust the interventions to ensure that they are appropriate to address the goals of the project and to minimize variation and risk to the participants (2013). The PI conducted a mock implementation with a VHA staff member, who was a female veteran. During the mock implementation, PI distributed the letter of intent to participate, the WHRM, and the pre-questionnaire and gave the veteran 24 hours to review the manual. After the allotted time period, the PI returned, collected the pre-questionnaire, and distributed the post-questionnaire. Thirty minutes later, the PI returned to the mock participant to obtain the post-questionnaire. The mock implementation revealed that minor adjustments needed to be made in the order that information was distributed to the participant and that the length of time at the initial encounter needed to be shorter.

During the first phase of project implementation, the PI conducted another PDSA cycle with the first five participants in the study. Data in the mock cycle identified that the length of

the initial encounter needed to be reduced for efficiency in larger scale implementation. During this cycle and all items in the project were distributed at the initial encounter to increase efficiency, and reduce disturbance to the participants during their hospitalization. The PI returned to the participants at the end of the allotted time period to collect both the pre- and post-questionnaires. and allowed participants time to discuss their experiences as veterans and provide valuable feedback.

After the second PDSA cycle, the PI observed that the most convenient time to implement the project was after the patients' morning medication administration and before lunch was delivered. Strategically implementing the PDSA during this time ensured that participants medical and pain needs were addressed and that the participants were more willing to participate in the study and return the questionnaires during the allotted time period. These changes in the operating procedure minimized the number of times the PI had to disturb the participants during their hospitalization.

The PDSA cycle data identified small problems that were not predicted in the project planning process. Adjustments to the method of implementation were made before each subsequent PDSA cycle to improve the impact of the project outcomes and reduce error and variation (Taylor, McNicholas, Nicolay, Darzi, Bell, & Reed, 2013).

Strengths of the Study

The study protocol of implementing the intervention without nursing staff assistance improved the project's precision and reduced the risk of error by increasing the consistency in the recruitment and implementation procedures. The PI alone implemented the project, which eliminated the time that would be needed to train multiple staff members in the standard operating procedure, and utilizing multiple interviewers could have contributed to random error

due to deviation in the execution of tasks (Hulley, Cummings, Browder, Grady, & Newman, 2013).

Limitations

The limitations that affected the significance and generalizability of the project include time constraints, a small sample size, and the lack of electronic questionnaires. The study was implemented within a time-frame of two weeks to collect data from the minimal number of 20 participants. A longer implementation time would have allowed the PI to recruit a larger sample and would have allowed inferences from the data about WV's knowledge that, in turn, would have increased the validity of the study and allowed generalizable conclusions about the larger population of WV (Hulley, Cummings, Browder, Grady, & Newman, 2013). Also, not using electronic questionnaires in the implementation of the study increased the risk of error in marking the paper questionnaires and skipping questions. Consulting with The Odum Institute at the University of North Carolina at Chapel Hill would have been beneficial in data organization and safety by ensuring that all data were in a secure electronic location (The Odum Institute, n.d.). Data sets would have been automatically categorized in the electronic system, thereby decreasing error associated with manually inputting data into a statistical program.

Suggestions for Future Research

The VA has initiatives underway to increase access to care and remove barriers to care for WV. However, suggested areas for future research to reduce gaps in women's health-related knowledge and improve WV's experiences include the care of transgender and intersex veterans, provision of reproductive and infertility services, and minimizing healthcare disparities among WV (Carter et al., 2016).

The VA needs to focus research on education, training, policies, and EBP interventions for healthcare providers and staff to acknowledge biases and misconceptions of LGBTQI veterans and their status in the military. According to Kauth, Shipherd, Lindsay, Blosnich, Brown, and Jones, numerous veterans seek services for cross-sex hormone therapy (2014). Research concerning healthcare provider biases, stereotypes, and their impact on the delivery of patient care and the ability of LGBTQI veterans to overcome the stigma of seeking services within the male-centric VHA system can reduce barriers to care and improve the veteran's experience.

Another area of research should target the provision of infertility and reproductive services for WV. The population of WV continues to increase, and women serving in OEF/OIF/OND are of reproductive age (ages 18 to 45years) and seek services in the VHA (Mattocks, Kroll-Desrosiers, Zephyrin, Katon, Weitlauf, Bastian, Haskell, & Brandt, 2015). According to an infertility study, 15 percent of OEF/OIF/OND WV reported a diagnosis of infertility and 39 percent of that population received infertility treatment from non-VA providers (Mattocks et al., 2015).

Furthermore, understanding understand the gender-specific needs of OEF/OIF/OND WV is needed to decrease racial and gender-specific healthcare disparities and improve determinants of health. Most WV with an infertility diagnosis also have a mental health diagnosis (Mattocks et al., 2015). Studying these conditions can improve women's health programs, policies, and reduce the costs incurred from receiving treatment from non-VA providers.

Conclusion

The services that the VHA provides must reflect the core characteristics of the organization, such as trustworthiness, accessibility, quality, innovation, agility, and integration

(United States Department of Veterans Affairs, 2015). This project was the first in the VISN 6 network to provide a comprehensive intervention for WV in the inpatient setting. The purpose of the project was to evaluate whether a WHRM would increase WV's knowledge of services and available resources to meet their unique healthcare needs. Additionally, the project identified content that WV would like to be included in the WHRM.

Data suggest that the WHRM was significant in improving the information and quality of gender-specific outreach in the VHA. Use of the WHRM also improved WV's sense of acknowledgement and inclusion. The project and increased WV's awareness of different areas of care within the VISN 6 network and addressed several barriers to care that have been identified in several studies.

The PDSA framework guided the successful implementation of the project. With regard to sustainability and future dissemination of the WHRM, regular review of PDSA cycles can increase the outreach of the WHRM and encourage WV to enroll in VHA services and reduce attrition from VA providers. The WHRM, accompanied by organizational decision-making and policies designed to improve health outcomes for WV, is necessary to ensure that all WV have access to services in the VHA.

Appendix A VA IRB Approval Letter

Durham VAMC Institutional Review Board (IRB)
CHECKLIST: QUALITY ASSURANCE OR IMPROVEMENT (OPERATIONS ACTIVITY) OR RESEARCH

In accordance with VHA Handbook 1058.05, "VHA Operations Activities[1] That May Constitute Research", Durham VAMC employees may conduct certain operations activities which may or may not constitute research. Whenever the research versus non-research status of an operations activity may be in question, a determination of the status must be made.

Project Title: Increasing Access to care for Women Veterans in the Durham VA Hospital	
Project Lead: Dakar Howell, RN	**Email:** Dakar.Howell@va.gov
Reason for Project: ☐ Locally Initiated ☐ Mandated by (name Program Office):	■ Degree Program Requirement

Research: A systematic investigation (including research development, testing and evaluation) designed to develop or contribute to generalizable knowledge. ***NOTE:*** *Research typically involves the testing of concepts by the scientific method of formulating a hypothesis or research question, systematically collecting and recording relevant data, and interpreting the results in terms of the hypothesis or question to expand the knowledge base of a field of study (VHA Handbook 1058.05, VHA Handbook 1200.05; 45 CFR 46.102(d) and 45 CFR 164.50).*

Generalizable Knowledge: Information that expands the knowledge base of a scientific discipline or scholarly field of study. Systematic investigations designed to develop or contribute to a generalizable knowledge constitute research. Systematic investigations designed to produce information to expand the knowledge based of a scientific discipline or other scholarly field of study constitute research (*VHA Handbook 1058.05*).

Operations Activities: Operations activities are certain administrative, financial, legal, quality assurance, quality improvement, and public health endeavors that are necessary to support VHA's missions of delivering health care to the Nation's Veterans, conducting research and development, performing medical education, and contributing to national emergency response. Operations activities may or may not constitute research *(VHA Handbook 1058.05)*. [1]

CONDITIONS TO BE CONSIDERED FOR DETERMINATION OF RESEARCH VS. NON-RESEARCH OPERATIONS		
NOTE: If answers to questions 1 through 9 are marked **"TRUE"** the project is more than likely not research.	TRUE	FALS
1) The project is designed and/or implemented for internal VA purposes in support of the VA mission(s).	☑	☐
2) The findings are designed to be used by and within VA (or by entities responsible for overseeing VA).	☑	☐
3) The project is not designed for the purpose of contributing to generalizable knowledge. [2]	☑	☐
4) The project is not designed to produce information that expands the knowledge base of a scientific discipline (or other scholarly field).[2]	☑	☐
5) The project is not funded or otherwise supported as **research** by the Office of Research and Development (ORD) or any other entity.	☑	☐
6) The project does not involve administration, dispensing and/or use of any drugs, devices and/or biologics.	☑	☐
7) The project does not involve design characteristics typically reflective of research, e.g.: • Double-blind interventions • Use of placebo controls • Prospective patient-level randomization to clinical interventions not tailored to individual benefit	☑	☐

Version Date 4/15/16

Durham VAMC Institutional Review Board (IRB)

CHECKLIST: QUALITY ASSURANCE OR IMPROVEMENT (OPERATIONS ACTIVITY) OR RESEARCH

8) The proposal includes provisions to ensure that the safety, rights, and welfare of patients and staff are appropriately protected as applicable.[3]	☑	☐
9) As the project currently reads, the activity **will not be** supplemented or modified before, during, or after implementation in order to produce information to expand the knowledge base of a scientific discipline or scholarly field of study or otherwise contribute to generalizable knowledge.	☑	☐

Multisite Projects or QA/QI Projects Mandated, Funded or Supported by a VA Program Office:

☐ This project includes obtaining data or participation from VA sites other than those covered by the DVAMC. Approval from the other facilities must be made prior to initiating the project at those facilities.

☐ This project includes quality improvement/assurance activities that are mandated by, funded by, or otherwise supported by a VA Program Office. The Program Office is responsible for documentation regarding the determination of status as non-research.

Durham VAMC IRB Determination:

■ **Not Research**. The IRB has determined that based on the responses above and the proposed project description, approval by an IRB or other review committee is not needed. The project is considered to be non-research VHA operations activity. If the results of this project are presented or published they cannot be presented as research, nor does it have research approval. ***Any changes or modifications to this project will require re-review.***

☐ **Research Project**. As designed this project requires review by an IRB or other appropriate review committee *prior* to initiation.

☐ Additional information is needed to make a determination. See comments below.

IRB Comments:
Verbal consent is sufficient, as this is not a research project, but rather a QA project.

IRB Chair or Co-Chair Signature: _____ **Date:** 11/17/17

Reference:
VHA Handbook 1058.05: VHA Operations Activities That May Constitute Research

[1] Examples of operations activities include activities designed for internal VA purposes, including routine data collection and analysis for operational monitoring, evaluation and program improvement purposes, VHA system redesign activities, patient satisfaction surveys, case management and care coordination, policy and guidance development, benchmarking activities, Joint Commission visits and related activities, medical use evaluations, business planning and development such as cost-management analyses, underwriting, and similar activities.

[2] Any change made before, during, or after implementation that results in an intent to expand the knowledge base of a scientific discipline or scholarly field of study, or otherwise contribute to generalizable knowledge, constitutes research and must be submitted to an IRB or other pertinent review committee.

[3] Potential risks (including physical, psychological, social, financial, privacy, and confidentiality, and other foreseeable risks) associated with non-research operations should be evaluated and appropriate protections established to mitigate them.

[4] Please note it is the responsibility of this individual and/or each VA author and coauthor (in cases of publication) to retain a copy of this form signed by the IRB Chair or Co-Chair for a minimum of 5 years after publication and in accordance with any applicable records retention schedules. A copy will also be retained by Research Service.

Version Date 4/15/16

APPENXIX B UNC IRB APPROVAL LETTER

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

OFFICE OF HUMAN RESEARCH ETHICS
720 Martin Luther King, Jr. Blvd.
Bldg. 385, 2nd Floor
CB #7097
Chapel Hill, NC 27599-7097
(919) 966-3113
Web site: ohre.unc.edu
Federalwide Assurance (FWA) #4801

To: Dakar Howell
School of Nursing

From: Office of Human Research Ethics

Date: 2/27/2018
RE: Determination that Research or Research-Like Activity does not require IRB Approval
Study #: 17-3268

Study Title: INCREASING ACCESS TO CARE AND KNOWLEDGE OF SERVICES FOR WOMEN VETERANS IN THE VA HEALTHCARE SYSTEM

This submission was reviewed by the Office of Human Research Ethics, which has determined that this submission does not constitute human subjects research as defined under federal regulations [45 CFR 46.102 (d or f) and 21 CFR 56.102(c)(e)(l)] and does not require IRB approval.

Study Description:

Purpose:

The purpose of this evidence based practice (EBP) quality improvement project is to evaluate the effects of a gender-specific intervention for inpatient WV about the policies and services available to meet their needs and increase their access to VA care. The intervention for this project is a Women's Health Resource Manual consisting of resources within all four NC VA hospitals.

Participants:

Inclusion criteria consist of WV receive care in the VISN 6 healthcare network who are eligible for VHA healthcare of any age, race, ethnicity, with any length of military service, and are admitted to the inpatient setting. Participants must be mentally competent to make decisions concerning their medical care.

Exclusion criteria consist of unconscious WV, involuntarily committed patients, and patients admitted to the mental health inpatient setting.

Procedures (methods):

Women Veterans admitted into the inpatient setting will be provided with a Women Veteran Resource Manual, a cover letter with consent, and two randomly coded questionnaire forms (pre-intervention and post-intervention). The Veteran will complete the pre intervention questionnaire and then read the manual. At discharge the Veteran will complete the post intervention questionnaire.

Please be aware that approval may still be required from other relevant authorities or "gatekeepers" (e.g., school principals, facility directors, custodians of records), even though IRB approval is not required.

If your study protocol changes in such a way that this determination will no longer apply, you should contact the above IRB before making the changes.

CC:
Elaine Harwood, School of Nursing
Lisa Miller , School of Nursing Deans Office

Appendix C Letter of Intent to Participate

2/14/2018
Dakar Howell BSN, RN
University of North Carolina at Chapel Hill
School of Nursing

Dear Veteran,

My name is Dakar Howell. I am currently a doctoral candidate in the School of Nursing at the University of North Carolina at Chapel Hill. I also have been a nurse with the Durham Veteran's Administration Healthcare System for the past 6 years.

As a part of my graduate education, I am pursuing a project aimed at improving Women Veteran's knowledge of the eligibility, support services and resources available to them through the VA Health Care System. I invite you to participate in this study by completing two brief surveys and reviewing the accompanying booklet.

The accompanying Women's Health Resource Manual was created for you to use and keep. Please complete a brief survey before and after reading the manual.

- ✓ **BEFORE reading the manual**, please complete the survey attached to this letter titled "Pre-Questionnaire." After completing this survey, please place the survey in the accompanying envelope.

- ✓ **AFTER reading the manual**, please complete the survey attached to this letter titled "Post-Questionnaire." After completing this survey, please place the survey in the accompanying envelope.

- ✓ **PLEASE NOTE: Do not provide your name on either survey.**

As the Principal Investigator in this study, I will return to collect both surveys prior to your discharge from the Durham VA Medical Center.

Your decision to participate in this project is voluntary. You may refuse to take part in the study *at any time* without affecting your relationship with the investigator of this project or the Veteran's Administration Health Care System. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from completing the surveys at any point during the process.

There are no risks or discomforts anticipated from participation in this project. Benefits of this project include providing Women Veterans with enhanced knowledge of the benefits offered them through the VA Health Care System.

All surveys collected for this project are anonymous. No information will be collected regarding your identity. Any report published using the information collected will never include identifying information.

Completion of the two surveys will indicate your willingness to volunteer as a participant in this project and that you have read and understood the information provided above. You will return this letter along with the two surveys.

You will be provided a copy of this letter attached to the Women's Health Resource Manual.. Keep these for your personal records.

You have the right to ask questions about this project and to have those questions answered by me before, during or after completing the surveys. If you have any further questions about the project, feel free to contact me, Dakar Howell, at (919) 286-0411, extension 5861.
This project has been approved by the University of North Carolina at Chapel Hill's Institutional Review Board and by the Veteran's Administration Institutional Review Board. You may contact the University of North Carolina at Chapel Hill's Institutional Review Board by calling (919) 966-3113. You may contact the Durham Veteran's Administration Institutional Review Board by calling (919) 286-0411, ext. 4726.

Today's date_____

On behalf of myself and the Women Veterans throughout the VA Health Care System, I would like to thank you for taking the time to review the Women's Health Resource Manual and complete the surveys.

Dakar Howell BSN, RN
Doctoral Candidate
University of North Carolina at Chapel Hill

APPENDIX D WOMEN'S HEALTH PRE-SURVEY

Women's Health Resource Pre-Survey

Introduction: Thank you for taking the time to participate in this questionnaire. Your response will help assess your knowledge regarding the women's health resources at the Durham VA Medical Center.

Instructions: Please read each question below and place a circle around your response.

1. Age

18-24
25-34
35-44
45-54
55-64
65-74
75-84
85 or older

2. Branch of Service

-Army
-Navy
-Air Force
-Marines
-Reserves

3. When (years) did you serve in the military?

_____

4. How would you rate the Durham VA Hospitals ability to make women veterans feel included and acknowledged as veterans?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

5. Do you feel included and acknowledged as a veteran in the Durham VA Hospital?

1 – Yes
2 – No

6. How would you rate the Durham VA in providing information on gender specific services available to enhance healthcare for women veterans?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

7. How would you rate the quality of the gender specific information that the Durham VA Hospital provides?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

8. During this visit to the Durham VA Hospital did a physician, nurse, or other healthcare provider talk with you about Women's Health Primary Care?

1 – Yes
2 – No

9. During this visit to the Durham VA Hospital did a physician, nurse, or other healthcare provider talk with you about Women's Health Resources in the VA?

1 – Yes
2 – No

10. Do you receive women's health or reproductive services from the Durham VA Hospital?

1 – Yes
2 – No

11. Has the Durham VA Hospital provided information about any of the following services available to you: emergency birth control, healthy aging, sexually transmitted infections (STI), cervical cancer?

1 – Yes
2 – No

12. Does the Durham VA Hospital have an App store to download applications on computers, phones, and i-pads to support a healthy lifestyle?

1 – Yes
2 – No

13. Does the Durham VA Hospital provide female escorts for you to accompany you to your appointments in the VA for mammograms or Papanicolau test (Pap Smear)?

1 – Yes
2 – No

14. Have you ever received a resource focused specifically on women veteran's healthcare services from the Durham VA Hospital?

1 – Yes
2 – No

15. What would you like to see in a Women's Health Resource Manual?

_____
_____
_____
_____

16. Would you recommend the Durham VA Hospital to other women veterans?

1 – Yes
2 – No

APPENDIX E WOMEN'S HEALTH POST-SURVEY

Women's Health Post Survey

POST QUESTIONNAIRE: After you review of the Women's Health Resource Manual, please complete this form.

Introduction: Thank you for taking the time to participate in this questionnaire. Your response will help to assess your knowledge regarding the available women's health resources at the VA Medical Center. The answers given are strictly confidential. You will not be asked to tell us who you are.

Instructions: Below are questions and statements related to knowledge about women's health resources and the Women's Health Resource Manual. Please read each question below. Place a circle around your response.

1. After reading the Women's Health Resource Manual, how would you rate the Durham VA Hospitals ability to make women veterans feel included and acknowledged?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

2. After reading the Women's Health Resource Manual do you feel acknowledged as a veteran in the Durham VA Hospital?

1 – Yes
2 – No

3. After reading the Women's Health Resource Manual how would you rate the Durham VA Hospital on providing information regarding gender-specific resources to enhance healthcare for women veterans?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

4. After reading the Women's Health Resource Manual how would you rate the quality of the gender-specific information that the Durham VA Hospital provides?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

5. How would you rate the quality of the Women's Health Resource Manual?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

6. Does the Women's Health Resource Manual contain information that is useful to you?

1 – Yes
2 – No

7. After reading the Women's Health Resource Manual how would you rate the quality of the information regarding the following service available to women veterans: emergency birth control, healthy aging, sexually transmitted infections (STI), and cervical cancer, breast cancer?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

8. How would you rate the order of information (table of contents) contained in the Women's Health Resource Manual?

1 – Extremely Satisfied
2 – Slightly Satisfied
3 – Neither Satisfied or Dissatisfied
4 – Slightly Dissatisfied
5 – Extremely Dissatisfied

9. Does the Durham VA Hospital have an App store to download applications on computers, phones, and i-pads to support a healthy lifestyle?

1 – Yes
2 – No

10. Does the Durham VA Hospital provide female escorts to accompany women veterans to appointments in the VA for mammograms or Papanicolau test (pap Smear)?

1 – Yes
2 – No

11. Do you want to speak to a physician, nurse, or healthcare provider about Women's Health Primary Care?

1 – Yes
2 – No

12. Would you recommend the Women's Health Resource Manual to other women veterans?

1 – Yes
2 – No

13. What information would you like included in the Women's Health Resource Manual?

_____
_____
_____
_____
_____

14. Would you recommend the Durham VA Hospital to other women veterans?

1 – Yes
2 – No

Thank you for your service and time.

Durham VA Healthcare System

Women's Health Resource Manual

Guide to the VA Healthcare System and the Services you have earned!

Survey attached to this page.

Welcome

Welcome to the Durham Veteran's Administration Medical Center (DVMAC). We salute your courage, your honor, and most of all, your sacrifice. Women Veterans are the fastest growing population of patients that access the VA for care. Women have a very distinct set of needs to include gender specific care, reproductive services, wellness, and preventative care. This manual will help you navigate the resources available to best meet YOUR needs as a female Veteran. In this manual you will find resources available, both within the VA system and in the surrounding communities to optimize your health and support you as a Veteran. Please take time to read the manual thoroughly. It is not necessary to read the entire manual in one setting.

Feel free to discuss any questions you may have with your healthcare team. We are here to assist you in making informed decisions about your care and meeting your needs as a female Veteran. Your valuable input into this manual will assist the VA in meeting the needs of all female Veterans.

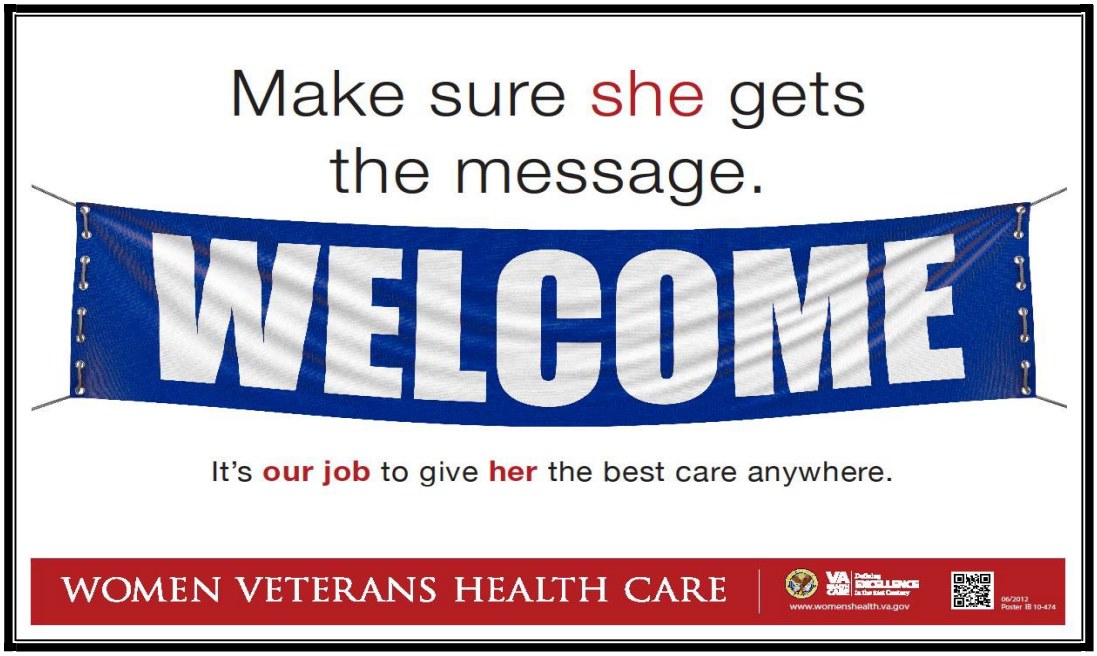


TABLE OF CONTENTS

Veteran Eligibility

Basic Eligibility

A person who served in the active military, Army, Navy, Air Force, Marines, or Coast Guard, and who was discharged or released under conditions other than dishonorable may qualify for VA healthcare benefits. Reservist and National Guard members may also qualify for VA health care benefits if they were called to active duty (other than for training) by a Federal order and completed the full period for which they were called or ordered to active duty.

Minimum Duty Requirements

Veterans who enlisted after September 7, 1980, or who entered active duty after October 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty in order to be eligible. This minimum duty requirement may not apply to Veterans discharged for hardship, early out or a disability incurred or aggravated in the line of duty.

Enrollment

For most Veterans, entry into the VA health care system begins by applying for enrollment. Veterans can now apply and submit their application for enrollment (VA form 1010EZ), online at www.1010ez.med.va.gov/sec/vha/1010ez/. If assistance is needed while completing the online enrollment form, an online chat representative is available to answer questions Monday – Friday between 8:00 am and 8:00 pm EST. Veterans can also enroll by calling 1-877-222-VETS (8387) Monday – Friday 8:00 am-8:00 pm EST. Enrollment is available at any VA health care facility or VA regional office. Once enrolled, Veterans can receive health care at any VA health care facility throughout the country.

Privacy

Veterans enrolled in the VA health care system are afforded rights to privacy under federal law. The VA's Notice of Privacy Practices, which describes how the VA may use and disclose Veterans' medical information, is also available online at:

www.va.gov/publications/viewpublication.asp?pub_ID=1089

Important Documents

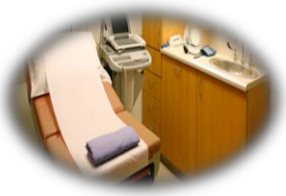
To expedite benefits delivery, Veterans seeking VA benefits for the first time must submit a copy of their service discharge form (DD-214, DD-215, or for World War II Veterans a WD form) which documents service dates and type of discharge, or provides full name, military service number, branch and dates of service.

All staff please KNOCK, WAIT, and enter only after invited in!

Please Respect Privacy

Please Tear Out and Place On Room Door.

Protecting your Privacy is important to all VA staff.



Privacy Policy

Patient privacy and dignity must be maintained at all times.

- Privacy curtains must shield the exam table.
- The exam table should be placed with the foot of the table facing away from the door.
- Doors must have locks such that the Veteran can lock the door from inside the exam room.
- Gowns and sheets are available for privacy. Appropriate draping techniques will be used during breast and pelvic examinations.
- The Veteran should not be asked to disrobe in the provider's immediate presence.
- The provider will explain the necessity of a complete physical examination or components being performed in order to minimize the patient's anxiety and any possible misunderstanding.
- Exam room doors, inpatient bathroom doors, and inpatient Mental Health rooms have locks on the doors that allow a Veteran to lock the door from the inside, and give the staff the ability to open immediately if needed.
- Availability of personal hygiene products, appropriate gowns, pajamas, robes, and haircare products are available on all shifts.
- Measures will be taken to maintain and adjust environments to support dignity, privacy and security in the inpatient and outpatient settings for women Veterans.

Chaperones and Escorts

- A female chaperone must be in the room during examinations or procedures involving the breast, genitalia, and rectum regardless of the gender of the provider.

- Female escorts will be provided upon request to female Veterans for any visit.

- Staff that can function as a female chaperone include nurse aides, licensed practical nurses, registered nurses, and trained female volunteer.

Lactation Room

- A lactation room is available for breastfeeding mothers and is located on the **5th floor** in room **B5001.**

- The lactation room has privacy curtains and the room can be locked from the inside for safety.

Women Veterans Program

Women Veteran Program Managers (WVPM)

Women Veterans Program Manager's (WVPM) execute planning for women's health issues to improve the quality of care provided to women Veterans. There is a WVPM is at each VA medical center nationwide.

WVPM Goals:

- Conduct outreach activities that encourages women Veterans to enroll in the VA.
- Ensures that the needs of women Veterans are met and services are available and accessible at all VA sites.
- Coordinate comprehensive services from primary care to specialized care.
- Focus on safety, dignity, and sensitivity to gender specific needs.

Women Veterans Program Managers for North Carolina:

VISN Lead WVPM
(919)956-5541 ext. 222

Durham VA Medical Center:
(919)286-0411 ext. 5229
508 Fulton Street Durham, NC 27704
Toll Free 1-888-878-6890

Salisbury VA Medical Center:
(704)638-9000 ext. 14949
1601 Brenner Avenue Salisbury, NC 28144
Toll Free 1-800-469-8262

Fayetteville VA Medical Center:
(910)488-2120 ext. 7979
2300 Ramsey Street Fayetteville, NC 28301
Toll Free 1-800-771-6106

Asheville VA Medical Center:
(828)298-7911 ext. 5434
1100 Tunnel Road Asheville, NC 28805
Toll Free 1-800-932-6408

Women's Health Primary Care Providers

Women's health primary care provider's (WH PCP) are primary care providers who deliver proficient women's health care. A designated WH PCP is assigned women Veterans within their primary care clinic to coordinate care and to deliver gender specific care for acute and chronic illness, mental health, and preventative maintenance.

Goals of Women's Health Primary Care Providers

- **Gender Specific Care:** Breast exams, pap smears, contraceptive care, sexually transmitted infection (STI) treatment, issues related to pregnancy, management of menopause, pelvic and abdominal pain, and urinary incontinence.

- **Preventative Screenings:** Age appropriate screenings for cancer, immunizations and boosters, smoking cessation, weight management, and STI screening.

- **Acute and Chronic Illness:** Management of chronic obstructive pulmonary disease (COPD), osteoporosis, thyroid disease, upper respiratory illness, hypertension, and screening for breast and cervical.

- **Mental Health:** Assessment and treatment for depression, substance abuse, military sexual trauma (MST), and post-traumatic stress disorder (PTSD).

Women's Health Liaisons

- Assist women Veterans with any difficulties encountered during any visit to the VA
- Provide information and education about the Women Veterans Health Program
- Monitor the environment for safety and privacy issues
- Be an advocate for women Veterans in all sites
- Welcome all women Veterans admitted to the inpatient setting and present them with a welcome kit and document in CPRS that patient has been oriented to women's health policy

Durham VA Hospital Services

All Inpatient Units and ICU's have women's health liaisons.

Primary Care Sites

Hillandale 1, 1F, and 1D clinics have women's health liaisons to assist with examinations and promote safety and comfort.

Community Based Outreach Clinic's (CBOC's)

Raleigh, Greenville, and Morehead City CBOC's have women's health liaisons.

Patient Aligned Care Team (PACT)

A Patient Aligned Care Team (PACT) is each Veteran working together with health care professionals to plan for their care and life-long health and wellness goals.

The goals:

- **Partnerships** with Veterans
- **Access to care** using diverse methods
- **Coordinated care** among team members
- **Team-based care** with Veterans as the center of their PACT

Specialized Care Services:

- Group diabetes classes
- Women's Cardiovascular Clinic
- Transgender Care
- Mindfulness Bases Stress Reduction
- Chronic Pain Management

How does a PACT function?

A PACT is a partnership between you and your health care team to make sure you receive whole-person care. This is personalized care to meet your individual health care goals. The emphasis is on prevention and health promotion.

A PACT uses a team-based approach. All members of your health care team meet to talk with you and each other about your progress toward achieving your health goals. The result is coordination of all aspects of your health care.

You are the center of the care team, which also includes your family members, caregivers, primary care provider, nurses, and clinical staff.
This is our PACT with you —To deliver excellence in every aspect of patient care.

Resources

Durham Women's Health PACT

Clinic 919 416-8091

Optimization of Health and Healthy Aging

The Women Veteran's Health Program is dedicated to women Veterans. Living healthy and staying well during every stage of your life matters.

Immunizations

Vaccinations do not stop at childhood. It is important for adults to be vaccinated, too. By vaccinating yourself against preventable diseases, you are less likely to contract serious illnesses and pass them on to your family.

- At your next visit, ask your health care professional if you're up to date on all recommended vaccinations.

Recommended Adult Immunization Schedule—United States, 2016

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended immunization schedule for adults aged 19 years or older, by vaccine and age group[1]

VACCINE ▼ AGE GROUP ▶	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥65 years
Influenza*[,2]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap)*[,3]	Substitute Tdap for Td once, then Td booster every 10 yrs					
Varicella*[,4]	2 doses					
Human papillomavirus (HPV) Female*[,5]	3 doses					
Human papillomavirus (HPV) Male*[,5]	3 doses					
Zoster[6]					1 dose	
Measles, mumps, rubella (MMR)*[,7]	1 or 2 doses depending on indication					
Pneumococcal 13-valent conjugate (PCV13)*[,8]	1 dose					
Pneumococcal 23-valent polysaccharide (PPSV23)[8]	1 or 2 doses depending on indication					1 dose
Hepatitis A*[,9]	2 or 3 doses depending on vaccine					
Hepatitis B*[,10]	3 doses					
Meningococcal 4-valent conjugate (MenACWY) or polysaccharide (MPSV4)*[,11]	1 or more doses depending on indication					
Meningococcal B (MenB)[11]	2 or 3 doses depending on vaccine					
Haemophilus influenzae type b (Hib)*[,12]	1 or 3 doses depending on indication					

*Covered by the Vaccine Injury Compensation Program

- Recommended for all persons who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection; zoster vaccine is recommended regardless of past episode of zoster
- Recommended for persons with a risk factor (medical, occupational, lifestyle, or other indication)
- No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, NW, Washington, DC 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m.–8:00 p.m. Eastern Time, Monday–Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG), and American College of Nurse-Midwives (ACNM).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Avoid the Flu

Get a Flu Shot each year because the flu virus can change from one year to the next. Flu shots are especially important for people at high risk, including pregnant women, young children, people with chronic health conditions such as asthma, diabetes, or heart and lung disease, and people 65 years and older.

Can the Flu shot give me the flu?

No. There is no live virus in the flu shot so it cannot give you the flu. Some people experience minor headache, low grade fever, or minor body aches, but this is not the flu. **Most people never experience these symptoms.**

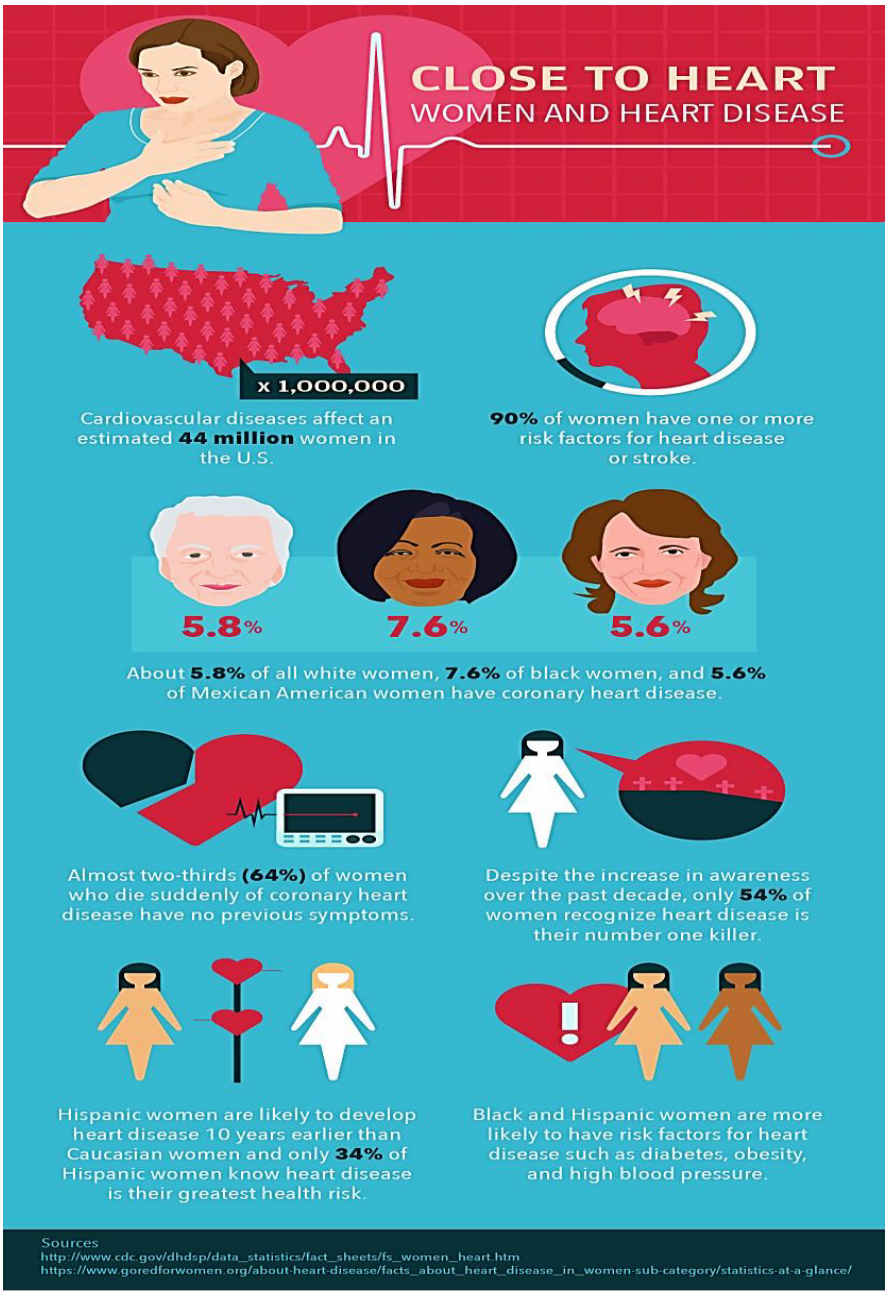
How Can You Avoid the Flu?

- **Get your flu shot**-Everyone 6months of age or older should get the flu shot.
- Clean your hands often with soap and water or hand sanitizer.
- Cough or sneeze into the bend of your elbow or a tissue.
- Limit or avoid contact with people who are sick.
- Clean surfaces often.

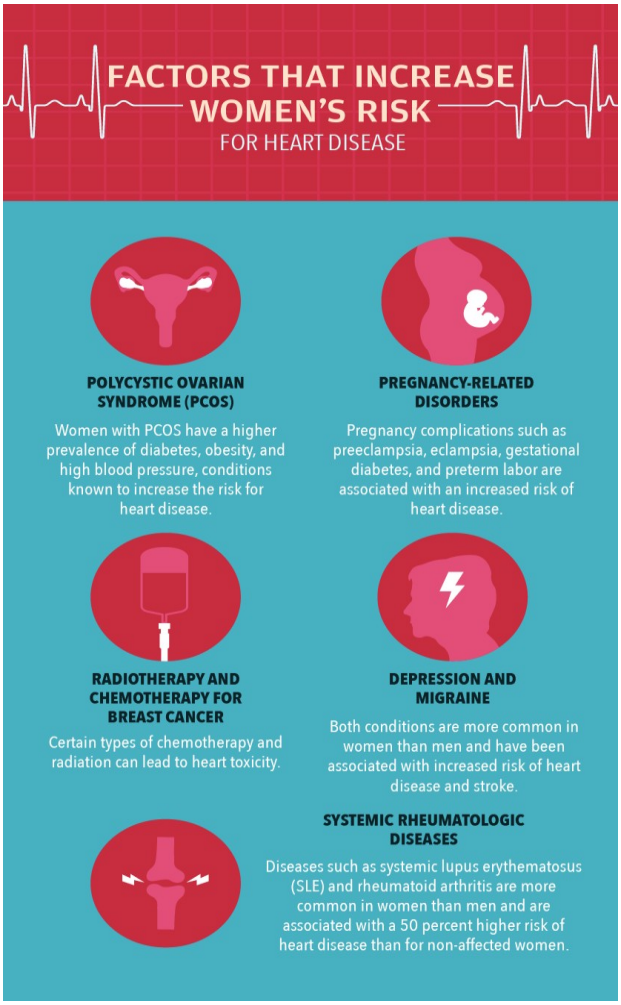
Heart Health

Women tend to experience heart attacks about 10 years later in life than men. Also, women are twice as likely as men to die within the first few weeks after suffering a heart attack.

- Recognize signs and symptoms.
- Do not delay seeking care.



Risk Factors and Symptoms of a Heart Attack



There are many things you can do to lower your risk:

- Report any pain or discomfort in the chest, left arm, shoulder, neck, or back.
- Do aerobic exercise (such as walking, bicycling, swimming) for 30 minutes, five or more days a week (make sure your provider approves any exercise regimen).
- Maintain/watch your weight.
- If you smoke, **QUIT.**
- Control your blood pressure.
- Eat a low-fat diet.
- If you are diabetic, control blood sugar.
- See your doctor regularly for blood pressure monitoring, cholesterol, blood tests, and routine checkups.

High Blood Pressure (Hypertension)

A blood pressure of **140/90 mmHg** or higher is considered high for most people.

Risk Factors for High Blood Pressure

- Being overweight or obese
- Not exercising
- Eating too much salt and sodium
- Not eating enough potassium (found in fruits and vegetables)
- Drinking too much alcohol
- Having diabetes

Lifestyle Changes

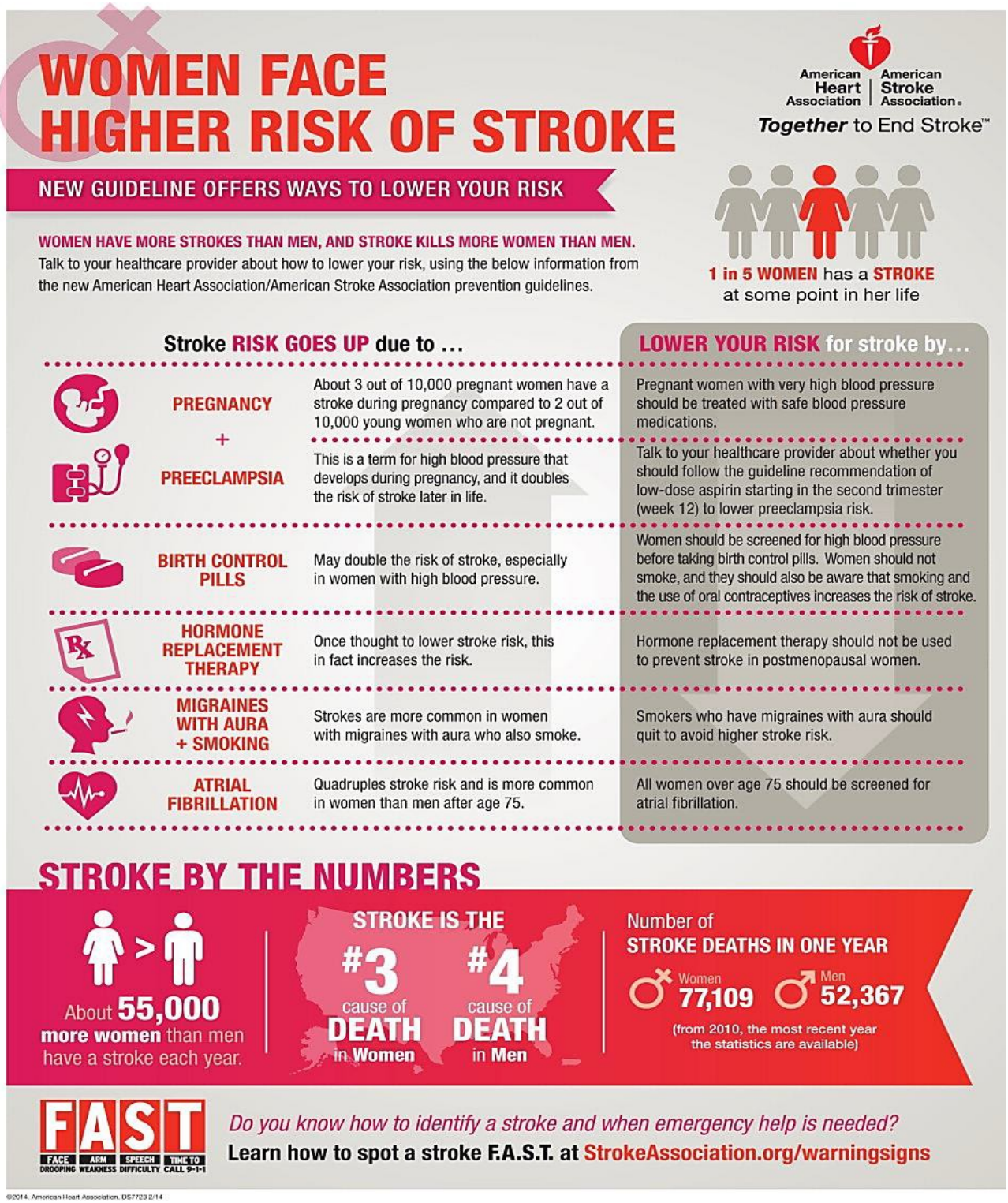
- Maintain a healthy weight
- Be physically active
- Follow a healthy eating plan
- Reduce salt and sodium in your diet
- Drink alcohol only in moderation
- **Quit smoking**
- Control your blood sugar if you have diabetes
- Take prescribed medicine as directed

See your doctor regularly for routine checkups, blood pressure monitoring, cholesterol screening and other blood test.

The VA goes RED for Women's Heart Health the first Friday in February, in conjunction with the American Heart Association.

Stroke

One in five women in the United States will have a stroke in her lifetime. Nearly 60% of stroke deaths are in women. Stroke kills twice as many women as breast cancer.



STROKE is an Emergency.

Every minute counts.

ACT F.A.S.T!

FACE

Does one side of the face droop?
Ask the person to smile.

ARMS

Is one arm weak or numb?
Ask the person to raise both arms. Does one arm drift downward?

SPEECH

Is speech slurred?
Ask the person to repeat a simple sentence. Is the sentence repeated correctly?

TIME

If the person shows any of these symptoms, Call 911 or get to the hospital immediately.

Diabetes

If you have diabetes, your body either doesn't make enough insulin or cannot use the insulin it makes as well as it should. People with diabetes are twice as likely to have heart disease or a stroke as people without diabetes. Smokers are 30–40% more likely to develop type 2 diabetes than nonsmokers.

You are at risk for developing prediabetes or type 2 diabetes if you:

- Are overweight
- Are age 45 or older
- Have a parent, brother, or sister with type 2 diabetes
- Are physically active less than 3 times a week
- Have ever had gestational diabetes (diabetes while pregnant) or given birth to a baby weighing more than 9 pounds
- Have more infections than usual

Symptoms:

- Urinate (pee) a lot, often at night
- Are very thirsty
- Lose weight without trying
- Are very hungry
- Have blurry vision
- Have numb or tingling hands or feet
- Feel very tired
- Have very dry skin
- Have sores that heal slowly

Managing Diabetes

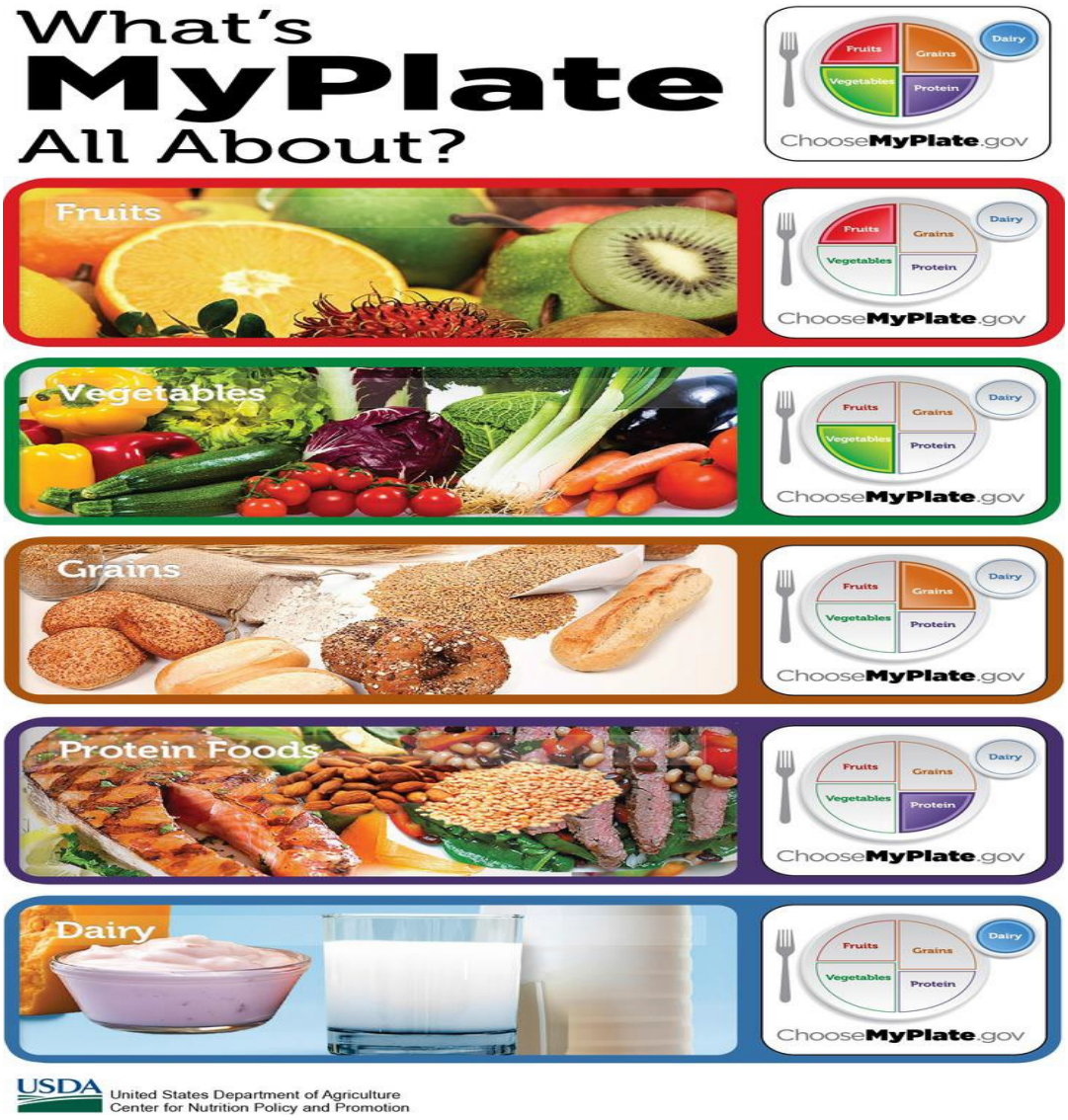
Eat Less Sugar- Eat fewer foods that are high in sugar. Drink water, sugar-free soda, or unsweetened iced tea instead of fruit drinks, regular soda, or sweet tea.

Eat Healthy Portions- Eat less fat. Choose fewer high-fat foods and use less fat for cooking.

Be Physically Active- Experts recommend moderate-intensity physical activity for at least 30 minutes on 5 or more days of the week.

Stay Healthy- Get a hemoglobin A1C test at least twice a year to determine what your average blood glucose level was for the past 2 to 3 months.

Health Portions



Resources

Diabetes Management and Education

Durham VA

919 286-0411 ext. 6145

Asheville VA

828 298-7911 ext. 4735

Salisbury

704 638-9000 ext. 13645

https://www.cdc.gov/diabetes/basics/index.html

Menopause

Menopause is a point in time 12 months after a woman's last period. The menopausal transition most often begins between ages 45 and 55. It usually lasts about 7 years but can last as long as 14 years.

Symptoms:

- Hot flashes
- Night sweats
- Vaginal dryness
- Emotional changes
- Change in interest in sexual activities

A woman who does not want to get pregnant should continue to use birth control for at least a full 12 months after her last period.

If you are having symptoms commonly associated with the menopausal transition discuss your concerns and treatment options with your women's health primary care provider.

Resources

American Congress of Obstetricians and Gynecologists
1-800-673-8444 (toll-free)
www.acog.org

National Institutes of Health Menopausal Hormone Therapy Information
www.nih.gov/PHTindex.htm

North American Menopause Society
1-440-442-7550
www.menopause.org

MENOPAUSE

[TIPS FOR A HEALTHY TRANSITION]

Staying healthy and attending to bothersome symptoms can help ease the menopause transition.

It's also important to manage the increased risk for **heart disease** and **osteoporosis** that come with menopause.

Take care to:

Quit smoking or using tobacco products, if you currently do.

Eat a healthy diet, low in fat, high in fiber, with plenty of fruits, vegetables, and whole-grain foods.

Make sure you get enough calcium and vitamin D.

Learn what your healthy weight is, and try to stay there.

Do weight-bearing exercise, such as climbing stairs or dancing, at least 3 days each week for healthy bones. Try to be physically active in other ways for your general health, too.

Remember:

Menopause is not a disease that has to be treated.

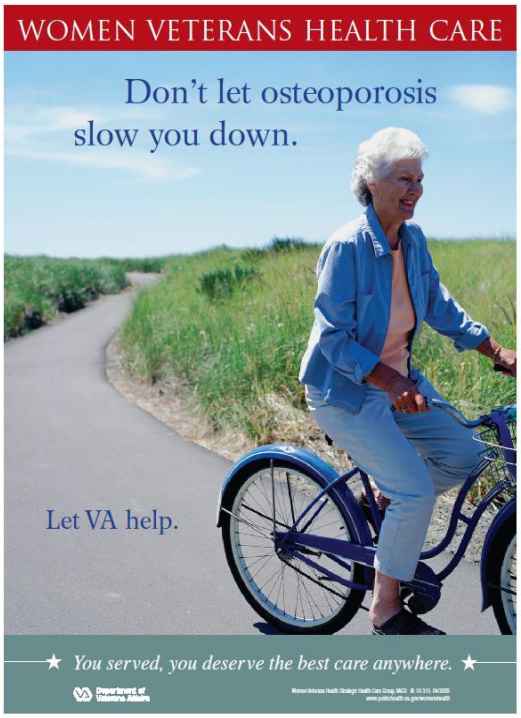
But it's a good idea to talk to your doctor about staying healthy and things you can do if symptoms like hot flashes bother you.

Visit www.nia.nih.gov/menopause for more information about menopause.

NIH National Institute on Aging

Osteoporosis

Osteoporosis is a “silent disease” characterized by weakened bones. You may not notice any changes until a bone breaks. Most often, bones in the hip, spine, and wrist break easily. Around the age of 30 bone mass stops increasing and bones become weaker.



Risk Factors:

- Family history
- Thin/petite build
- Caucasian/Asian descent
- Certain medications (steroids, excessive thyroid hormone)
- Smoking
- Too much caffeine/alcohol
- Decreased estrogen levels
- Lack of physical exercise
- Inadequate calcium and vitamin D

Symptoms:

- Loss of height over the years
- Certain types of back pain
- Curved upper back
- Breaking a bone in hip, wrist, or spine from minimal trauma

Resources

National Institutes of Health Osteoporosis and Related Bone Diseases National Resource Center
1-800-624-2663 (toll-free)
NIHBoneInfo@mail.nih.gov
www.bones.nih.gov

National Institute of Arthritis and Musculoskeletal and Skin Diseases
1-877-226-4267 (toll-free)
www.niams.nih.gov

National Osteoporosis Foundation
1-800-231-4222 (toll-free)
info@nof.org

Smoking Cessation

1-800-Quit-Vet (784-8838)

Smoking is known to increase the risk of:

- Depression and anxiety.
- Coronary heart disease by 2 to 4 times.
- Stroke by 2 to 4 times.
- Women developing lung cancer by 13 times.
- Dying from chronic obstructive lung diseases (such as chronic bronchitis and emphysema) by 12 to 13 times.
- Pregnancy complications.

If you are a woman of child-bearing age, smoking has several reproductive side-effects, including increased risk for:

- Infertility.
- Preterm delivery.
- Stillbirth.
- Low birth weight.
- Sudden infant death syndrome (SIDS).

Tobacco & Health
Policy and Programs

Interested in *Quitting?* VA can help.

Talk to your VA health care provider today!

Quit VET — A toll free telephone smoking quitline

Speak with a counselor and get:

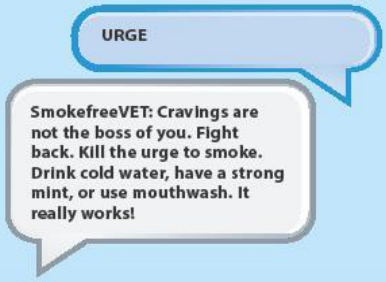
- Individualized counseling
- Help developing a quit plan
- Strategies to prevent relapse
- Follow-up calls to help you stay quit

1-855-QUIT VET
(1-855-784-8838)
Mon–Fri 8AM–8PM (ET)
Consejería en Español
es disponible

smokefreeVET — A mobile text message smoking cessation service

24/7 encouragement, advice, and tips to help you stop smoking for good.

To Sign Up: text the word **VET** to **47848** from your mobile phone
Or Visit: **www.smokefree.gov/VET**



You don't need to sign up to get support!
Text **URGE**, **STRESS**, or **SMOKED** anytime to **47848** for support.

**If you pay for individual texts, this program may not be for you. Standard messaging rates apply.*

A partnership between the
U.S. Department of Veterans Affairs
and the National Cancer Institute at the
National Institutes of Health,
U.S. Department of Health and Human Services

VA | U.S. Department of Veterans Affairs

www.va.gov
www.cancer.gov

July 2013
IB 10-414 | P96582

Exercise

MOVE! is a weight management health promotion program designed to improve the lives of Veterans. The MOVE! Program encourages healthy eating behavior and increased physical activity. Even small weight losses can reduce health risks, prevent or reverse certain diseases, and improve quality-of-life.

MOVE! Group Sessions are the most common way Veterans participate in MOVE! Time-limited, clinician-led groups meet regularly and follow a structured format for weight loss.

MOVE! Telephone Lifestyle Coaching is for Veterans who prefer one-on-one contact via telephone with a designated weight management coach.

TeleMOVE! is for Veterans who may benefit from frequent reminders to stay on track with their weight management goals. This includes daily interaction with in-home messaging technologies and clinician contact as needed.

MOVE! Coach is a mobile app for Veterans who prefer to manage their weight on their own. Simply go to the App Store on any iOS device (version 6.0 or higher) and download the app.

Weight Loss Medications and Bariatric Surgery are treatment options that may be offered to Veterans who have tried MOVE! and continue to struggle with being overweight or weight-related issues.

Resources

Durham VA

Nutrition Clinic/ MOVE Program

919 286-0411 ext. 8034

Advance Directives

An advance directive is a legal form that helps your doctors and loved ones understand your wishes about medical and mental health care in the event that you are unable to make decisions for yourself. It is the best way to ensure that your medical care reflects your wishes.

Durable Power of Attorney - Allows you to identify a Health Care Agent, the person who would make health care decisions for you if you are unable to make decisions for yourself. Choose someone you trust and who knows you well.

Living Will - Allows you to identify the treatments you would and would not want, such as resuscitation, mechanical ventilation (breathing machine) and feeding tube.

Do Not Resuscitate - A Do Not Resuscitate (DNR) order is a medical order indicating that you do not want to have cardiopulmonary resuscitation (CPR) if your heart stops beating. Unless given other instructions, hospital staff will use CPR if a person's heart stops.

How Do I Get Started

- Ask your social worker for a VA Advance Directive form or go to www.va.gov/vaforms for the form and related information.
- You can also talk with your social worker if you need help starting a conversation with loved ones about your wishes or completing the Advance Directive.

Can I Change my Advance Directive?

Yes, you may change or cancel your advance directive at any time. You should review your advance directive often to make sure it is up to date. If you change it, be sure to tell your health care team and have them put it in your health record. And share your new directive with your family members and other loved ones.

Resources

www.va.gov/Geriatrics
www.va.gov/Ethics

Social Work Services

Durham	Asheville	Salisbury	Fayetteville
919 286-0411 ext. 7065	828 298-7911 ext. 5335	638-9000 ext. 16299 or 13699	910 488-2120 ext. 5742

Advance Directive Care Planning

Think about these questions before you prepare your advance directive. They are also good topics to discuss with your loved ones, health care providers and spokesperson.

- Do you want to take part in making decisions about your care and treatment?
- Do you always want to know the truth about your condition?
- Would you want palliative care, which offers comfort measures that focus on relief of suffering and control of symptoms so you can do what is most important to you?
- How do you feel about life sustaining measures in the face of terminal illness?
- Do you have strong feelings about certain medical treatments, such as CPR, feeding tube, dialysis, intensive care?
- Do you want to be an organ donor?
- What will be important to you when dying?

Patient Advocate

The patient advocate program was established to promote positive experiences for all Veterans. The goal of the program is to provide customer service in a manner that addresses the Veterans needs in a proactive, convenient, and timely manner.

Patient Advocates

Durham
919 286-0411 ext. 7065

Asheville
828 298-7911 ext. 5335

Fayetteville
910 488-2120 ext. 5742

Salisbury
704 638-9000 ext. 16299 or 13699

Durham VA Chaplain Services:

919 286-6867

My Healthe*V*et

My Healthe*V*et is a secure, web-based personal health record that provides women Veterans with information and tools to improve their health.

How to Register:

www.myhealth.va.gov/

Step 1. There are two ways to access the registration page. When you enter MyHealthe*V*et:

- Select the green **Register Today Start Here** button on the landing page, or
- Select the red REGISTER button in the Member Login box on the right side of the screen

Step 2. Complete the registration form:

- Identification - enter the following information exactly as it appears in your VA/DoD record:
  - First, middle, and last name. Do not include any special characters in your name The exception: If you have two last names separated by a hyphen (-); then you can add the hyphen.
  - Social Security Number (SSN)
  - Gender (male, female)
  - Date of birth (DOB)
- Relationship to VA* - you must select Veteran, VA Patient (or both) for **MyHealthe*V*et** to map your account with your VA/DoD records
- Contact Information - select a preferred method of contact, for example: email address, phone/fax/page number
- Account Information:
  - Create a user ID that is unique and contains no spaces; it must be 6-12 characters
  - Create a password that is unique, contains no spaces; must be 8-12 characters and have at least one letter, one number and one special character (such as !, #, %, etc.)
  - Create two password hint questions and answers
  - Terms & Conditions and Privacy Policy - select the Terms & Conditions and Privacy Policy links, read and then accept

Step 3. Select the red SAVE button at the bottom of the registration form. You can now go to the **MyHealthe*V*et** homepage and login using your user ID and password.

VA APP Store

https://mobile.va.gov/appstore

These apps help you better manage your care and stay in touch with your VA care team. The apps are available from the VA App Store and may be accessed on any device that has internet access (e.g., personal computer, iPad, iPhone, Android device, etc.). Make sure your device's browser is up to date so that the apps work correctly.

Mobile Blue Button

The Mobile Blue Button App was designed to help both you and your Caregivers better manage your health care needs and communicate with your care teams. By using the Mobile Blue Button App, you can access, print, download and store information from your VA Electronic Health Record (EHR) in a secure, reliable and simple way.

MOVE! Coach

MOVE!® Coach is a weight loss app for Veterans, service members, their families, and others who want to lose weight. This 19-week program guides the participants to achieve success with weight loss through education, and use of tools, in an easy and convenient way. Participants can monitor, track, and receive feedback regarding their progress with weight, diet, and exercise goals.

Mindfulness Coach

Mindfulness Coach was designed to help Veterans, Service members and others learn how to practice mindfulness. Mindfulness means paying attention, on purpose, to whatever is going on in the present moment without passing judgment on it.

Moving Forward

With the Moving Forward mobile application (App) you can access on-the-go tools and learn problem solving skills to overcome obstacles and deal with stress.

My VA Health

The My VA Health App allows you to access your official VA medical record and enter information about your health. With the app, you can store contact information and health and military histories, as well as record your wellness goals, monitor your mood and create entries about a variety of health topics.

Parenting2Go

The Parenting2Go App is designed to provide convenient tools to help you strengthen your parenting skills and reconnect with your children. The App addresses challenges that come with parenting children of all ages and includes advice on how to handle every day parenting situations unique to military life.

VA APP Store

https://mobile.va.gov/appstore

PTSD Coach	Stay Quit Coach	Summary of Care
The PTSD Coach App was designed for Service members and Veterans who have, or may have, Post -Traumatic Stress Disorder (PTSD). This App provides readily available tools to manage PTSD-related symptoms and stress and supports Service members and Veterans with self-assessments, symptom-tracking capabilities, educational materials, and coping skills to address and monitor stress.	**The Stay Quit Coach App was designed to help Veterans with Post-Traumatic Stress Disorder (PTSD) quit smoking. The App guides users in creating a tailored plan that takes into account their personal reasons for quitting. It provides information about smoking and quitting, interactive tools to help users cope with urges to smoke, and motivational messages and support contacts to help users stay smoke-free.**	**If you are a Veteran enrolled in VA health care, the Summary of Care App lets you receive and view your VA medical information – including lab results, medications, allergies, and more in one place and from the convenience of your mobile device.**

Family Planning: Plan A

Contraception (Birth Control)

Women have control over when, and if, they want to become pregnant. The VA offers may birth control options for women Veterans. All forms of birth control are available in all VA sites. To learn about birth control or get started on birth control please consult with your women's health provider.

Types of Birth Control

Barrier Methods: contraceptive sponge, cervical cap, female condom, male condom

Hormonal Methods: oral contraceptives, the patch, shot/injection, vaginal ring

Implantable Devices: Intrauterine device (IUD), Implantable rod

Permanent Birth Control: surgical sterilization

Emergency Contraception: Plan B, "Morning after pill"

Continuous Abstinence

Rhythm Method

When choosing birth control it is important to consider the following:

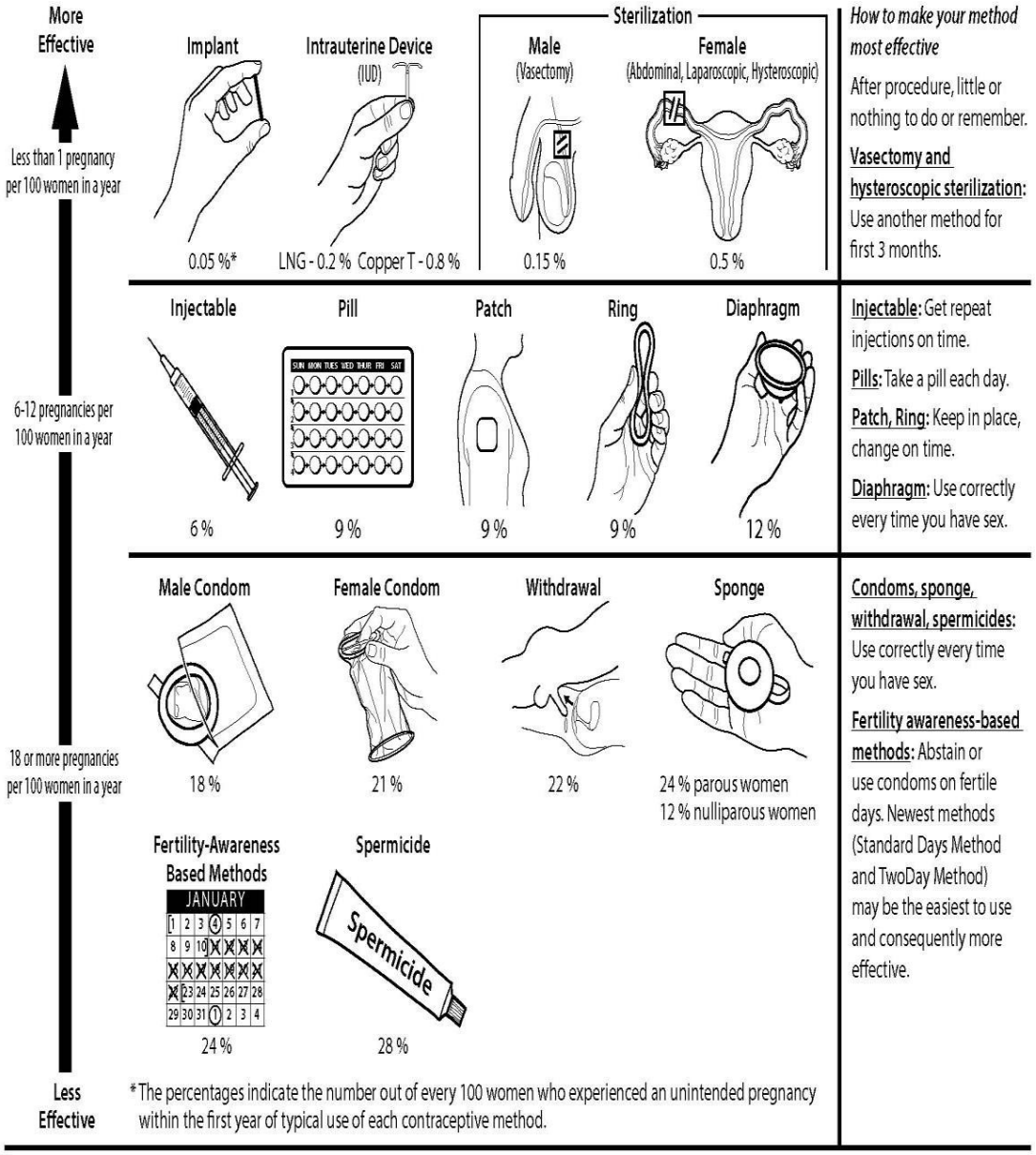
- Your current health status
- The number of sex partners you have
- How often you have sex
- If you want to have children at some point
- How well each method works to prevent pregnancy
- Possible side effects and risk
- Failure rate
- Your ability to use the method effectively
- Protection against sexually transmitted infections (STI) – **Male condom is only method proven to protect against STI**

Resources

Food and Drug Administration
www.fda.gov
1-888-463-6332

American College of Obstetrics and Gynecologist Resource Center
www.acog.org
1- 800-762-2264

Effectiveness of Contraceptive Methods



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

Lactational Amenorrhea Method: LAM is a highly effective, *temporary* method of contraception.

Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Adapted from WHO's Family Planning: A Global Handbook for Providers (2001) and Trussell et al (2011).

CS 231556

What is Contraceptive Failure?

- No contraception is used during intercourse
- A condom breaks, slips off, or is not used the whole time a couple is having sex
- A woman forgets to take her birth control pills two days in a row
- A woman who normally takes birth control pills containing just progestin takes her pill more than three hours late
- Greater than 15 weeks from last injection of depot-medroxyprogesterone acetate
- A diaphragm or cervical cap moves, breaks, tears, or is removed too soon
- Ortho-Evra patch comes off, is removed too early, or is put on too late
- Nuva ring comes out, is removed too early, or is inserted too late
- A sperm-killing tablet or film fails to melt before sexual intercourse
- A woman who uses the rhythm method makes a mistake figuring out the "safe time" in her cycle, or she has intercourse during the days she is likely to conceive
- An intrauterine device (IUD) accidentally comes out
- Sexual assault

Emergency Contraception

Plan B

Emergency Contraception is available at all of the Community Based Outreach Clinics and all VA Emergency Rooms. Emergency contraception stops pregnancy before it starts.

Plan B and Ella:

- Delays/inhibits ovulation

- Plan B contains Progesterone only
- Ella contains Antiprogestin
- Efficacy decreases if taken over 120hours after intercourse (FDA approval 72hours)
- Contraindications: Known pregnancy (Ella) and breast feeding

What is your Plan C?

- Any regular contraceptive method can be started immediately after the use of emergency contraception

- Ella- abstain from sexual intercourse or use barrier contraception for 14 days or until your next menses, whichever comes first.

- Plan B-abstain from sexual intercourse or use barrier contraception for 7 days or until your next menses, whichever comes first.

What's the Best Emergency Contraception for You?

	 Copper-T (ParaGard® IUD)	 ella®	  Plan B One-Step® Next Choice One Dose™ and others
Effectiveness	**Best**	**Very good**	**Good**
When to Use	Up to 5 days after unprotected sex.	Up to 5 days after unprotected sex.	Up to 3 days after unprotected sex. Less effective on days 4 and 5, but you can still use it.
Who Can Use	All women.	All women (unless breastfeeding). Less effective for women with a BMI over 35.	All women. Less effective for women with a BMI over 25. May not work for women with a BMI over 30.
How to Get	Inserted by a doctor or nurse at a health center.	By prescription from a doctor or nurse.	Plan B One Step: Anyone can get it over the counter (OTC) from a drugstore or health center. **A prescription is needed at the VA hospital, which can be obtained in the Emergency room.**
Extra Information	Provides very effective ongoing birth control for up to 12 years.	After using, use back up birth control (like a condom) for 14 days.	Do not use if you've already used ella since your last period.

Pregnancy and Prenatal Care

Maternity benefits begin with the confirmation of pregnancy with at pregnancy test. Maternity benefits continue through the final post-partum visit 6 weeks after delivery. Veterans are referred to a local OBGYN of the Veteran's choice within 50 miles to 1 hour of the Veteran's home.

Maternity Benefits include:

- Genetic Consultation
- Parenting Classes
- Birthing Classes
- Lactation Classes
- Breast pumps, nursing bras, nursing pads, and maternity belts (available through prosthetics and the pharmacy)

Newborn Services:

- Care is provided for the newborn children of Veterans that received maternity care through the VA
- Routine post-delivery care is provided from birth through the first 7 days of life

A Healthy Pregnancy

Ways to optimize your health to protect your pregnancy:

- Take 400 micrograms of folic acid a day for at least 3 months before getting pregnant to prevent birth defects.
- Stop smoking and drinking alcohol.
- Maintain a healthy weight.
- Consult your provider if you have any medical or mental health concerns.
- Check that your vaccinations are up to date.
- Talk to your provider about your prescribed medications, herbal supplements, and over the counter medications.
- Prevent sexually transmitted infections- they can cause low birth weights and severe problems in newborns

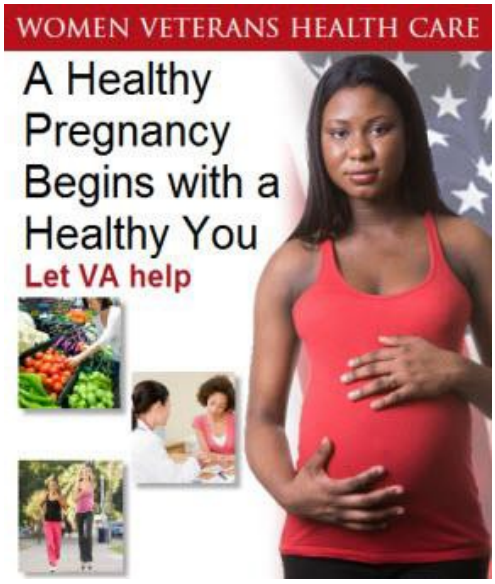
Maternity Care Coordinators

Durham
(919) 286-0411 ext. 5229

Asheville
(828) 298-7911 ext. 3133

Fayetteville
(910) 813-1647

Salisbury
(704)638-9000 ext. 14341



Immunization & Pregnancy

Vaccines help keep a pregnant woman and her growing family healthy.

Vaccine	Before pregnancy	During pregnancy	After pregnancy	Type of Vaccine
Hepatitis A	Yes, if indicated	Yes, if indicated	Yes, if indicated	Inactivated
Hepatitis B	Yes, if indicated	Yes, if indicated	Yes, if indicated	Inactivated
Human Papillomavirus (HPV)	Yes, if indicated, through 26 years of age	No, under study	Yes, if indicated, through 26 years of age	Inactivated
Influenza IIV	Yes	Yes	Yes	Inactivated
Influenza LAIV	Yes, if less than 50 years of age and healthy; avoid conception for 4 weeks	No	Yes, if less than 50 years of age and healthy; avoid conception for 4 weeks	Live
MMR	Yes, if indicated, avoid conception for 4 weeks	No	Yes, if indicated, give immediately postpartum if susceptible to rubella	Live
Meningococcal: • polysaccharide • conjugate	If indicated	If indicated	If indicated	Inactivated Inactivated
Pneumococcal Polysaccharide	If indicated	If indicated	If indicated	Inactivated
Tdap	Yes, if indicated	Yes, vaccinate during each pregnancy ideally between 27 and 36 weeks of gestation	Yes, immediately postpartum, if not received previously	Toxoid/ inactivated
Tetanus/Diphtheria Td	Yes, if indicated	Yes, if indicated, Tdap preferred	Yes, if indicated	Toxoid
Varicella	Yes, if indicated, avoid conception for 4 weeks	No	Yes, if indicated, give immediately postpartum if susceptible	Live

For information on all vaccines, including travel vaccines, use this table with www.cdc.gov/vaccines

Get an answer to your specific question by e-mailing cdcinfo@cdc.gov or calling 800-CDC-INFO (232-4636) • English or Spanish

National Center for Immunization and Respiratory Diseases
Immunization Services Division

CS238938B 09/2013

Infertility

The VA provides medically necessary infertility services for Veterans only. A Veteran with a service connected disability that results in the inability of the Veteran to procreate without the use of fertility treatment is eligible for In vitro Fertilization (IVF).

Diagnostics and Treatments for Women and Men Include:

- Infertility Counseling
- Laboratory blood testing
- Genetic Counseling and Testing
- Hormonal Therapies

Female Veterans	Male Veterans
Hysterosalpingogram	Semen Analysis
Saline Infused Sonohysterogram	Evaluation of Erectile Dysfunction
Reversal of Tubal Ligation	Reversal of Vasectomy
Intrauterine Insemination (IUI) Artificial Insemination (AI) Maximum of 6 cycles	Sperm Cryopreservation for medically indicated conditions
Surgical correction of structural pathology	Sperm Retrieval Techniques
Oral Medications	Transrectal or scrotal ultrasonography
	Post Ejaculatory Urinalysis

- Assisted reproductive technology will be provided through community providers.
- Routine fertility services may still be provided in house.
- The VA strongly encourages interested Veterans to start conversations with their VA healthcare provider to discuss eligibility.

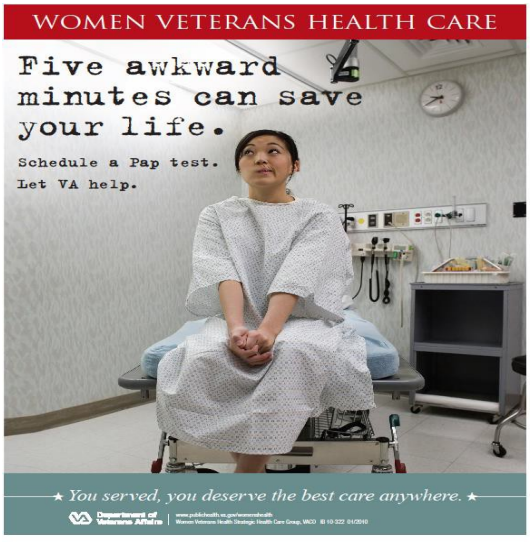
Gynecology Services

Gynecology services are available at the Durham VA in the inpatient or outpatient setting for the treatment of:

- Cervical Cytology
- Uterine Fibroids
- Endometriosis
- Polycystic Ovarian Syndrome
- Incontinence Procedures
- Abnormal Uterine Bleeding
- Pelvic Pain
- Gynecological Malignancies
- Hysterectomies and Surgical Care
- Pre and Post-Menopausal Care
- Preventative Screenings- Pap Smears, HPV testing

Women Veterans at the Morehead City Community Based Outreach Clinic (CBOC) can be seen at the Greenville Health Care Center or receive services at outside facilities since they live more than 50 miles from Durham and Greenville.

The Salisbury, Asheville, and Fayetteville VA facilities offer gynecology services in their Women's Health Clinics and inpatient settings.



Cervical Cancer

Cervical cancer is highly preventable and treatable when detected early through screening test (Pap smear and HPV testing). HPV is the main cause of cervical cancer.

Risk Factors:

- HPV
- HIV
- Smoking
- Birth Control Pills for greater than 5 years
- Birthing more than 3 children
- Multiple sexual partners

Signs and Symptoms:

- Asymptomatic (No symptoms at all)
- Abnormal Vaginal bleeding
- Abnormal Vaginal discharge
- Bleeding after sex

Treatment:

If your doctor diagnoses cervical cancer you will be referred to an oncologist (doctor that specializes in cancer treatment) to discuss what treatment is right for you:

- Surgery
- Radiation
- Chemotherapy
- Alternative medicine

Preventative Screenings

Pap Smear

The Pap smear test looks for cell changes on the cervix which may become cervical cancer if not treated properly. The Pap test is recommended for women ages 21-65 years.

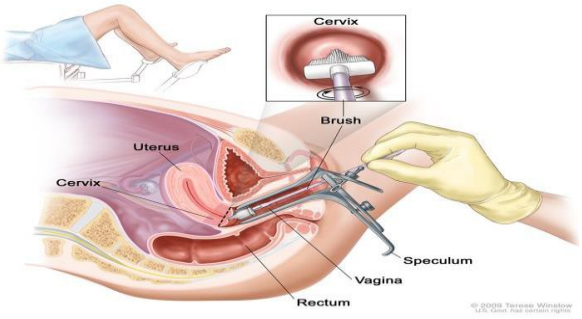
The Pap smear **only** screens for cervical cancer. It does not screen for ovarian, uterine, vaginal or vulvar cancers. If you are experiencing any unusual signs and symptoms consult with your doctor.

How to Prepare for Your Pap Smear

You should not schedule your Pap test for a time when you are having your period. If you are going to have a Pap test in the next two days—

- You should not douche (rinse the vagina with water or another fluid).
- You should not use a tampon.
- You should not have sex.
- You should not use a birth control foam, cream, or jelly.
- You should not use a medicine or cream in your vagina.
- You may have a pelvic exam after your Pap smear to assess the health and size of your reproductive organs.

If your test results are normal you do not have to get another pap smear for 3 years.
If you are **older than 65 and have had normal Pap test** results for several years, or if you have had your cervix removed as part of a total hysterectomy for non-cancerous conditions, like fibroids, your doctor may tell you that you do not need to have a Pap test anymore.



HPV Test

Human papillomavirus (HPV) is a virus that can causes cervical cell changes. HPV is the most common sexually transmitted infection in the United States.

- When the body's immune system cannot get rid of HPV it can cause normal cells to become abnormal which can lead to cervical cancer.
- There are several strains of HPV and 13 are known to cause cancer.

When to Get Tested

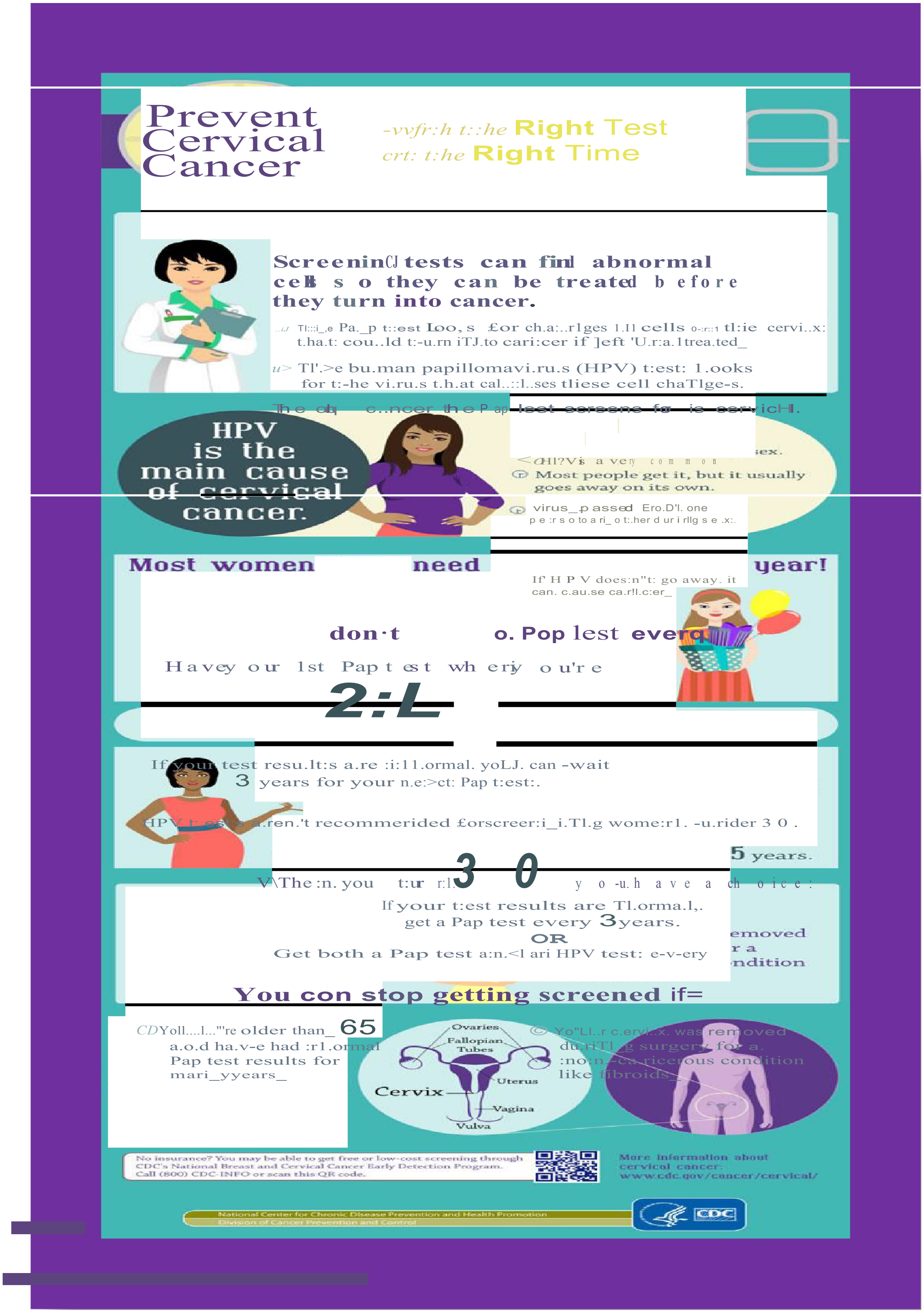
If you are **30 years or older** you may choose to have the Pap test and the HPV test done at the same time (Co-testing).

- Talk with your doctor, nurse, or other health care professional about whether the HPV test is right for you.
- **If you have both tests (Co-testing) and the results are normal you can get both test done every 5 years.**

HPV Vaccination

The HPV vaccination can be administered to prevent HPV in men and women.

- A series of 2-3 shots and can be given up until the age of 26 years.
- Even if you are vaccinated you need to get regular screening test to check for cervical cancer.


Prevent Cervical Cancer
Right Test
Right Time
Screening tests can find abnormal cells so they can be treated before they turn into cancer.
The human papillomavirus (HPV) test: looks for the virus that causes these cell changes.
HPV is the main cause of cervical cancer.
Most people get it, but it usually goes away on its own.
Most women
need
year!
don't
a Pap test every
2:L
years for your next Pap test.
3 0
5 years.
If your test results are normal,
get a Pap test every 3 years.
OR
Get both a Pap test and HPV test every
You can stop getting screened if
older than 65
Pap test results for
Ovaries
Fallopian Tubes
Uterus
Cervix
Vagina
Vulva
No insurance? You may be able to get free or low-cost screening through CDC's National Breast and Cervical Cancer Early Detection Program. Call (800) CDC-INFO or scan this QR code.
More information about cervical cancer: www.cdc.gov/cancer/cervical/
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
CDC

Sexually Transmitted Infections (STI)

STI's are passed from one person to another through unprotected sex or genital contact. STI's often have no signs and symptoms (asymptomatic). If you suspect that you have a STI or have been exposed to one please see your provider. If left untreated STI's can cause infertility.

Common STI's That Impact Women's Reproductive Health:

- Chlamydia
- Gonorrhea
- Pelvic Inflammatory Disease
- Syphilis
- Herpes
- HPV
- HIV

Risk Factors:

- Multiple sex partners
- Sex without a condom
- Sex for money or drugs
- Use of needles for illegal drugs

What Can I Do to Prevent Getting STI's:

- Use condoms consistently and correctly
- Reduce number of sexual partners
- Abstain from sex
- Reduce risky sexual behaviors
- Be honest with your healthcare provider

Breast Cancer

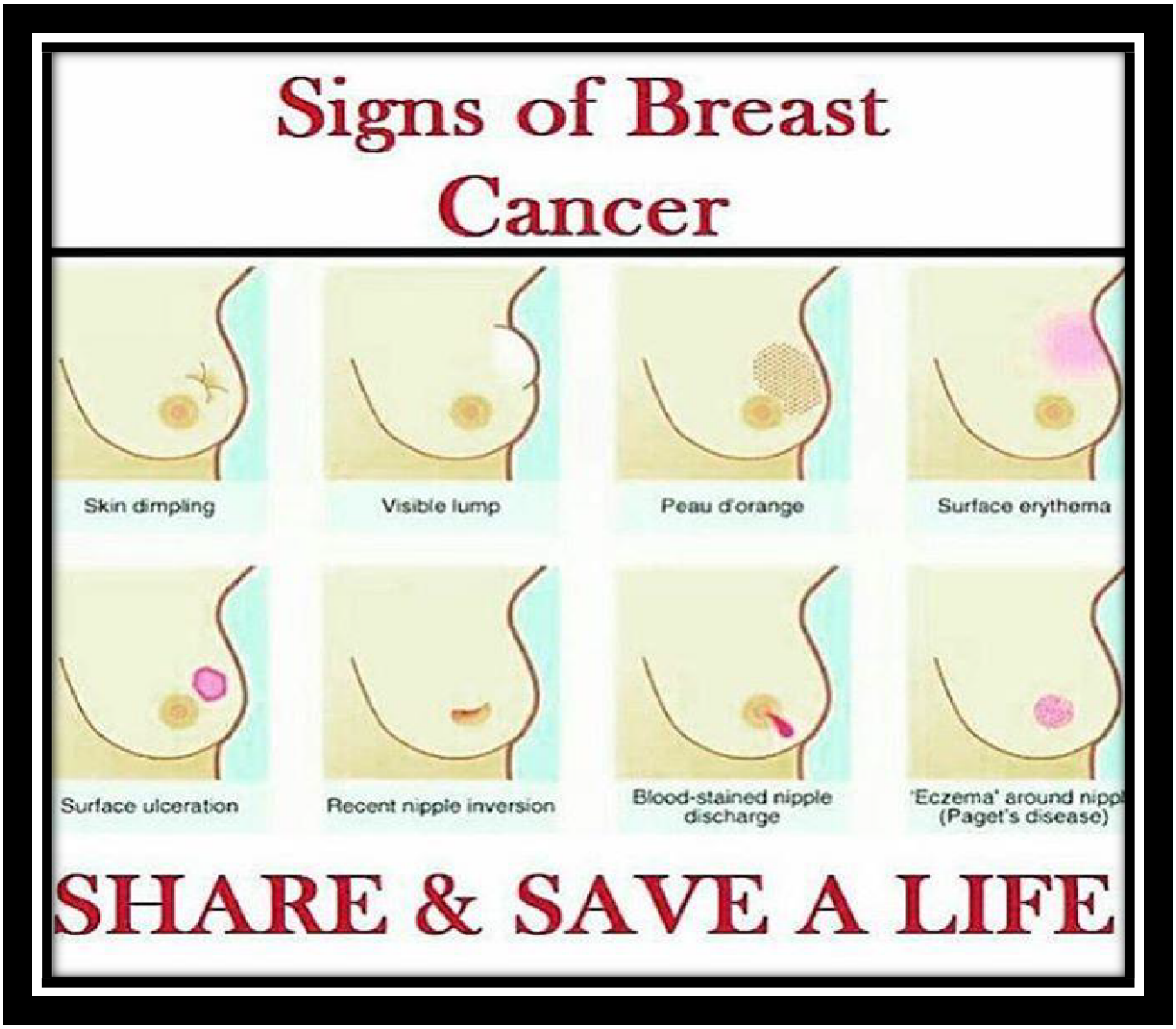
Breast cancer is a serious concern for women as 1 in 8 American women will develop inflammatory breast cancer. Breast cancer is the second most common cancer in women in the US. Breast cancer is an abnormal growth of breast tissue and has a 99% survival rate if detected early. The VA provides mammogram services for female Veterans and leads the nation in breast cancer screening.

Risk Factors:

- Race (African American, Hispanic, Asian)
- Smoking
- Age
- Family History (1 first degree relative doubles risk: sister, mother, daughter)
- Genetics- 5-10% of breast cancers are hereditary
- Obesity
- Breastfeeding (lowers risk if breastfeed longer than 1 year)
- Having Dense Breast Tissue
- Hormone Replacement Therapy
- Alcohol Use
- Menstrual History (women who began their periods before the age of 12 and women who begin menopause after the age of 55)
- Exposure to radiation
- Risk Assessment Tool: **https://www.cancer.gov/bcrisktool/**
- Genetic Risk Assessment Tool: **https://www.knowbrca.org/**

Signs and Symptoms of Breast Cancer

- A lump or thickening on or near the breast or underarm
- Change in size or shape of breast
- Dimple or puckering of the skin of the breast
- Nipple turned inward
- Fluid, other than breast milk, from the nipple, especially if bloody
- Scaly, red, swollen skin on the breast, nipple, or areola (dark area of skin around the nipple)
- Dimples in the breast that look like the skin of an orange, called peau d'orange



Breast Cancer Screening

The Durham VA provides annual mammograms in its full service mammogram suite* to all women Veterans between the ages of 45-54.

The American Cancer Society Guidelines:

- Women age 55 or older should be screened every 2 years and should continue as long as their health is good.
- If a woman is under the age of 45 and has a family history of breast cancer they can be screened 5 years earlier.

The VA strives to make all women feel safe during their exams in the medical center and female escorts are available to accompany you during your exam.

*A mammogram bus travels between the Greenville Health Care Center and the Wilmington CBOC's. The Salisbury and Asheville VA Hospitals perform mammograms in their facilities. Your primary care provider can order your screening mammogram at the location closest to your home.

Breast Cancer Screening Test

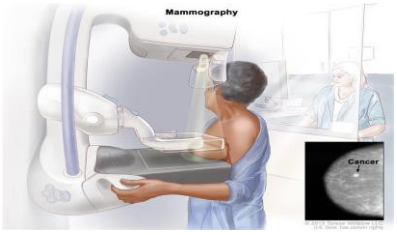
Mammogram- 3D mammogram technology coming to Durham VA

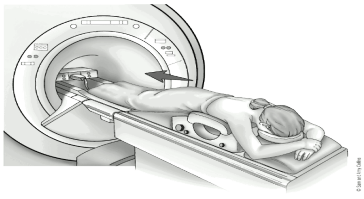
Clinical Breast Exam

Breast Self-Awareness

Ultrasound

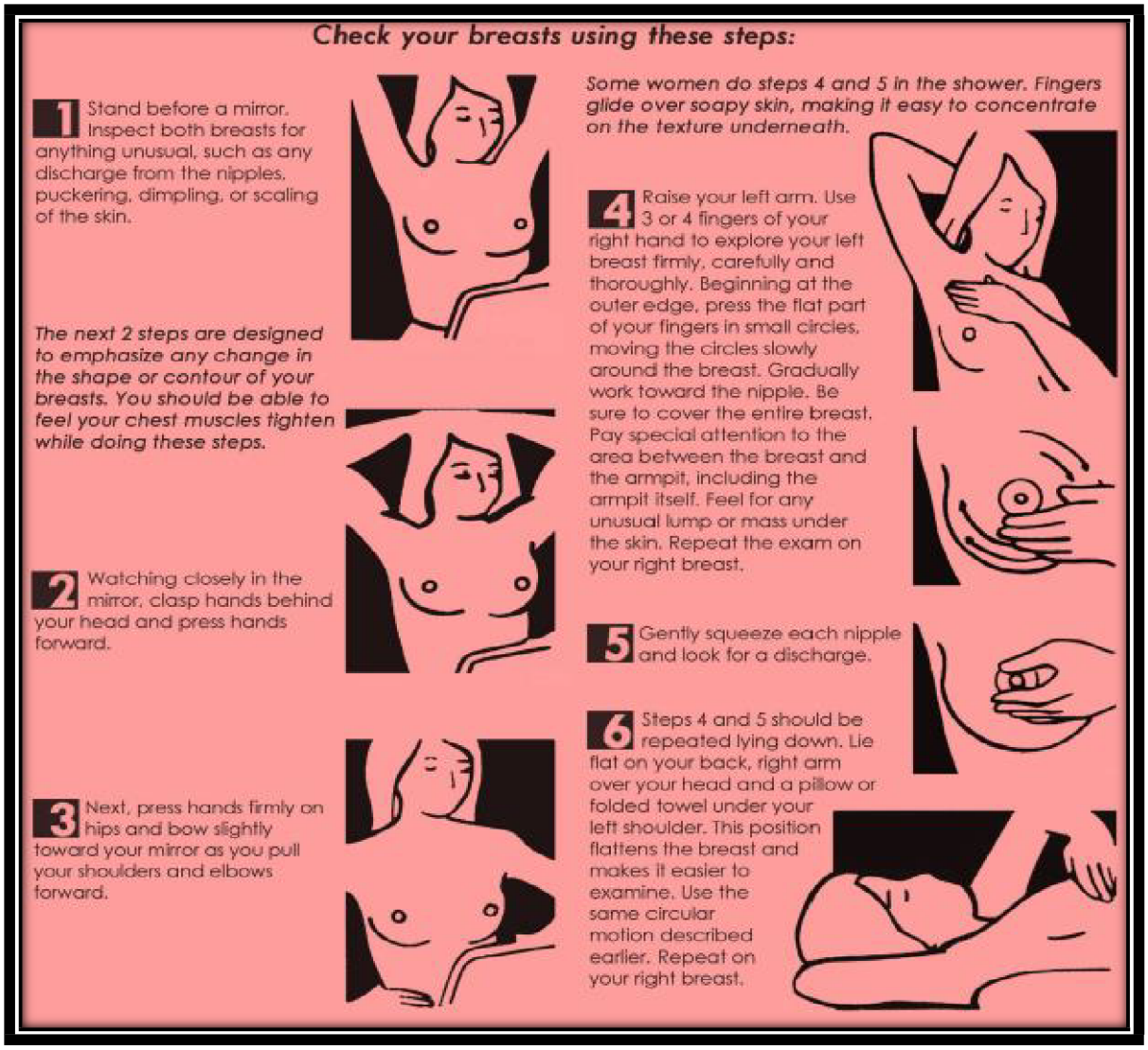
MRI




Breast MRI

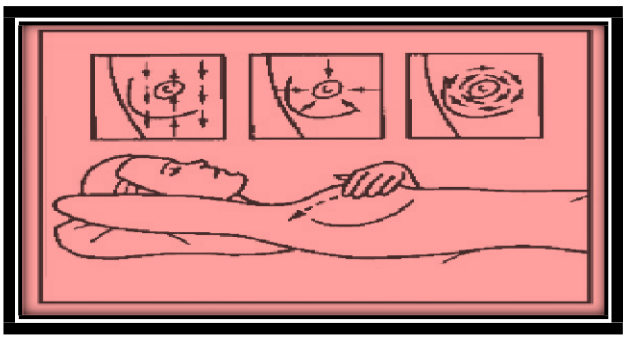

Clinical Breast Exam

Monthly Breast Self-Awareness Checks



Breast Palpation Techniques

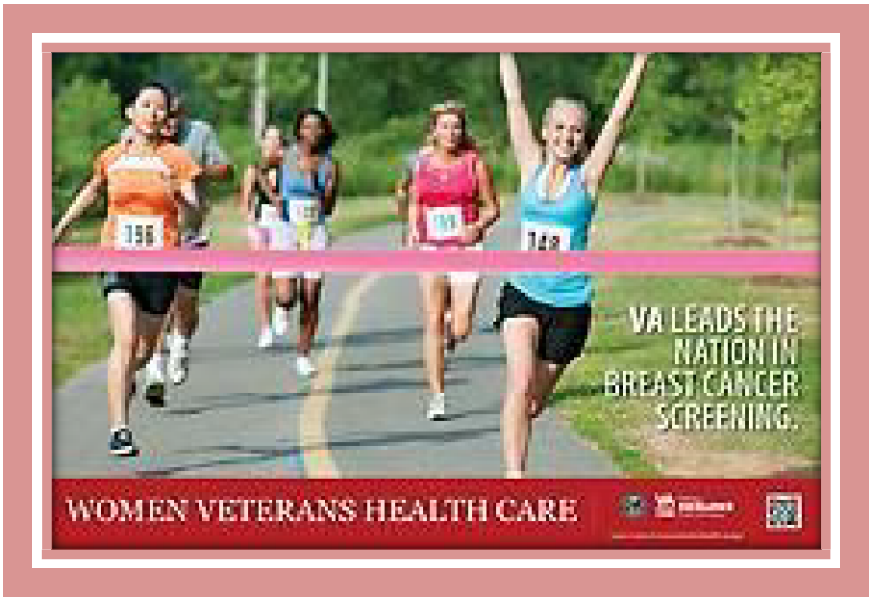
Up & Down **Wedge** **Circular**



Breast Cancer Treatment

If your doctor suspects that you may have breast cancer you will be referred for further evaluation. You may receive a diagnostic mammogram or be referred to an oncologist (doctor that specializes in cancer treatment) to discuss what treatment option is right for you:

- Surgery: Biopsy, Lumpectomy, Mastectomy, Breast Conserving Surgery, Reconstructive Care
- Radiation
- Chemotherapy
- Hematology / Oncology available in the Durham VA



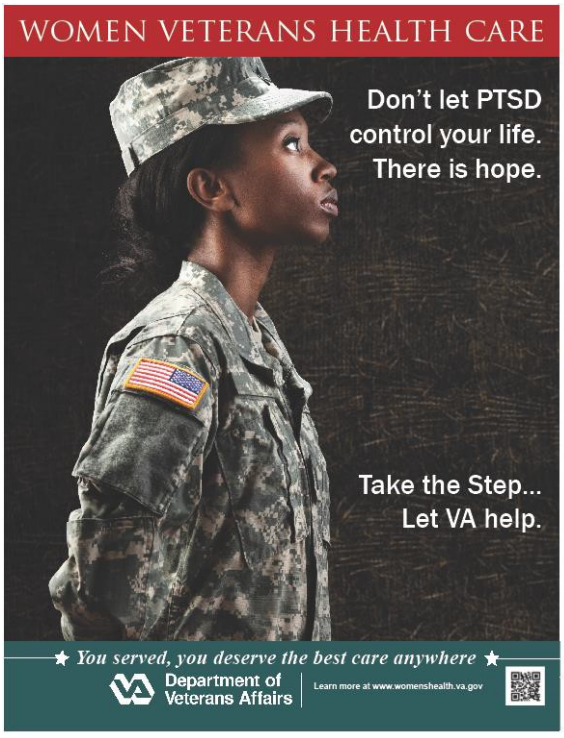
All diagnostic mammograms, surgeries, and reconstructions are performed at the Durham VA Hospital. Localized breast cancer has a 99% survival rate if detected early. **The VA leads the nation's healthcare systems in providing screening mammograms to women.**

Resources

MyhealtheVet.gov
Veteran Health Library
www.veteranshealthlibrary.org

Mental Health

The Durham VA offers a full range of mental health services for women Veterans in the inpatient and outpatient settings. All VA sites have women's health providers available. The VA offers resources and treatment to women in mixed gender or women only environments that support safety, dignity, respect, and privacy.



VA Services Focus on

- Recovery
- Gender Specific Care
- Coordinated Care
- Around the Clock Service
- Evidence Based Treatment
- Family Services

Specialty Services Target

- PTSD
- Substance Abuse
- Depression
- MST
- Homelessness
- Insomnia
- Chronic Pain
- IPV

Mental Health Contact Information

www.mentalhealth.va.gov

Durham
(919) 286-0411 ext. 6073/6074
(800) 878-6890 ext. 6073/6074

Fayetteville
(910) 488-2120
(800) 771-6160

Salisbury
(704) 638-3450

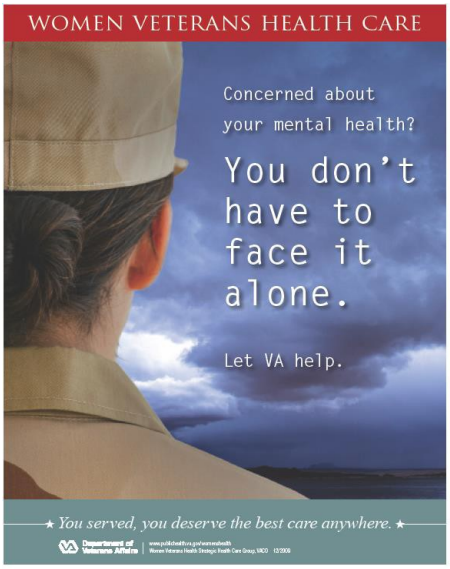
Asheville
(828) 298-7911

Depression

- Do you feel sad, empty, and hopeless most of the day, nearly every day?
- Have you lost interest or pleasure in your hobbies or being with friends and family?
- Are you having trouble sleeping, eating, and functioning?

If you have felt this way for at least 2 weeks, you may have depression, a serious but treatable mood disorder.

Signs and Symptoms



- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies or activities
- Decreased energy, fatigue, or being "slowed down"
- Difficulty concentrating, remembering, or making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide or suicide attempts
- Restlessness or irritability
- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment

Women have depression more often than men. Biological, lifecycle, and hormonal factors that are unique to women may be linked to the higher depression rate. Women with depression typically have symptoms of sadness, worthlessness, and guilt.

Suicide Prevention

Veterans considering suicide show signs of depression, anxiety, low self-esteem, and/or hopelessness, such as:

- Appearing sad or depressed most of the time
- Clinical depression: deep sadness, loss of interest, trouble sleeping and eating—that doesn't go away or continues to get worse
- Feeling anxious, agitated, or unable to sleep
- Neglecting personal welfare, deteriorating physical appearance
- Withdrawing from friends, family, and society, or sleeping all the time
- Losing interest in hobbies, work, school, or other things one used to care about
- Frequent and dramatic mood changes
- Expressing feelings of excessive guilt, shame, failure or decreased performance
- Feeling that life is not worth living, having no sense of purpose in life
- Talk about feeling trapped—like there is no way out of a situation
- Having feelings of desperation, and saying that there's no solution to their problems

Behavior may be dramatically different from their normal behavior. The Veteran may appear to be actively thinking about or preparing for a suicidal act through behaviors such as:

- Performing poorly at work or school
- Acting recklessly or engaging in risky activities—seemingly without thinking
- Showing violent behavior such as punching holes in walls, getting into fights or self-destructive violence; feeling rage or uncontrolled anger or seeking revenge
- Looking as though one has a "death wish," tempting fate by taking risks that could lead to death, such as driving fast or running red lights
- Giving away prized possessions
- Putting affairs in order, tying up loose ends, and/or making out a will
- Seeking access to firearms, pills, or other means of harming oneself

If you are a Veteran or know a Veteran who is showing any of the above warning signs, please call the Veterans Crisis Line at 1 800 273-8255.

Suicide Safety Plan

A Safety Plan is a written list of coping strategies and sources of support that Veterans can use before or during a suicidal crisis. The Safety Plan is a collaborative effort between the Veteran and the care team. There are 6 STEPS involved in the development of a Safety Plan.

- Recognizing warning signs
- Using internal coping strategies
- Social contacts who may distract from the crisis
- Family or friends who may offer help
- Professionals and agencies to contact for help
- Making the environment safe

Suicide Prevention Coordinators

Durham
(919) 765-9562 ext. 1026

Fayetteville
(910) 488-2120 ext. 7264

Salisbury
(704) 638-9000 ext. 16436

Asheville
(828) 298-7911 ext. 3135

Post-Traumatic Stress Disorder (PTSD):

Post-traumatic stress disorder can occur after someone goes through a traumatic event like combat, assault, an accident, or a disaster.

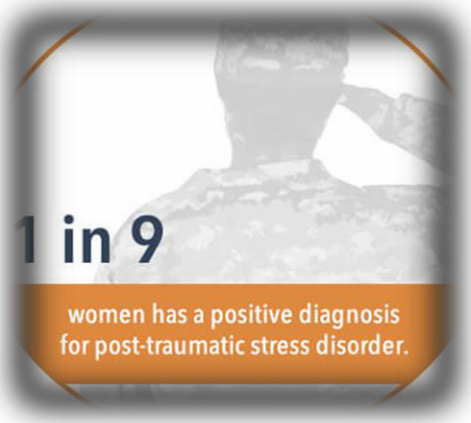
Trauma can be something that happens to you, or something that you saw happen to someone else. Your Women's Health Primary Provider can refer you to a Mental Health Provider.

Signs and Symptoms

- Reliving an event- bad memories, nightmares, or flashbacks
- Avoiding situations or people that remind you of the trauma
- Having negative feelings and beliefs- shame, guilt, no pleasure in activities that you use to enjoy
- Feeling angry, anxious, jittery, hyper alert

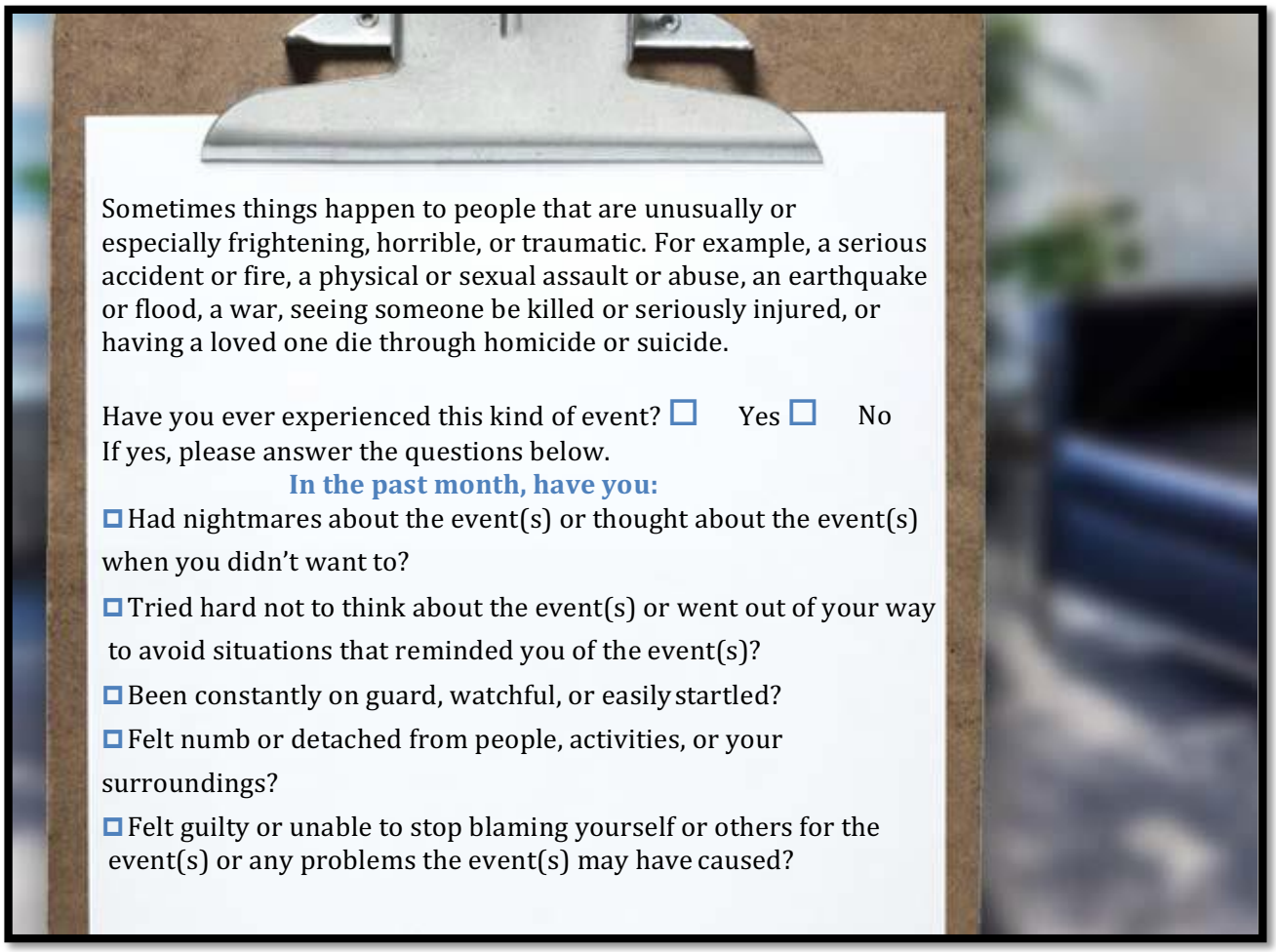
Other Problems that can occur with PTSD

- Depression
- Drinking and drug abuse
- Physical symptoms and chronic pain
- Relationship problems
- Feelings of hopelessness
- Employment problems



PTSD Screening Tool

Take time to respond to this screening tool



If you answered "yes" to 3 or more of these questions, talk to a mental health provider. Answering "yes" to 3 or more questions does not mean you have PTSD. Only a mental health care provider can tell you for sure.

If you answered yes to less than 3 questions you can still benefit from speaking with your mental health provider.

Where and How to Get Help

Know that recovery is an ongoing daily process.

Positive coping mechanisms include:

- Exercise
- Spiritual Meditation
- Relaxation exercises and breathing techniques
- Talk to someone you trust
- Tell your counselor or doctor about your flashbacks
- Psychotherapy and Behavioral Counseling
- Medications
- Family and Group Counseling

PTSD Clinical Team (PCT) Outpatient Treatment

Durham
(919) 286-0411 ext. 7977
Psychiatric Emergency ext. 5418

Asheville
(828) 299-2519

Fayetteville
(910) 488-2120

Salisbury
(704) 638-9000 ext. 13175

Text 838255 to get help right away

Intimate Partner Violence (IPV)

It is Not Your Fault and You Are Not Alone

Everyone is at risk for experiencing intimate partner violence (IPV). Women between the age of 18-35 and female Veterans are at higher risk. IPV occurs when a current or former intimate partner harms, threatens, or stalks their partner.

Types of IPV

- **Emotional**- When a person tries to hurt their partner by attacking their self worth with name caling, bullying, isolation from family and friends, stalking
- **Physical**- When a person tries to hurt their partner with physical force with hitting, slapping, choking, biting, shiving, kicking, restraining
- **Sexual**- When a person forces or tries to convince his/her partner to engage in unwanted sexual activities or is unable to consent (alcohol or drugs)
- **Threats of violence**- When threats are used to cause fear through weapons, words or actions

Effects to Health

- Pain
- Headaches
- Pregnancy complications
- Broken bones
- Stomach issues
- Fatal injuries

Effects to Mental and Social Health

- Social isolation
- Homelessness
- Nightmares
- Trouble sleeping
- Shame, guilt, depression, anxiety

The National Domestic Violence Hotline

1-800-799-SAFE (7233)

1-800-787-3224 (TTY)

www.thehotline.org

IPV Treatment and Resources

Let your Women's Health Provider know if you are a victim of IPV ordomestic violence, or if you engage in IVP behaviors. Help is available for both partners in the relationship.

Treatment Programs:

- 15 week Women's Therapy Gorup for survivors of Domestic Violence and Intimate Partner Violence- meets 2hrs 1 time a week
- 12 week Therapy Program for those that engage in IPV behaviors or violence-meets 2hrs 1 time a week

Treatment focus:

- Self- care, mindfulness, stress management, and behavioral tecniques
- Defining ideal intimate relationships
- Impact of IVP and domestic violence on mental, physical, and emotional health

Steps to increase your safety:

- Talk to Womens Health Provider about IPV and safety concerns
- Create a safety plan with your provider
- Locate shelters and crisis hotline
- Save money in a safe place
- Identify safe places you can go if needed
- The most important thing is Your safety and the safety of your children

IPV Coordinators

Durham
(919) 286-0411 ext. 4721

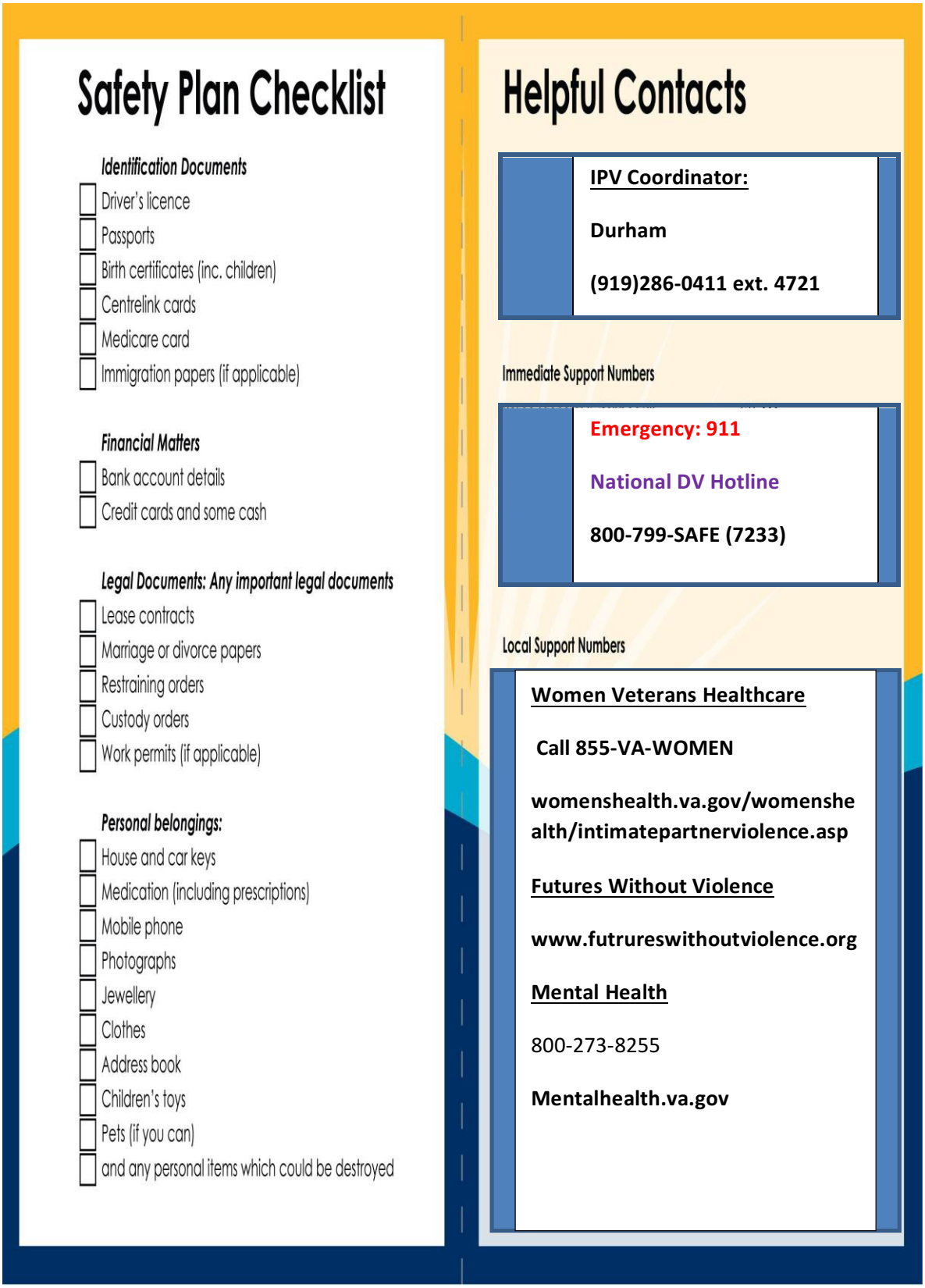
Salisbury
(704) 638-9000 ext. 15536

Fayetville
(901) 482-5224

Asheville
(828) 298-7911 ext. 5335

Call 911 for Immediate Help.

IPV Safety Plan: Keep this information in a safe place.



Safety Plan Checklist

Identification Documents

- ☐ Driver's licence
- ☐ Passports
- ☐ Birth certificates (inc. children)
- ☐ Centrelink cards
- ☐ Medicare card
- ☐ Immigration papers (if applicable)

Financial Matters

- ☐ Bank account details
- ☐ Credit cards and some cash

Legal Documents: Any important legal documents

- ☐ Lease contracts
- ☐ Marriage or divorce papers
- ☐ Restraining orders
- ☐ Custody orders
- ☐ Work permits (if applicable)

Personal belongings:

- ☐ House and car keys
- ☐ Medication (including prescriptions)
- ☐ Mobile phone
- ☐ Photographs
- ☐ Jewellery
- ☐ Clothes
- ☐ Address book
- ☐ Children's toys
- ☐ Pets (if you can)
- ☐ and any personal items which could be destroyed

Helpful Contacts

IPV Coordinator:

Durham

(919)286-0411 ext. 4721

Immediate Support Numbers

Emergency: 911

National DV Hotline

800-799-SAFE (7233)

Local Support Numbers

Women Veterans Healthcare

Call 855-VA-WOMEN

womenshealth.va.gov/womenshealth/intimatepartnerviolence.asp

Futures Without Violence

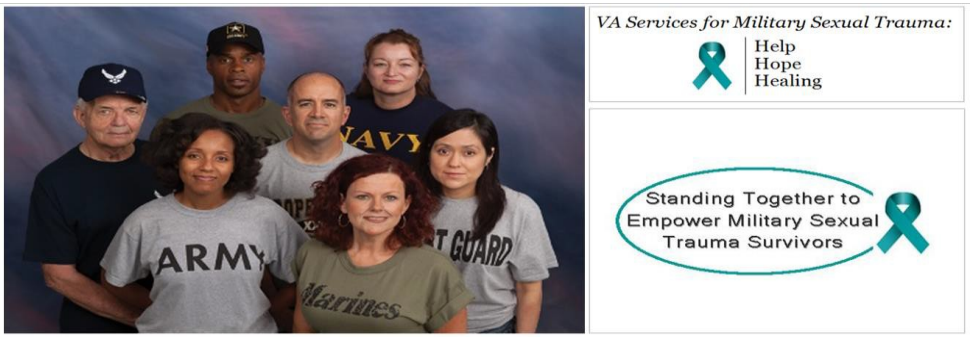
www.futrureswithoutviolence.org

Mental Health

800-273-8255

Mentalhealth.va.gov

Military Sexual Trauma (MST)



Military sexual trauma (MST) is sexual assault, or repeated threatening sexual harassment experienced while on federal active duty, active duty for training, or inactive duty training.

Any Veteran or Service member can experience MST. 1 in 4 women and 1 in 100 men have told their health care provider that they experienced MST.

Impact of MST

- PTSD
- Depression
- Substance abuse
- Chronic pain, chronic fatigue, gastrointestinal issues
- Sexual dysfunction
- Difficulty sleeping
- Anxiety

MST Services

Veterans may be eligible for counseling and treatment for conditions related to MST even if they are not eligible for other VA care.

- Outpatient counseling services and group counseling
- Inpatient programs
- Substance abuse programs

Military Sexual Trauma

People can recover from trauma and the VA is here to help.

- All VA treatment for physical and mental health problems related to MST is **confidential** and **free**.
- You **do not** need to have reported the MST when it happened or have documentation that it occurred.
- You **do not** need to be service connected and may be able to receive MST-related care **even** if you are not eligible for other VA care.
- You can ask to meet with a provider of the same or opposite sex if it would be more comfortable for you.
- All VA health care providers receive training on MST.
- Every VA health care system has an **MST Coordinator**, who can help you access VA services and may know of additional resources.

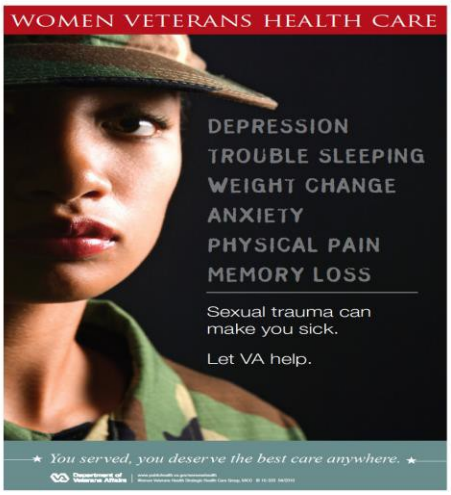
MST Coordinators

Durham
(919) 286-0411 ext. 5243

Asheville
(828) 298-7911 ext. 5707

Fayetteville
(910) 488-2120

Salisbury
(704) 638-9000 ext. 14230



MST Resources

MakeTheConnection.net

A one-stop resource where Veterans and their families and friends can privately explore information on mental health issues and easily find and access the support and resources they need.

After Deployment

Afterdeployment.org provides a program designed to provide support to service members who are healing after having experienced sexual trauma.

MyDuty.mil

If you are an active duty service member and have been a victim of military sexual assault (or know someone who has), MyDuty.mil provides information and guidance on your reporting options and rights.

DoD Safe Helpline is a crisis support service for members of the Department of Defense (DoD) community affected by sexual assault. Through the Safe Helpline, you can "click, call or text" to receive anonymous one-on-one advice, support, and information 24/7. You can go to **www.safehelpline.org** for a live chat or to view resources. From anywhere in the world, you can call 877-995-5247, or text your zip code or base/installation name to 55-247 inside the US (202-470-5546 outside the US) to get the contact information for your nearest Sexual Assault Response Coordinator

It takes a lot of courage and strength to speak up.

The VA takes PRIDE in serving LGBT Veterans

LGBT= Lesbian, Gay, Bisexual, and Transgender

3.5% of American adults identify as LGBT

2.9% of active duty women identify as LGB

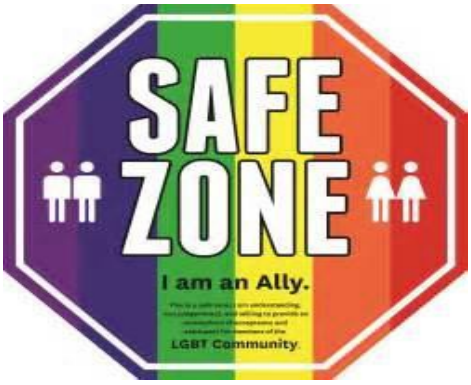
134,000 transgender Veterans in the VHA

Health Status

- Increased rates of mental health conditions(anxiety, depression)
- Barriers to accessing care
- Increased physical health conditions and chronic pain (STD, HIV)
- High rates of military sexual trauma
- Higher rates of substance abuse
- Higher rate of suicidal ideation vs heterosexual Veterans
- 25% of LGBT Veterans void VHA services due to concerns about stigma

What the VA is DOING

- Creating an affirming environment
- Use of preferred names and pronouns
- Gender Counsseling and Support Groups
- Mental Health Service
- Trianing for VA health care providers
- Cross-sex hormone therapy
- Evaluation for gender transitioning services
- LGBT Pride Month in June



LGBT Veteran Care Coordinators

Durham
(919) 286-0411 ext. 7063

Asheville
(828) 298-7911 ext. 4335 or ext. 5707

Fayetville
(910) 475-6121

Salisbury
(704) 638-9000 ext. 13037

Non Discrimination Policies for Veterans and their Families

Rights and Responsibilities fo VA Patients and Residents of Community Living Centers

www.va.gov/health/rights/patientrights.asp

Rights and Responsibilities of Family Menbers fo VA Patients and Residents of Community Living Centers

www.va.gov/health/rights/familyrights.asp

Resources

Lesbian Gay Bisexual and Transgender Program

http://go.usa.gov/cuth4

Healthcare Equality Index

http://www.hrc.org/hei

Homeless Veteran Program

The VA is committed to ending Veteran homelessness. The VA's specialized programs for homeless Veterans provide at risk Veterans with housing solutions, employment opportunities, and health care.

U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH)

HUD-VASH is a collaborative program between HUD and the VA to provide HUD housing vouchers. These VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing. VA case managers may connect these Veterans with support services. Health care, mental health treatment, and substance abuse counseling help them in their recovery process and with their ability to maintain housing in the community.

Homeless Veteran Community Employment Services (HVCES)

Community Employment Coordinators (CEC) work out of each VA facility to create partnerships and relationships with local organizations and employers who hire Veterans. Employment is a key element in helping Veterans permanently transition out of homelessness, and avoid it all together.

Homeless Veteran Program

Supportive Services for Veteran Families (SSVF)

For very low-income Veterans, SSVF provides case management and supportive services to prevent the loss of a Veteran's home or identify a more suitable housing situation for the individual and his or her family; or to rapidly re-house Veterans and their families who are homeless and might remain homeless without this assistance.

Homeless Veteran Supported Employment Program (HVSEP)

A national program that provides vocational assistance, job development, housing placement, and support services for homeless Veterans. The program improves employment outcomes among homeless Veterans and those at-risk of homelessness.

Compensated Work Therapy (CWT) Program

A national vocational program comprised of three unique programs which assist homeless Veterans in returning to competitive employment: Sheltered Workshop, Transitional Work, and Supported Employment. Veterans in CWT are paid at least the federal or state minimum wage, whichever is higher.

Resources

Homeless Program/Social Work

Durham	Asheville	Fayetteville	Salisbury
919 286-0411 ext.7065	828 298-7911 ext.5335	910 488-2120 ext.5742	704 638-3450

Ending Veteran Homelessness, One Home at a Time.

Resources

Durham VA Women Veteran Program Manager

(919) 286-0411 ext. 5229

Women Veteran Call Center

1-855-829-6636

Durham VA Chaplain Service

(919) 286-6867

Durhan VA OEF/OIF Team

(919) 286-0411 ext. 7476

Raleigh Vet Center

(919) 361-6419

National Domestic Violence Hotline

1-800-799-SAFE (7233)

Veterans Crisis Line

1-800-273-TALK

Patient Advocate

919 286-0411 ext. 7065

Notes

Write down questions and concerns you have for your provider

REFERENCES FOR MANUAL

American Stroke Association strokeassociation.org/warningsigns

Breast Cancer Screening for Women at Average Risk 2015 Guideline Update from the American Cancer Society: http://jamanetwork.com/journals/jama/fullarticle/2463262

Division of Cancer Prevention and Control, Centers for Disease Control and Prevention https://www.cdc.gov/cancer/cervical/basic_info/screening.htm

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National Institutes of Health Menopausal Hormone Therapy Information www.nih.gov/PHTindex.htm

National institute of Health https://www.nia.nih.gov/health/what-menopause

National Institutes of Health Osteoporosis and Related Bone Diseases National Resource Center www.bones.nih.gov

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December 2017

Approved by VHE Committee

VEM # 0241

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