PERSPECTIVE

Delivery of Gender-Sensitive Comprehensive Primary Care to Women Veterans: Implications for VA Patient Aligned Care Teams

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The Veterans Health Administration (VA) has undertaken a major initiative to transform primary care delivery through implementation of Patient Aligned Care Teams (PACTs). Based on the patient-centered medical home concept, PACTs aim to improve access, continuity, coordination, and comprehensiveness using team-based care that is patient driven and patient centered. However, how PACT principles should be applied to meet the needs of special populations, including women veterans, is not entirely clear. While historical differences in military participation meant women veterans were rarely seen in VA healthcare settings, they now represent the fastest growing segment of new VA users. They also have complex healthcare needs, adding gender-specific services and other needs to the spectrum of services that the VA must deliver. These trends are changing the VA landscape, introducing challenges to how VA care is organized, how VA providers need to be trained, and how VA considers implementation of new initiatives, such as PACT. We briefly describe the evolution of VA primary care delivery for women veterans, review VA policy for delivering gender-sensitive comprehensive primary care for women, and discuss the challenges that women veterans' needs pose in the context of PACT implementation. We conclude with recommendations for addressing some of these challenges moving forward.

KEY WORDS: primary care; women's health; veterans.
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INTRODUCTION

Patient-centered medical homes have been shown to improve quality of care and patient, provider, and staff satisfaction, while reducing costs.[1,2] The VA has mandated national implementation of its medical home model—Patient Aligned Care Teams (PACTs), which focus on continuity through team-based care, patient access, care management/coordination, and patient-centered communication.[3]

VA leaders have increasingly begun to explore how and when PACT should be adapted for special populations based, for example, on age, gender, or condition. The purpose of this article is to describe the evolution of primary care (PC) for one of those special populations, women veterans, review VA policy on delivery of gender-sensitive comprehensive PC for women, and discuss implications of women's complex care needs for PACT implementation.

Why Women Veterans?

Unlike the typically balanced gender mix of practices outside the VA, women veterans represent a numerical minority, at about 7 % of VA users. Their numbers have created proficiency challenges among VA providers and logistical and fiscal challenges to delivering comprehensive PC in gender-sensitive environments that take account of women's military roles/experiences and complex healthcare needs.[3–5] Women VA users have higher mental health burdens than their male counterparts, including high rates of exposure to military sexual trauma, which require trauma-sensitive approaches to care and special attention to the safety and security of clinic environments.[6–8] Their quality of care has also lagged behind that of men,[9] and they typically have to seek multiple visits within and outside the VA to achieve the level of care men achieve through a single on-site visit.[10–11]

Evolution of VA Primary Care for Women

The VA healthcare system has been investing in improved PC delivery for women since the early US Government Accounting Office reports that were critical of the VA's lack of gender-specific services, gaps in care, and privacy/safety concerns.[12,13] Landmark legislation followed (PL102-585) (1992), which led to the establishment of eight Compre-

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Table 1. Tenets of Gender-Sensitive Comprehensive Primary Care for Women Veterans: Implications for VA Patient Aligned Care Teams (PACTs)

VA Policy Requirements for Women's Health (VHA Handbook 1330.01)	Definitions and expectations	Implications for PACT implementation
Comprehensive primary care for women veterans • Patient centered • Accessible • Continuous • Coordinated • In setting of team-based care	• Provide complete primary care and care coordination by one primary care provider at one site • Longitudinal relationship designed to fulfill all primary care needs ○ Care for acute and chronic illnesses ○ Gender-specific primary care ○ Preventive services ○ Mental health services (e.g., depression) ○ Coordination of care	• Varying local primary care practice structures (e.g., general primary care clinic, women's health clinic, women's health primary care teams, etc.) • Many part-time physicians, requiring adapted teamlet* structures • Varying reliance on non-VA, community-based providers for basic and advanced gender-specific services (may result in heavier care management load for teamlet* RNs) • VA primary care-mental health integration has had unknown penetration into VA women's health clinics • Variable access to on-site vs. off-site preventive services such as mammography • Varying provider experience with gender-specific exams (e.g., Pap smears)
One of three approved comprehensive primary care clinic models for women veterans	• Model 1: General primary care clinic (gender neutral) with one or more designated women's health providers, co-located mental health care, efficient referral to specialty gynecology care • Model 2: Designated women's health providers deliver primary care in separate but shared space (within or adjacent to primary care clinic) with readily available, co-located gynecological and mental health care • Model 3: Women's health center, with separate, exclusive use space with separate entrance, comprised of designated women's health providers; co-located specialty gynecological, mental health and social work services; other sub-specialty services (e.g., breast care, endocrinology, rheumatology) may also be provided in same location	• Varying adherence to required clinic models • Varying completeness of PACT team and teamlet* staffing • Competition for resources with general primary care PACT • Not all VA PACTs have a designated women's health provider regardless of clinic model • Some VA PACTs designate all providers but with varying proficiency and interest • Some VAs have more than one model, requiring clearer outreach, education and guidance for women veterans • Evidence suggests need for greater local guidance on accountability for women veterans' primary care-related quality of care (performance measures) • Varying integration of gynecology clinics (separate vs. integrated into specific clinic model) • Space and privacy issues in general primary care clinics remain (e.g., orientation of exam table to door, availability of privacy curtains, availability of female chaperones)
Designated women's health provider roficient and interested in serving as primary care clinician for women veterans	• Comprehensive planning for women's health that increases women veterans' quality of care • Must be available in all VA primary care clinics regardless of clinic model	• Substantial mini-residency training program has trained >1,000 providers, but more training and proficiency development is still needed • Additional preceptorship, training and support needed among designated women's health providers, especially among those in community-based outpatient clinics • No measures of proficiency or interest currently available or being assessed
Safety, dignity, sensitivity to gender-specific needs	Privacy in all settings, respect for safety/security needs	• Women's-centric environment of care assessments variably conducted • No regular assessments of patient ratings of care that are gender-sensitive (i.e., sensitive to women's care preferences)
Use of state-of-the-art health care equipment and technology	Includes wide array of equipment and technology, e.g., appropriate breast imaging and osteoporosis screening equipment, access to clinical genetic services such as BRCA1/2 tests	• Variable access to necessary equipment on site • Currently limited access to reproductive health technologies on site • Variable access to clinical genetic testing related to reproductive or gender-specific concerns
Availability and use of female chaperones for gender-specific exams	Must be in exam room with PC provider during exams, procedures, and/or treatments involving breast and/or genitalia regarding provider gender (or if requested by woman veteran)	• Variable access to female chaperones • Limited backups or redundancy in primary care staffing for time needed to chaperone (vs. direct clinical care and/or care management duties) (e.g., if one health technician or nurse calls in sick, there may be no chaperone available in a small clinic) • Lack of chaperone training, orientation and cross-coverage • Variable comfort with addressing gender-specific exams

**Teamlets are at the heart of the restructuring of PACT's primary care staffing and represent small teams comprised of one full-time PC provider (MD or non-MD) and support staff including an RN care manager, LVN/medical technician, and clerk in a 3-to-1 staffing ratio*

hensive Women's Health (WH) Centers by 1994. Designed to provide "one-stop shopping" through interdisciplinary teams in same-gender environments, these centers were quickly overwhelmed with demand.[14,15] The VA concurrently mandated creation of WH Clinics or Women's PC teams (e.g., designated WH provider/team in general PC) for the rest of the VA, consistent with model programs in the community.[16–18] These changes occurred in parallel with PC delivery improvements integral to the VA's quality transformation of the mid to late 1990s.[19,20]

Women's clinic prevalence subsequently expanded eightfold, improving access to gender-specific services, while the volume of women seen in the VA doubled over the decade.[10,21] Recruitment of WH clinicians and reliance on academic trainees/fellows were deciding factors in building these programs.[22,23] However, the range of WH services available on site actually declined through 2007, as four in ten of the new women's clinics focused chiefly on gender-specific exams.[24] The new clinics were also less consistently able to offer same-gender providers or adequate privacy compared to the original comprehensive centers.[24] Women's clinics offering more comprehensive services enjoyed better women's ratings of care and higher quality, as did integrated general PC clinics that included experienced WH providers and made gender-specific care available.[11,25–28]

VA Policy on Gender-Sensitive Comprehensive Primary Care for Women

Recognition of women's special needs led to VA policy action requiring system-wide achievement of patient-centered comprehensive PC for women.[29] Launched alongside PACT in 2010, the policy established standards for what constitutes "complete PC" in either separate comprehensive women's clinics or gender-integrated PC clinics, with one or more designated WH providers and explicit attention to gender sensitivity (Table 1). Compliance also requires co-location of mental health care, co-location or efficient referral to specialty gynecology services, use of state-of-the-art equipment and technology, and ready access to female chaperones for gender-specific exams.

PACT and Women Veterans' Health

The PACT model itself does not include specific accommodations for gender-specific care or improved gender sensitivity. Medical home evaluations outside the VA typically fail to report outcomes by gender, providing a limited evidence base to support potentially useful adaptations other than those that may improve provision of gender-specific services.[30,31] VA policy nonetheless establishes expectations that VA PC and women's clinics will develop comparable team-based staffing, meet the same standards for access and continuity, and be equally accountable for all prevention and chronic disease performance measures and expansion of telephone care and secure messaging.

Despite policy alignment, challenges remain (Table 1). For example, access to PACT resources in individual women's clinics varies, as does availability of designated WH providers, female chaperones and privacy arrangements in integrated models. Greater reliance on community providers for women's services increases care coordination demands on PACT teams. Women veterans also tend to bypass community-based practices to get to women's clinics at larger VA medical centers,[32] which may meet their preferences but adversely affect PACT continuity measures.

CONCLUSION

There is growing awareness of the complexity and constraints of effectively and efficiently delivering PC to women veterans in a healthcare system where they represent a characteristically low volume of patients. An underlying tension remains unresolved on how best to achieve PACT goals for women in a system that has been described as a "patchwork quilt with gaps."[33,34] Some evidence suggests that the VA may have one visit to "make or break" women's decisions to use VA care, especially under the promise of broader healthcare options under the Affordable Care Act.[35]

Careful attention must be paid to the differences in how women access and use PC, the mix of their healthcare needs, and the proficiencies that PC teams must acquire and sustain. PACT outcomes should be reported by gender to identify intervention opportunities for reducing gender disparities in care.[36] Gender-sensitive measures of women veterans' experiences with PACT care should also be used to tailor PC to meet their needs.[37,38] Research-clinical partnerships may also help accelerate testing of innovative approaches to delivering the fundamental tenets of PACT to special populations, bringing evidence-based approaches to bear on these issues.[39–41] Key lessons may yield insights for ensuring that all veterans equitably benefit from the promise of PACT.

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