Recommendations and Initiatives In Women's Health from Select Agencies

23 January 2020
0855 – 0955 (ET)

Presenters

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Army Col. R Elaine Freeman, B.S.

- COL Freeman was commissioned through the Reserve Officer Training Corps (ROTC) as a Lieutenant of the Signal Corps following graduation from Arizona State University in 1995.
- COL Freeman's active duty assignments include: Battalion Signal Officer, Platoon Leader, and Company Executive Officer in Schofield Barracks, Hawaii; Assistant Operations Officer and Battalion Adjutant, Mannheim, Germany; Company Commander, Fort Hood, Texas and Iraq; Career Manager, Personnel Distribution Account Manager and Chief of Retirements and Separations Branch, U.S. Army Human Resources Command, Alexandria, VA; Battalion Commander, Warrior Transition Battalion, FT Benning, GA; Chief of Plans, Deputy Chief of Staff, Warrior Care and Transition, Arlington, VA. Her most recent assignment was as the Deputy G3, 335th Signal Command (Theater) (Provisional) located in Camp Arifjan, Kuwait.
- COL Freeman joined the United States Army Reserve (USAR) in 2009 and her assignments include Battalion Executive Officer, COB Speicher Iraq; Secretary to General Staff (SGS), Darien, Illinois; and Command and General Staff College Instructor, FT Knox, KY.
- COL Freeman currently serves as the Military Director for the Defense Advisory Committee on Women in the Services es (DACOWITS) located in Alexandria, VA

Navy Capt. Gregory Gorman, M.D., M.H.S.

- Capt Gorman is currently the Executive Director and Designated Federal Officer, Defense Health Board, Defense Health Agency in Falls Church, Va.
- He is also an Associate Professor of Pediatrics at the F. Edward Hébert School of Medicine at the Uniformed Services University and consultant at the National Institutes of Health.
- A graduate of Georgetown University and the Washington University School of Medicine in St. Louis, he is double-boarded in Pediatrics and Pediatric Nephrology and board-eligible in Clinical Informatics.
- He completed a Masters in Epidemiology at the Johns Hopkins Bloomberg School of Public Health, and has authored over 30 peer-reviewed journal articles focusing on the health of military-connected children, pediatric kidney disease, and the epidemiology and informatics needs of humanitarian assistance operations.
- He is a member of the American Academy of Pediatrics and the American Society of Nephrology. He was named Master Clinician at Walter Reed National Military Medical Center and is the recipient of multiple military and civilian research and teaching awards.

Sally Haskell, M.D., M.S.

- Dr. Haskell is the Deputy Chief Consultant for Clinical Operations and Director of Comprehensive Women's Health in Women's Health Services, for the Veteran's Health Administration, VA Central Office in Washington DC. In this role she directs policy and implementation for Comprehensive Women's Health nationally. Dr. Haskell is based in Connecticut where she practices and teaches General Internal Medicine with a special interest in women's health issues. In addition she is a women's health services researcher at VA Connecticut Healthcare System and Professor of Medicine at Yale School of Medicine. Since 2018, Dr. Haskell has also been the National Co-Chair of the Ambulatory Council for the VA Electronic Health Record Modernization program.
- Dr. Haskell is the co-principal investigator on the Veterans Affairs Health Services Research and Development funded Women Veteran's Cohort Study. Her research interests include gender differences in post-deployment health, chronic pain in women Veterans, gender disparities in cardiovascular risk prevention, and menopause and hormone therapy. She is the author of over 80 publications on women health and healthcare. Dr. Haskell is also the Director of the VA Connecticut Advanced Fellowship in Women's Health, and the Director of Women's Health Research for the VA Connecticut based Pain Research, informatics, Multimorbidities, and Education (PRIME) Center. She is the VA liaison for the Yale National Clinician Scholars Program. Dr. Haskell attended Emory University School of Medicine in Atlanta, Georgia.

Navy Cmdr. Shannon Lamb, M.D., B.A.

- CDR Lamb earned her BA and MD at University of Virginia and completed her residency in OB/GYN at NMC Portsmouth.
- Following residency, CDR Lamb was assigned to NH Guantanamo Bay as the Division Chief of OB/GYN and a member of the Executive Committee of Medical Staff (ECOMS).
- In 2008, CDR Lamb transitioned to NNMC and served as the Transitional and Internal Medical Intern Coordinator for OB/GYN and ambulatory and GYN Surgical Rotation Coordinator for the residency program.
- From September 2010 to Jun 2011, CDR Lamb deployed to Afghanistan where she served as the lead physician mentor for the North Atlantic Treaty Organization 9NATO) Training Mission-Afghanistan and Combined Security Transition Command-Afghanistan.
- CDR Lam next completed a fellowship in Female pelvic Medicine and Reconstructive Surgery at WRNMC.
- CDR Lamb then transitioned to Fort Belvoir Community Hospital where she was the assistant Department Chief of OB/GYN and Urogynecology Division Chief.
- In July 2017, CDR Lamb was selected as the Chief for the Office of Women's Health at BUMED (M32), and in December 2018 became the OB/GYN Specialty Leader.

Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Compare how different agencies address women's health
2. Identify the roles of select federal agencies in women's health
3. Summarize the recommendations and initiatives in women's health from different agencies

DEFENSE ADVISORY COMMITTEE
ON WOMEN IN THE SERVICES

DACOWITS:
Recommendations on Women's Health

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History

In 1951, following the signing of the Women's Armed Services Integration Act of 1948, the Secretary of Defense established the Defense Advisory Committee on Women in the Services (DACOWITS) to assist with the recruitment of women during the Korean War.

Current Charter

The current DACOWITS Charter authorizes 20 women and men to serve on the Committee (i.e., civilians, veterans, and retirees).

Members are nominated by the Military Services, the White House Liaison Office, members of Congress, various Department of Defense Components, or current Committee Members.

Membership is approved by Secretary of Defense or his/her designated representative and selection is based upon the nominees military background and/or experience with women-related workforce issues.

Additionally, the DACOWITS Charter authorizes one non-voting ex-officio member: Department of Veterans Affairs, Executive Director, Center for Women Veterans.

Mission & Goal

DACOWITS' **mission** is to provide independent advice and recommendations to the Secretary of Defense on matters and policies relating to women in the Armed Forces of the United States.

https://www.defense.gov/observe/photo-gallery/igphoto/2002145006/

DACOWITS' **goal** is to enhance the Department of Defense's overall efficiency and effectiveness in the recruitment, retention, employment, integration, well-being, and treatment of women in the Armed Forces.

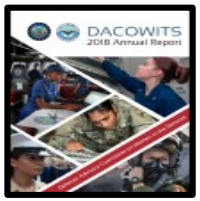
https://www.defense.gov/observe/photo-gallery/igphoto/2002157893/

Research Collection

To develop an informed and research supported annual report for the Secretary of Defense each year, DACOWITS analyzes qualitative and quantitative information gathered from:

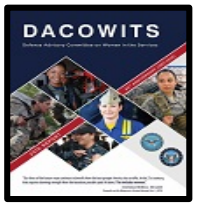
- Feedback from "the Field"
  - Approximately 60 Focus Groups with over 600 Service members conducted at an average of 10 installations annually (i.e., male/female; officer/enlisted; junior/senior)
- Informative briefings from the Department of Defense and the Military Services
- Office Calls with Senior Leaders
- Independent research and literature reviews
- Public comments

2019

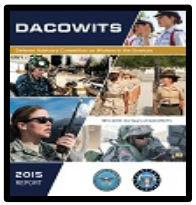


2018

2017



2016



2015

https://dacowits.defense.gov/Reports-Meetings/

Current Population

Breakdown of the current population of the Total Force:

- 17% of Army personnel are women
- 20% of Navy personnel are women
- 8% of Marine Corps personnel are women
- 21% of Air Force personnel are women
- 15% of Coast Guard personnel are women

Women's Health Recommendations

Since 1951, the Committee has submitted 1,022 recommendations to the Secretary of Defense for consideration. As of 2019, approximately 98 percent have been either fully or partially adopted by the Department. Over the last 35 years, several DACOWITS' recommendations have been related to women's health:

- 1984, design uniforms and equipment for women (i.e., boot designed for women's feet).
- 1996, fund the Defense Women's Health Research Program (DWHRP).
- 1997, each Service establish a women's health curriculum for providers that would be applicable for each level of care.
- 2003, establish additional safeguards to ensure patients' rights to privacy and confidentiality, be included in DoD policy to the extent feasible, widely disseminated, enforced, and included in on-going education for all health care professionals and commanders.

Women's Health Recommendations

Continued:

- 2003, that health care providers be trained in a customer service-oriented model of patient service and care which includes sufficient time and opportunity for patient-provider dialogue that conveys the importance of patient needs, especially those of junior enlisted members.
- 2003, in the event of undue delay in access to Military Treatment Facility OB/GYN health care providers, that the Services outsource OB/GYN care for female military personnel.
- 2007, incorporate more female-specific questions into the Pre-Deployment Health Assessment form.
- 2007, require that all deploying females receive a comprehensive women's health evaluation approximately 90 days prior to the expected deployment date.
- 2007, incorporate female-specific health and hygiene briefings as a standard component of the pre-deployment process for deploying female Service members to better prepare them for conditions in-theatre.

Women's Health Recommendations

Continued:

- 2007, refresher training on female-specific health care be provided prior to deployment to physicians and other practitioners who not do not routinely practice gynecologic care.
- 2007, enhance female-specific health care capabilities in-theatre by increasing the inventory of gynecological equipment and supplies at centralized locations.
- 2009, invest in research and development of equipment designed specifically for use by women. Improved equipment can facilitate the success of women in combat. For example, due to the difficult logistics of urinating while wearing their normally issued clothing and equipment, particularly in austere environments, women often minimize fluid intake, placing them at risk for dehydration and urinary tract infections.
- 2010, ensure the timely development and delivery of properly designed and fitting combat-related equipment for women.

Women's Health Recommendations

Continued:

- 2012, establish a means for oversight, collection and dissemination of research, lessons learned and best practices for the health of women.
- 2012, the pre-deployment health assessment for women should provide information on effective urogenital hygiene practices, use of female urinary diversion devices, symptoms and treatment of vaginitis and urinary tract infections, options for birth control and menstrual cycle control.
- 2012, all health care providers should be trained to diagnose and treat women's health issues in a deployed setting in a competent and professional manner, respecting the privacy of the women treated.
- 2012, inventory and ready availability of equipment and supplies for women's health should be assured in deployed environments, including birth control, emergency contraception, medications for vaginitis and urinary tract infections, tampons and sanitary napkins, and female urinary diversion devices.

Women's Health Recommendations

Continued:

- 2013, educate women on methods of contraception and makes various contraceptive methods available.
- 2013, ensure properly designed and fitted individual combat equipment is provided to women on an expedited basis.
- 2015, require the Services to increase the number and quality of lactation rooms available throughout the Military Services.
- 2015, issue a policy regarding the proper use and distribution of the computer generated OB MultiID Discharge Summaries and make every effort to eliminate the release of this protected health information.
- 2016, issue a policy regarding the proper use and distribution of the computer-generated OB MultiID discharge summaries and make every effort to restrict the release of Protected Health Information (PHI).

Women's Health Recommendations

Continued:

- 2018, require all Military Services, including the Reserve/Guard, to provide servicewomen with gender appropriate and properly fitting personal protective equipment and gear for both training and operational use.
- 2018, to improve their support to active duty women transitioning to the Reserve/Guard or civilian sector by offering programs similar to the Women's Health Transition Pilot Program.
- 2018, direct the Marine Corps to eliminate the pregnancy references found in the Marine Corps' Performance Evaluation System, which currently identifies a female Marine's health status by using the code "PREG" in the weight section.
- 2019, direct the Military Services to implement a holistic, preventative health screening, conducted by medical professionals, as part of the overall physical fitness assessment and provide access to uniform and consistent health and nutritional counseling as part of their physical fitness program.

Key Takeaways

- Properly fitting combat equipment and uniforms
- Improvements to the health of deployed servicewomen
- Revisions to pregnancy and parenthood policies

https://www.defense.gov/observe/photo-gallery/igphoto/2002124355/

https://www.military.com/daily-news/2019/09/25/air-force-ditches-medical-waiver-some-pregnant-airmen-who-want-fly-longer.html?utm_source=Sailthru&utm_medium=email&utm_campaign=EBB%2009.26.19&utm_term=Editorial%20-%20Military%20-%20Early%20Bird%20Brief

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Defense Advisory Committee on Women in The Services (DACOWITS). (n.d.). *Charter - Defense advisory committee on women in the services.* https://dacowits.defense.gov/About/Charter/

Department of Defense (DoD). (2018). *Active Duty Master Personnel File [Dataset].* https://www.dmdc.osd.mil/appj/dwp/dwp_reports.jsp

U.S. Department of Veterans Affairs. (n.d.). Center For Women Veterans. https://www.va.gov/womenvet/

Active Duty Women's Health: Tasking to the Defense Health Board

Gregory H Gorman, MD, MHS
Executive Director, Defense Health Board
23 Jan 2020

Disclosures

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The Defense Health Board

The DHB is a Federal Advisory Committee

- Our mission is to provide independent advice to maximize the health, safety, and effectiveness of the United States Armed Forces.
- Operates in compliance with the Federal Advisory Committee Act (FACA) and other laws and regulations that promote transparency
- Members are eminent authorities in one or more of the following disciplines: health care research/academia, infectious disease, occupational/environmental health, public health, health care policy, trauma medicine/systems, clinical health care, strategic decision making, bioethics or ethics, beneficiary representative, neuroscience, and behavioral health.
- Tasked by the SECDEF, Deputy SECDEF, USD(P&R) or the ASD(HA)
- Taskings last 6-12 months
- Current Taskings
  - Screening for mental health conditions in new recruits
  - MMR immunization strategy
  - Active Duty Women's Health

Tasking

On July 29, 2019, the Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness, directed the Defense Health Board ("the Board") to **provide recommendations to the DoD to identify Active Duty (AD) women's health care needs, improve accessibility and quality of health services, and optimize individual medical readiness.**

Key Areas for Recommendations

Musculoskeletal Injuries

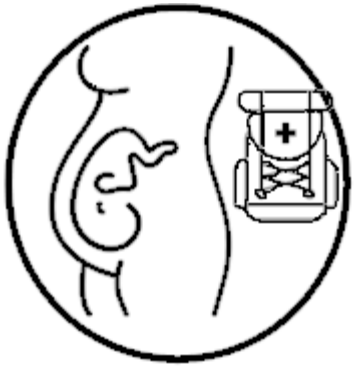
Reproductive Care & Field Gynecologic Health

Psychological Health

Systems Integration

Key Areas for Recommendations

Musculoskeletal Injuries



Reproductive Care & Field Gynecologic Health

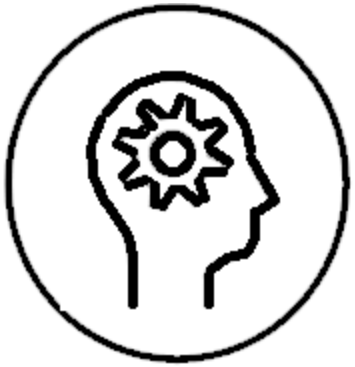
Psychological Health

Systems Integration

Key Areas for Recommendations

Musculoskeletal Injuries

Reproductive Care & Field Gynecologic Health



Psychological Health

Systems Integration

Key Areas for Recommendations

Musculoskeletal Injuries

Reproductive Care & Field Gynecologic Health

Psychological Health

Systems Integration

Key Takeaways

- The Defense Health Board is the only federal advisory committee in the Department of Defense for health matters.

- In 2020, the Board is reviewing active-duty women's health, specifically as it relates to:
  - Musculoskeletal injuries
  - Reproductive care and urogenital infections
  - Behavioral health
  - How to integrate best practices in women's health into the Department

- Findings and Recommendations expected in late 2020

References

Defense Health Board. (n.d.). Defense Health Board Overview. PowerPoint Presentation. https://www.health.mil/Reference-Center/Presentations/2016/11/01/DHB-History

Health.mil. (2019). Defense Health Board Meeting Materials. https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Defense-Health-Board/DHB-Meeting-Materials

U.S. Department of Veterans Affairs

Veterans Health Administration

Women's Health Services

Defense Health Agency Clinical Communities Speaker Series
Advances in Women's Health
January 23, 2020

Sally G. Haskell, MD, MS
Deputy Chief Consultant for Clinical Operations
Director of Comprehensive Women's Health,
Women's Health Services (WHS)
Veterans Health Administration (VHA)
Department of Veteran Affairs (VA)

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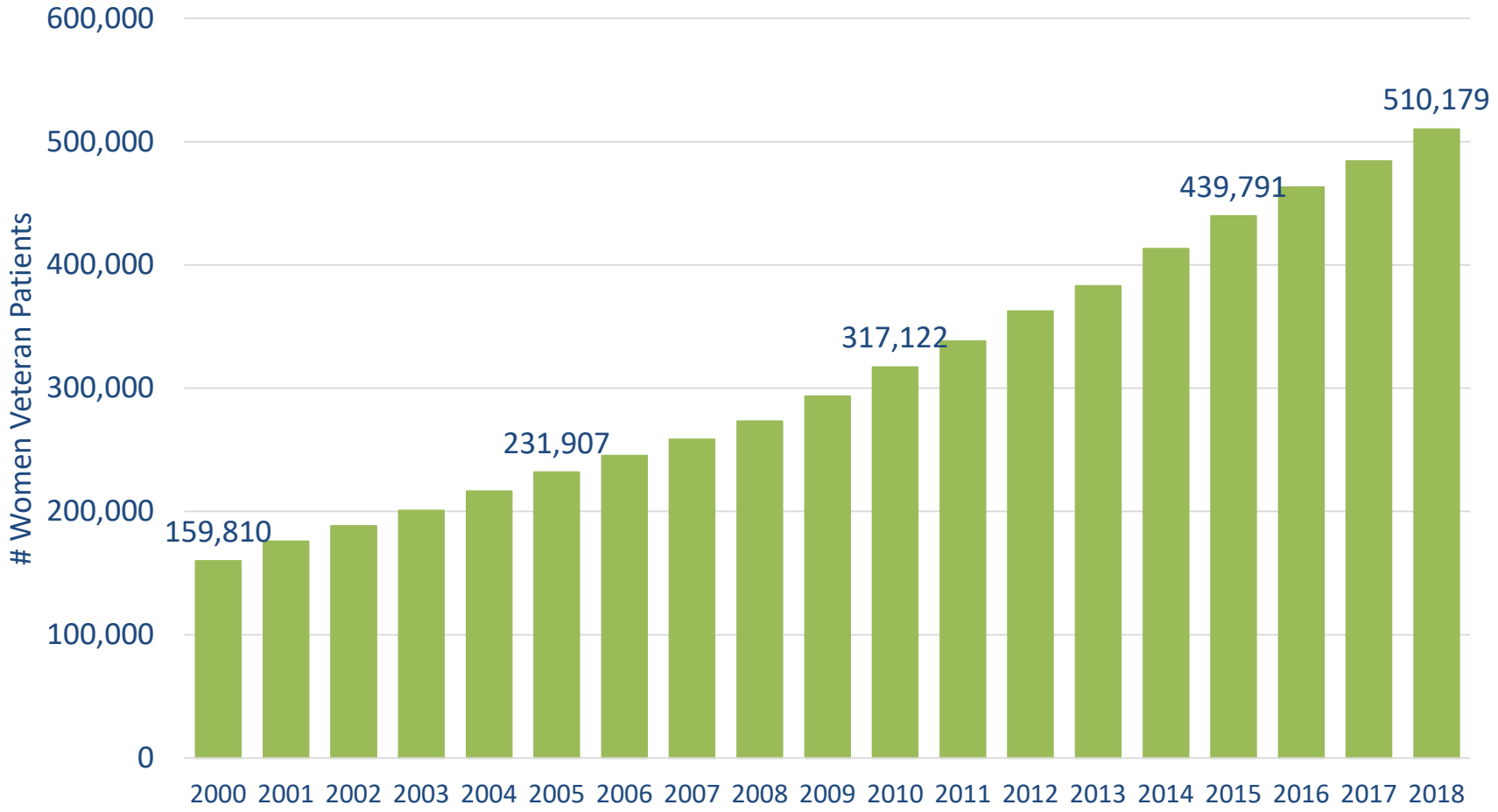
Women in the Military: A growing trend

http://www.va.gov/VETDATA/docs/SpecialReports/Final_Womens_Report_3_2_12_v_7.pdf

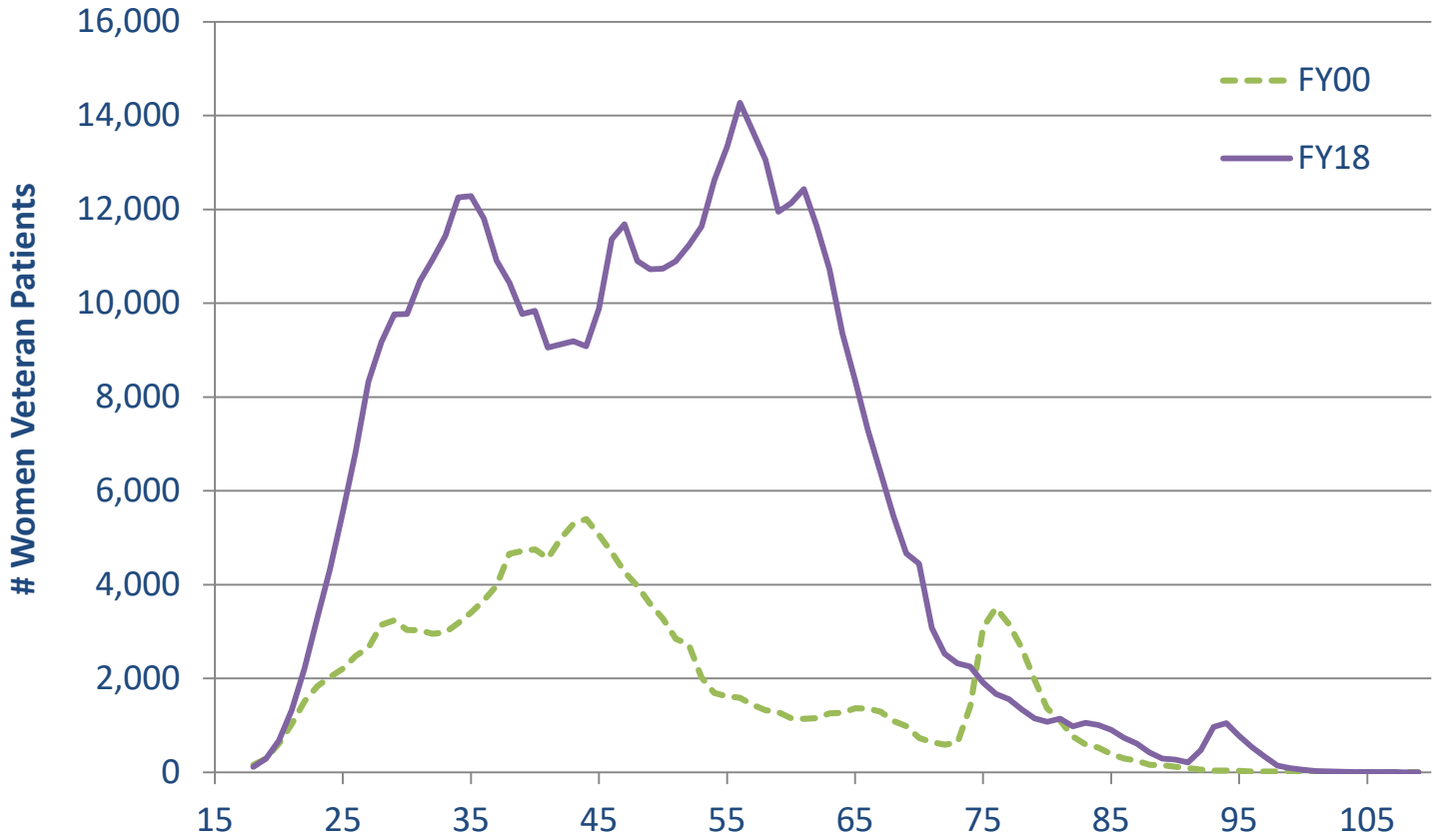
Number Of Women Veteran VHA Patients In Each Year, Fiscal Year(FY) 2000-FY 2018

The number using VHA services has more than tripled since 2000, growing from 159,810 in FY00 to 510,179 in FY18, representing a 219% increase over 19 years.



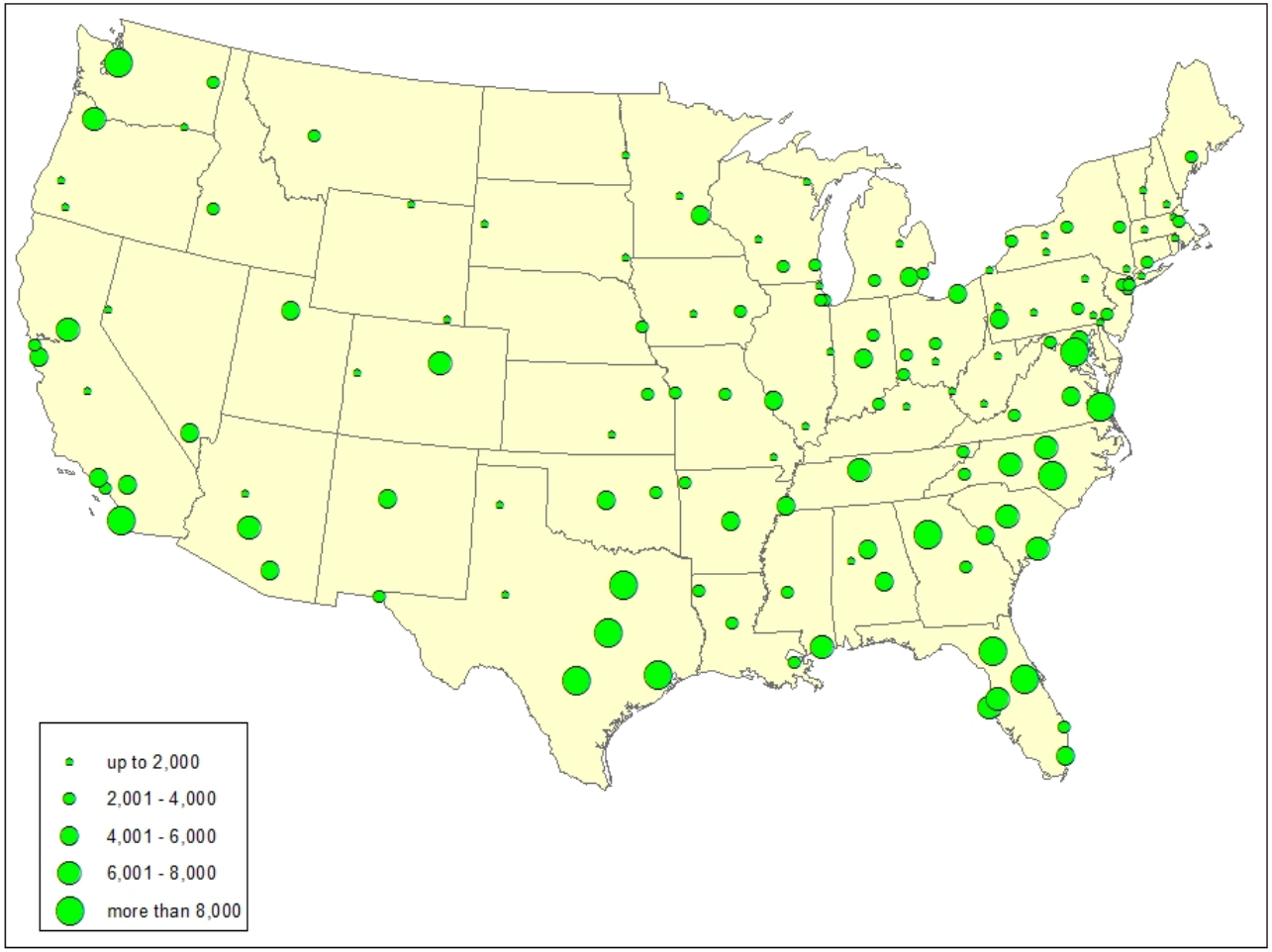
Women's Health Evaluation Initiative, Center for Innovation to Implementation, VA Palo Alto, Palo Alto, California

Age Distribution Of Women Veterans In VHA Care



Cohort: Women Veteran VHA patients with non-missing ages 18-110 years (inclusive) in FY00 and FY18. Women in FY00: N=159,553; FY18: N=510,013.
Source: WHEI Master Database, FY00-FY18

Number of Women VA Patients in 2015



Women's Health Evaluation Initiative, Center for Innovation to Implementation, VA Palo Alto, Palo Alto, California

Health Needs of Women Veterans

Top 10 Conditions For Women Veterans Using VA

- Hypertension
- Depression
- Lipid Disorders
- Joint Disorders - Lower Extremity
- Spine Disorders - Lumbosacral
- Dermatologic Disorders
- Anxiety Disorders
- Overweight/Obesity
- Refraction Disorders
- Posttraumatic stress disorder (PTSD)

Most Common Health Domains For Women Veterans Using VA Care

Domain	Women Veterans		Δ (FY15-FY00)
	FY00 N=159,810	FY15 N=439,791	
	%	%	Δ %
Infectious Disease	30.2	27.5	-2.7
Endocrine/Metabolic/Nutritional	34.1	51.2	+17.1
Cardiovascular	31.4	36.1	+4.7
Respiratory	29.1	32.3	+3.2
Gastrointestinal	22.8	31.6	+8.8
Urinary	12.1	15.0	+2.8
Reproductive Health	28.9	31.2	+2.3
Breast	7.2	6.8	-0.4
Cancer	4.5	5.1	+0.6
Hematologic/Immunologic	6.0	9.6	+3.6
Musculoskeletal	43.0	58.7	+15.7
Neurologic	22.3	31.8	+9.5
Mental Health/Substance Use Disorder	29.9	48.4	+18.5
Sense Organ	23.3	33.3	+10.0
Dental	9.1	10.5	+1.3
Dermatologic	19.0	22.6	+3.5
Other	32.7	52.1	+19.5

Sourcebook 4, Women's Health Evaluation Initiative, Center for Innovation to Implementation, VA Palo Alto, Palo Alto, California

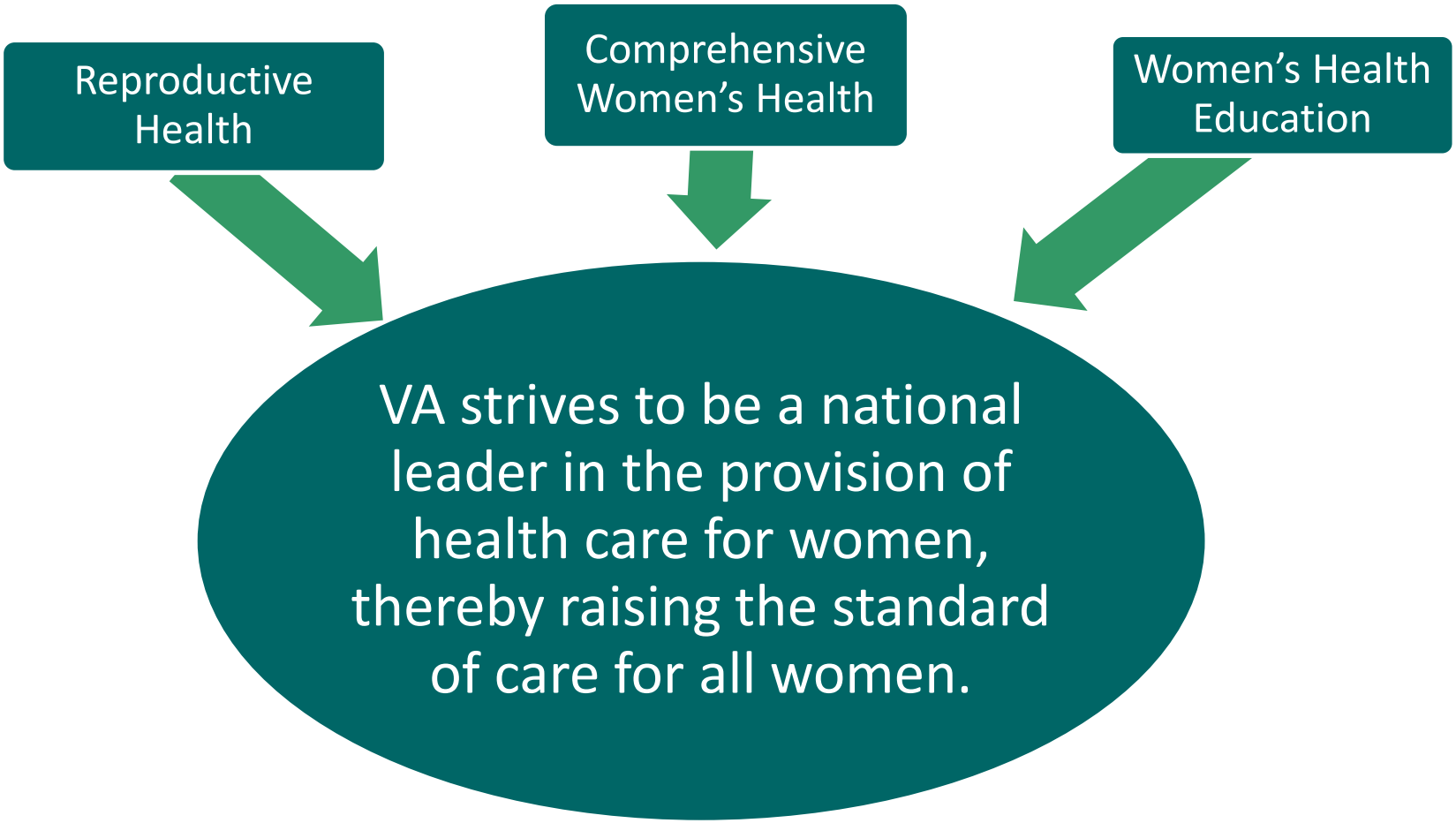
Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND)

Medical Diagnoses of 149,452 Women Veterans seen in VA (2002-2015,Quarter 3)

• Musculoskeletal (MSK)	62%
• Mental Disorders	57%
• Nervous System/Sense Organs	51%
• Genitourinary System	46%
• Digestive System (Dental)	41%
• Endocrine System	40%
• Respiratory	38%
• Skin Diseases	32%
• Injury/Poisoning	31%
• Infectious/Parasitic Diseases	23%
• Circulatory	21%

https://www.publichealth.va.gov/epidemiology/reports/oefoifond/index.asp

Vision: Office of Women's Health Services, VHA



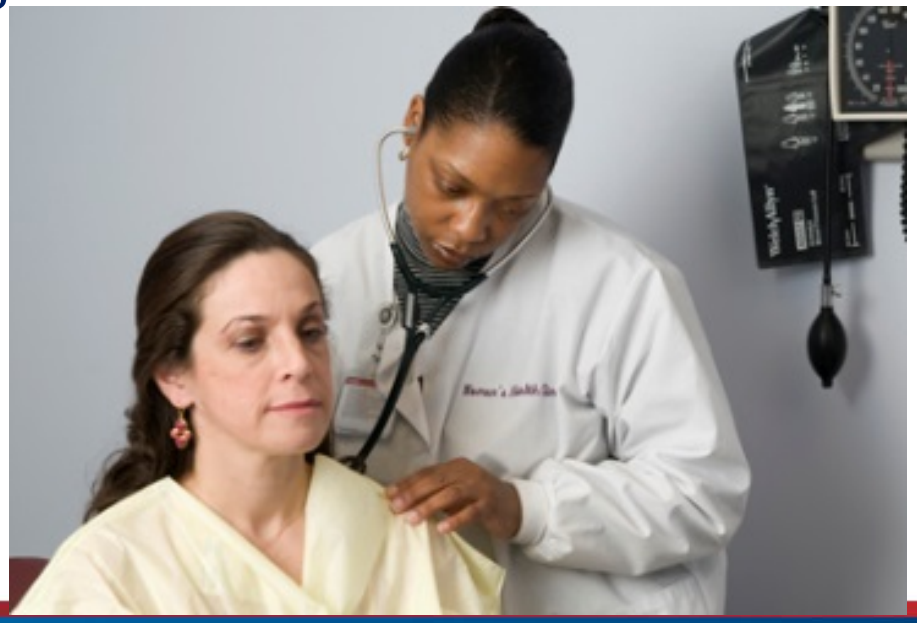
VA Services for Women Veterans

- VA Provides Complete Care for Women Veterans
  - Comprehensive Primary Care
  - Preventive Care
  - Gynecology
  - Maternity Care, Delivery and 7 days of newborn care
    - Provided off site through Community Care paid by VA
  - Mental Health Care
  - Specialty Care Services

Policy to create WH-PCPs

- To increase comprehensive primary care for women Veterans, VHA in 2010 established designated Women's Health Primary Care Providers in VHA Directive 1330.01, Health Care Services for Women Veterans

- Goal to have WH-PCPs at all sites of care and to offer all women Veterans assignment to WH-PCP for their primary care needs.



Satisfaction of Women Assigned to WH-PCPs

In analysis of FY 2012 data on VA women's health providers and data from the VA Survey of Healthcare Experience of Patients (SHEP)

- Women assigned to WH-PCPs had higher overall experiences with care compared to women assigned to other primary care providers.
- Women assigned to WH-PCPs were more satisfied on 6 composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.

Bastian LA, Trentalange M, Murphy TE, Brandt C, Bean-Mayberry B, Maisel N, Wright SM, Gaetano VS, Allore H, Skanderson M, Reyes-Harvey E, Yano EM, Rose D, Haskell S. Women's Health Issues 24-6(2014) 605-12

Quality of Care for Women Assigned to WH-PCPs

- Data from VA's External Peer Review Program (EPRP) were compared for women receiving care from WH-PCPs to those receiving care from other primary care providers

- Women assigned to WH-PCPs were more likely to receive age appropriate cervical cancer screening (94.4% vs. 91.9 %) and breast cancer screening (86% vs 83.3%)

- Of note, these rates in VA substantially exceed breast and cervical cancer screening rates in other health care data sets such as Medicaid, Medicare and commercial populations.

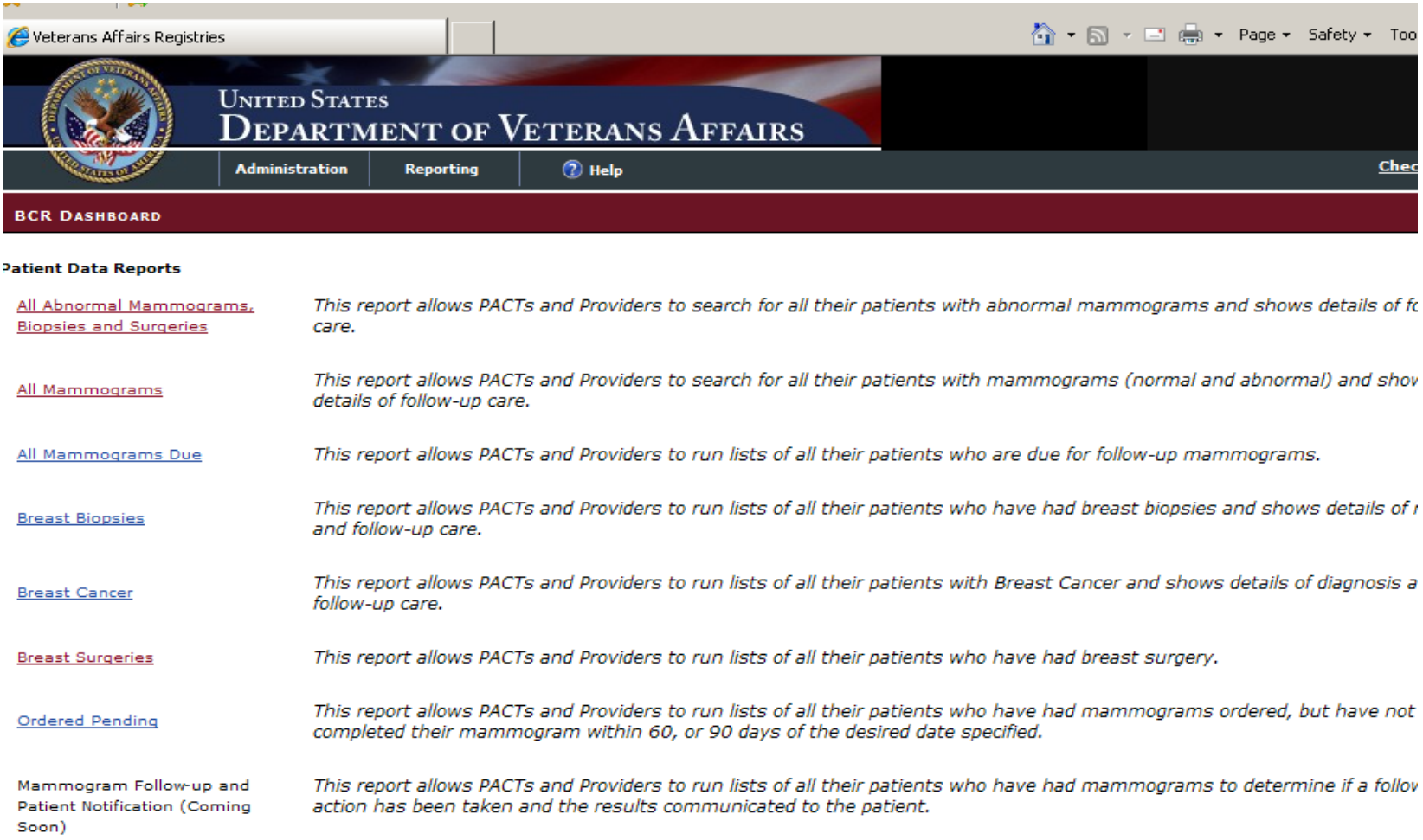
Women's Health Education

- 2 ½ day large face-to-face programs each summer
- Grant program: curriculum & funds to support mini-residencies run locally
- Started in FY 2018-Mini-Residency Program delivered at Rural Community Clinics
- Refresher course in gender-specific topics
- Over 7400 VA providers and nurses trained

Breast Care

- Women Veterans have full access to breast cancer screening and treatment
- VA offers on-site digital mammography at 65 VA sites and pays for breast care in the community for women receiving care at other sites
- VA exceeds U.S. private sector in rates of breast and cervical cancer screening

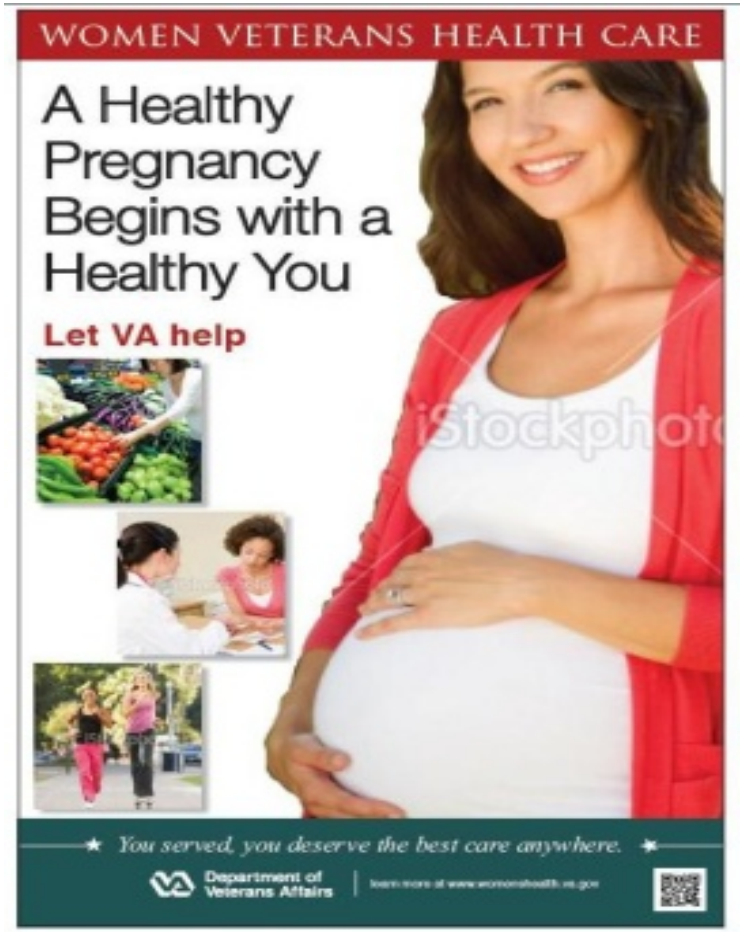
Information Technology Resources:



http://www.va.gov/

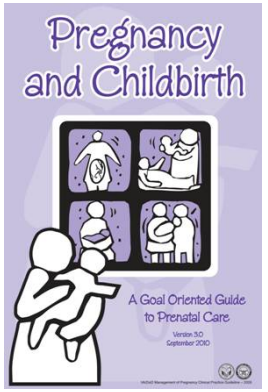
Reproductive Healthcare

- VA has onsite gynecologists at 133 Medical Centers
- VA pays for maternity care and delivery off site,
- And seven days of newborn care for eligible women Veterans



Maternity Care

- National policies for Maternity Care Coordination
- Maternity Care Coordinators at each VA Medical Center
  - Facilitate communication between non-VA maternity care providers and VA-based health care providers
  - Provide support and education
  - Assist with lactation needs
  - Screen for post-partum needs
- Electronic Record alerts providers to medications that may be hazardous during pregnancy



Infertility

Infertility Services:

- VA provides basic infertility evaluation, management, and treatment (not including IVF) services to all Veterans who are enrolled and are eligible for VA health care.

Infertility Services for Women Veterans
Infertility assessments and counseling
Laboratory testing
Imaging services such as ultrasounds and X-rays
Hormonal therapies
Surgical correction
Genetic counseling and testing
Fertility medications
Intrauterine insemination

In-Vitro Fertilization:

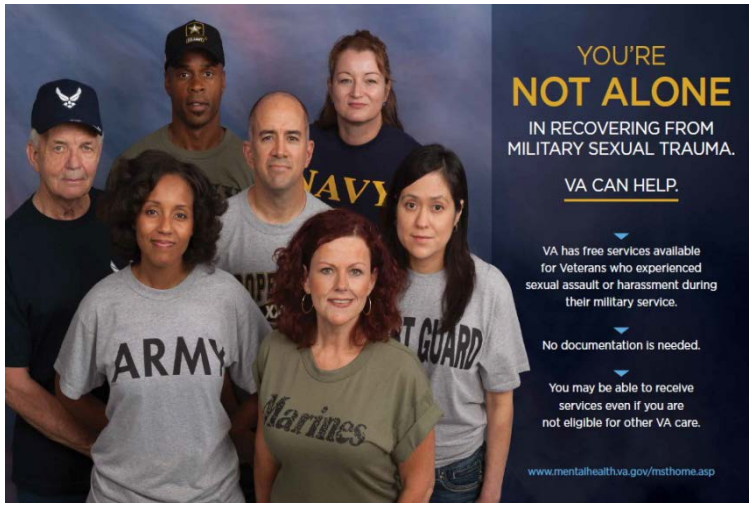
- In Vitro Fertilization is covered only for Veterans (and spouses) when the Veteran has a service connected condition causing infertility.
  - Must be legally married
  - Veteran must have service-connected infertility
  - Veteran or spouse must have an intact uterus
  - Must have at least 1 functioning ovary
  - Must be able to produce sperm
  - Donated sperm or eggs are not a covered benefit
  - Surrogacy is not a covered benefit

Women's Mental Health

- VHA policy requires that mental health services be provided in a manner that recognizes that gender-related issues are important components of care
- VA offers a full continuum of mental health services for women Veterans
  - General outpatient
  - Specialty services (e.g., PTSD, substance use disorders, homelessness)
  - Evidence-based therapies (e.g., prolonged exposure therapy for PTSD)
  - Inpatient and residential treatment options (mixed-gender and women-only)
- In fiscal year 2018, 44.1 percent of women Veterans who used VA healthcare accessed mental health services

Military Sexual Trauma (MST) Related Health Care

- Military sexual trauma, or MST, is a term used by VA to refer to experiences of sexual assault or repeated, threatening sexual harassment that occurred during an individual's military service
- VA provides all MST-related care free of charge
  - Treatment for mental and physical health conditions related to MST
  - Outpatient, inpatient, and residential care
  - Medications



http://www.va.gov/

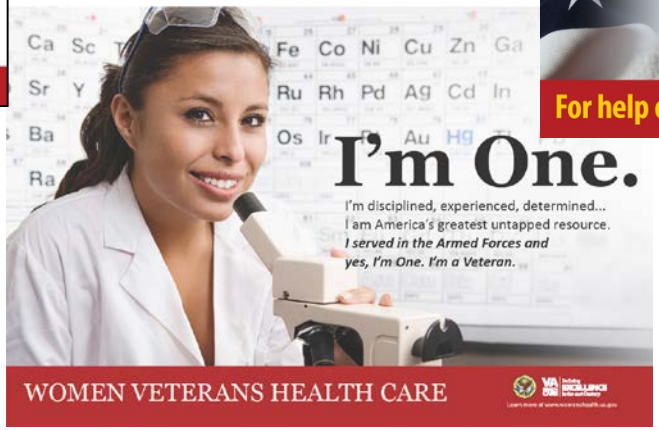
- All Veterans are screened for experiences of MST
- MST Coordinator at every VA Medical Center

Telehealth and Connected Health

Women Veterans Call Center

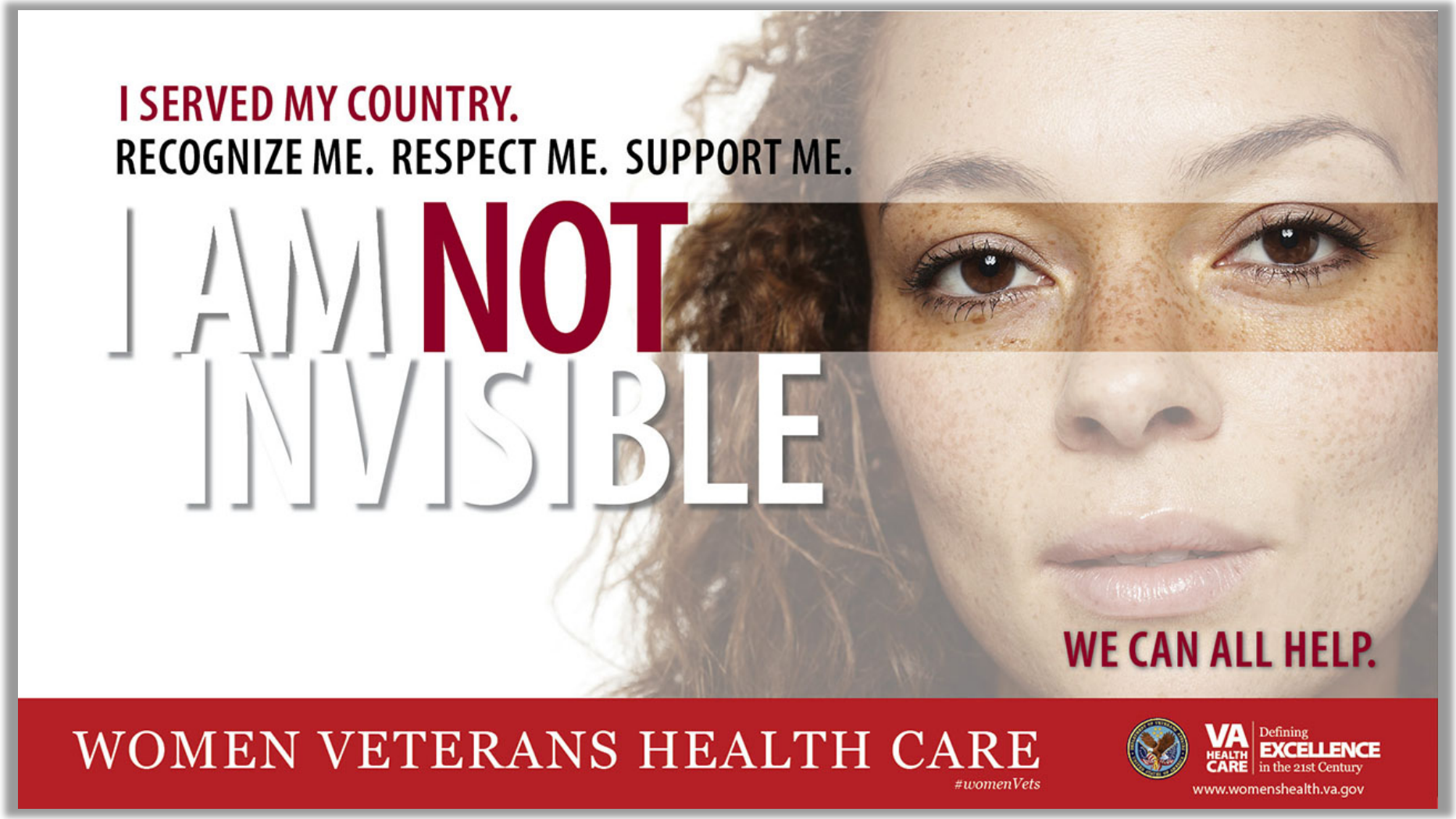
- In FY 2019, the WVCC had over 158,000 successful calls (spoke with Veteran or left a voice message)
- Implemented chat feature in May 2016 to increase access for women Veterans, and in April 2019 started offering Text option

Culture Change in VA



http://www.womenshealth.va.gov

Culture Change in VA



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Key Takeaways

- The VA provides complete care for women Veterans, including primary care, preventive care, maternity and gynecologic care, mental health care and specialty care services.

- The VA's goal is to have a WH-PCPs at all sites of care, and to offer all women Veterans assignment to WH-PCP for their primary care needs.

- Technology has played a vital part in connecting with the women Veterans in providing care anywhere, anytime.

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Process Improvement for Non-Delayed Contraception: Operation PINC

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MILITARY HEALTH SYSTEM (MHS)

Disclosures

- CDR Shannon Lamb has no relevant financial or non-financial relationships to disclose relating to the content of this activity.
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Operation PINC: Process Improvement for Non-Delayed Contraception

1- Brief Description of the Project

- Unplanned pregnancy rates have historically been higher among active duty women compared to civilians, with ages 18-24 being at highest risk.
- Lack of provider ability to place the most effective methods (Intrauterine devices and Nexplanon), as well as multiple appointments to access these methods, are identified as barriers.
- In an effort to improve readiness for active duty women by reducing unplanned pregnancy and providing menstrual management, multiple clinics have started walk in contraceptive services, providing full scope contraception, without an appointment required.
- There are now 24 clinics offering walk in contraceptive services
- **Collectively they have resulted in over 33% increase in contraception appointments among reproductive age women, an 108% increase among high risk women, a 207% increase in LARC use among high risk women, and a 142% increase in average number of provider total RVUs.**

2 – Recent Actions (Past quarter)

- Clinics expanded from 1 in 2016 to currently 24 existing tri-service; others in planning phases
- Navy educates and trains all incoming interns on Long-acting reversible contraception (LARC) placement and has conducted 15 traveling LARC training sessions in past 2 years
- Briefed and obtained support from WICC (Portal Submission 20190403-883)
- Health Overview and Scrutiny Committee (HOSC) Briefed October 2019; HA-WHIG supports
- Cited as a best practice in congressional hearing (Rep Speier May House Appropriations Sub-Committee [HASC])
- Received 2019 American College of Obstetricians and Gynecologists (ACOG) Council of District Chairs Service Recognition Award (National Award)

3 – Performance or Implementation Data

Quadruple Aim Category	Measure	Baseline	Target
Lower Cost	-Unplanned pregnancy rates -# LARC vs SARC	$52 M (cost of unplanned pregnancy in Navy)	-$41 M Savings -% increase in LARC over SARC
Better Care	Number of appointments in PINC clinics	Navy average visits based upon MTF size	All MTFs CONUS have PINC clinics by 2021
Improve Readiness, Health and Experience	Number of appointments in PINC clinics	25% (average use of LARC among active duty women in locations without PINC clinics)	Increased use of LARC to 55% to decrease # of unplanned pregnancies among active duty women

4 – Barriers to Implementation/ Support Needed

- As the MTFs move under DHA for management, there is a need to sustain ready access to walk-in contraception services for Active Duty Service Women.
- Currently here is no direct mandate for walk-in contraceptive care.
- Loss of the current care delivery model could result in:
  - Decreased access to and use of contraceptives and effective menstrual suppression.
  - Increased unwanted pregnancies and associated non-deployability and reduced readiness
  - Inadequate MTF resource availability or allocation to provide services.

RVU – relative value unit
WICC – Women and Infant Clinical Communities
MTF – Military Treatment Facilities
CONUS – Continental United States
SARC – Short acting Reversible Contraceptive
HA-WHIG – Health Affairs Women's Health Issues Working Group

Overall Impact

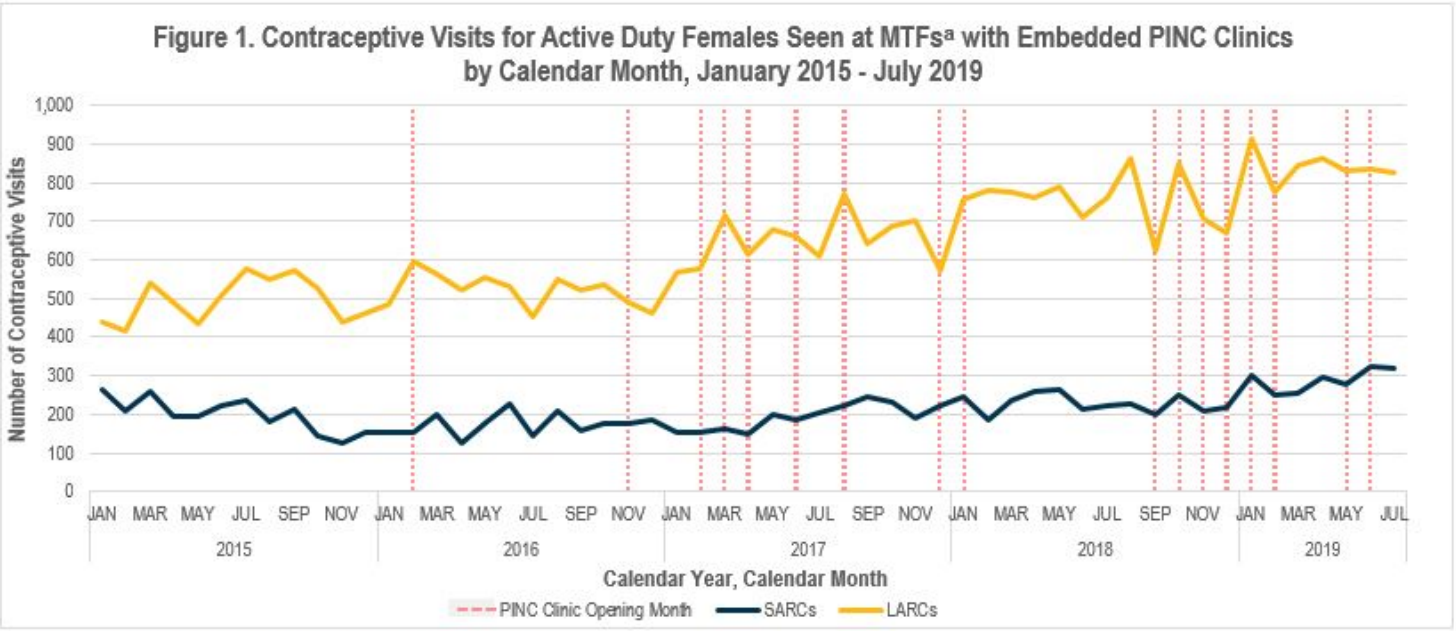
- For all active duty females, the average number of contraceptive visits per month for LARCs increased by 143% following the opening of the PINC clinics and by 207% for active duty females ages 18-24.
- On the contrary, the average number of contraceptive prescriptions per month for LARCs decreased by 14% for all active duty females following the opening of the PINC clinics and by 5% for active duty females ages 18-24. The decrease in LARC prescriptions for both cohorts is likely attributable to the bulk ordering of LARCs used to stock the PINC clinics and how this is captured in the Pharmacy Data Transaction System (PDTS).
- Both the average Provider Total Relative Value Units (RVU) per visit and the average number of Provider Total RVUs per month increased by 1% and 142%, respectively, for all active duty females following the opening of the PINC clinics. The greater increase in the average number of Provider Total RVUs per month versus per visit may indicate that more contraceptive visits are occurring over time but not necessarily visits that result in a higher RVU.
- The increase in visits for LARCs, a highly effective method for preventing unplanned pregnancies, helps increase readiness of active duty female service members (ADFSM).

Contraceptive Visits for Active Duty Females (17 Facilities)

Contraceptive Visits

- All active duty females:
  - The average number of visits for LARCs and SARCs increased following the opening of the PINC clinics by 143% and 168%, respectively (Table 1) (see the 'All PINC Clinics' tab for visit trends over time).
  - The majority of contraceptive visits after the PINC clinics opened were for LARCs (74%) (Table 2).
  - About 53% of LARC visits to the clinic type where PINC is housed were to the PINC clinics specifically and nearly 42% of SARC visits were to the PINC clinics (Table 2) (see Appendix C for monthly percentages of PINC visits for all active duty females).
- All active duty females ages 18-24:
  - The average number of LARC visits increased by 207% and SARC visits by 214% (Table 1) (see the 'All PINC Clinics' tab for visit trends over time).
  - Seventy-two percent of contraceptive visits after the PINC clinics opened were for LARCs (Table 2).
  - About 57% of LARC visits were to the PINC clinics and about 44% of SARC visits were to the PINC clinics (Table 2) (see Appendix C for monthly percentages of PINC visits for active duty females ages 18-24).

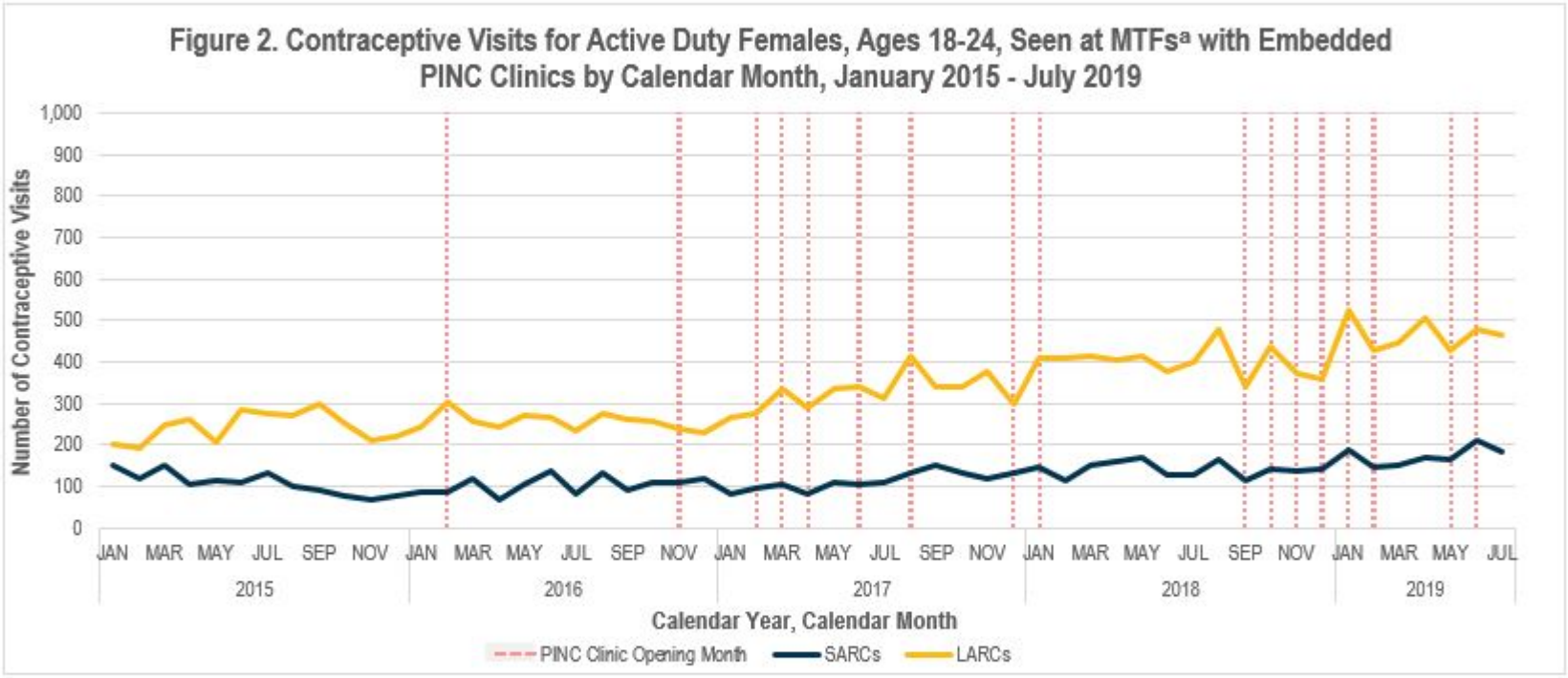
Figure 1. Contraceptive Visits for Active Duty Females Seen at MTFs[a] with Embedded PINC Clinics by Calendar Month, January 2015 - July 2019



Health Analysis Department, Navy and Marine Corps Public Health Center.
Data Source: MDR CAPER and GENESIS Basic Encounter Table, October 2019.
*Only included contraceptive visits to the clinic type that houses PINC.
Abbreviations: MTF = Military Treatment Facility; PINC = Process Improvement for Non-delayed Contraception; LARC = Long-Acting Reversible Contraception; SARC = Short-Acting Reversible Contraception;

Contraceptive Visits High Risk Active Duty Females

18-24 Year Olds



Health Analysis Department, Navy and Marine Corps Public Health Center.
Data Source: MDR CAPER and GENESIS Basic Encounter Table, October 2019.
•Only included contraceptive visits to the clinic type that houses PINC.
Abbreviations: MTF = Military Treatment Facility; PINC = Process Improvement for Non-delayed Contraception;
LARC = Long-Acting Reversible Contraception; SARC = Short-Acting Reversible Contraception;

Provider RVUS

Table 1. Percent Change in Contraceptive Visits[a] , Prescriptions, and Provider RVUs[b] Post PINC Clinic Opening for Active Duty Females Seen at MTFs with Embedded PINC Clinics, January 2015 - July 2019

	Visits		Prescriptions		Provider RVUs		Provider RVUs	
	Change in Average per Month[c]		Change in Average per Month[c]		Change in Average per Month[d]		Change in Average per Visit[e]	
	LARC	SARC	LARC	SARC	Work RVU	Total RVU	Work RVU	Total RVU
All Active Duty Females	⬆ 143%	⬆ 168%	⬇ 14%	⬆ 20%	⬆ 127%	⬆ 142%	⬇ 5%	⬆ 1%
All Active Duty Females, Ages 18-24	⬆ 207%	⬆ 214%	⬇ 5%	⬆ 35%	⬆ 197%	⬆ 212%	⬇ <1%	⬆ 5%

Health Analysis Department, Navy and Marine Corps Public Health Center.

Data Source: MDR CAPER, GENESIS Basic Encounter, and PDTS Tables, October & November 2019.

[a] Only included contraceptive visits to the clinic type that houses PINC.

[b] Provider RVUs related to contraceptive visits for active duty females.

[c] Percent change based on the average number of visits or prescriptions per month pre- and post- opening of the PINC clinics.

[d] Percent change based on the average number of provider RVUs per month pre- and post- opening of the PINC clinics.

[e] Percent change based on the average provider RVU per visit pre- and post- opening of the PINC clinics.

Abbreviations: MTF = Military Treatment Facility; PINC = Process Improvement for Non-delayed Contraception; LARC = Long-Acting Reversible Contraception; SARC = Short-Acting Reversible Contraception; RVU = Relative Value Units.

Recommended Course of Action

- **Develop DHA-PI mandating walk in contraceptive resources at MTFs.**
- **Create database with recommended metrics** using PCOR (Patient Centered Outcomes Research) technology to allow the beneficiary to complete a contraception questionnaire prior to their appointment, have that data immediately loaded into the electronic medical record, and accessible to provider for the appointment.
- **Continue walk in contraception services at MTFs under DHA**
  - **Continue to support existing clinics**
  - **Expand to additional MTFS prioritizing areas of high active duty concentration**
  - **Most cost effective and efficient when service is available to all beneficiaries**

Recommended PINC Performance Metrics

Metrics (*) and Measures	Definition	Initial Reporting Frequency	Data Source
Volume of Contraception Provided*	# of contraceptives dispensed	Monthly	MHS MDR
% of new SARC	# of initial SARC prescriptions / # of all SARC prescriptions	Monthly	MHS MDR
% of new LARC	# of new LARC insertions / # of all LARC procedures	Monthly	MHS MDR
% of LARC removals	# of LARCs removed / # of all LARC procedures	Monthly	MHS MDR
% of Emergency Contraception	# of emergency contraception / # of all contraception	Monthly	MHS MDR
% of PINC Patients by BenCat	# patients with PINC clinic services by beneficiary category / # of all PINC patients	Monthly	MHS MDR
% of PINC Patient Encounters by Active Duty Women age 18-24	# active duty patients of age 18-24 years with PINC encounters / # of all PINC patient encounters	Monthly	MHS MDR
% of PINC Contraceptives for Active Duty Women age 18-24	# active duty patients of age 18-24 years provided contraception by PINC clinic / # of all contraception provided by PINC clinic	Monthly	MHS MDR
Average Days to Next Available OB/GYN Appointment	Average number of days between referral placement and scheduled appointment for OB/GYN care	Monthly	MHS MDR
% of new PINC patients	# of first time patients at a PINC clinic / # of all PINC patients	Monthly	Patient Questionnaire
% of Non-Enrolled Patients	# of patients not enrolled at MTF where PINC clinic is located / # of all PINC patients	Monthly	MHS MDR, Patient Questionnaire
% of Patients Engaged in High-Risk Sexual Activity	% of patients at risk for pregnancy due to contraception decision	Monthly	Patient Questionnaire
% of Unplanned Pregnancies of PINC Patients*	# of unplanned pregnancies reported by PINC patients / # PINC patient responses	Annual	Patient Questionnaire
Contraception Access	Distirbution of previous contraception access sources	Monthly	Patient Questionnaire
Clinic Service Level	# of patients turned away due to the clinic reaching capacity	Monthly	Clinic Manual Tracking
Patient Satisfaction Level	# of PINC patients resporting a positive experience / # PINC patient responses	Monthly	Patient Questionnaire
Clinic Advertisement	Distribution of advertisement source providing patient awareness of PINC clinic	Monthly	Patient Questionnaire
Family Planning	# of patients desiring family planning services	Monthly	Patient Questionnaire

Backup/Original Analysis

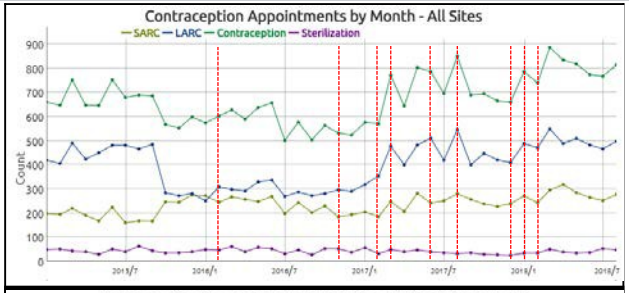
Analysis

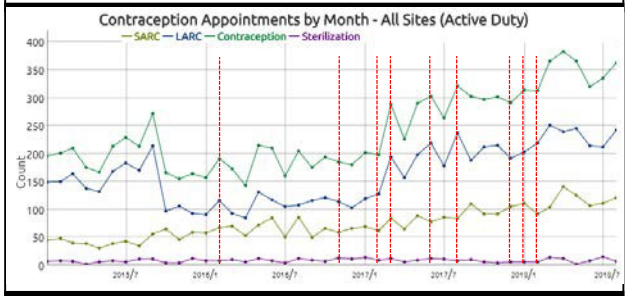
MTFs with PINC Clinics Prior to Sep 2018 (n= 11)

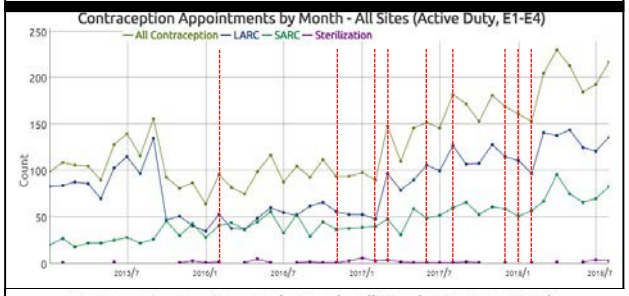
NMC San Diego (Feb 2016)
NHC Oak Harbor (Feb 2016)
NBHC Mayport (Nov 2016)
NBHC Kearny Mesa (Feb 2017)
NH Sigonella (March 2017)
NBHC NAVSTA Sewells (Apr 2017)
NHC Cherry Point (June 2017)
NMC Camp Lejeune (Aug 2017)
NH Jacksonville (Dec 2017)
NH Yokosuka (Jan 2018)
NH Okinawa (Feb 2018)

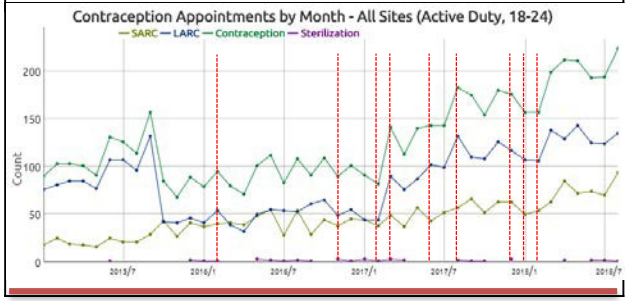
Contraception Appointment (11 MTFs)

Category	Type	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Total	Number of Appointments	690	695	666	661	787	740	887	835	819	775	768	815
Active Duty	Number of Appointments	303	297	302	291	314	313	366	383	366	320	335	363
Active Duty	Percentage of Total	44%	43%	45%	44%	40%	42%	41%	46%	45%	41%	44%	45%
Active Duty, E1- E4	Number of Appointments	172	153	181	169	161	153	205	230	213	185	193	217
Active Duty, E1- E4	Percentage of Total	25%	22%	27%	26%	20%	21%	23%	28%	26%	24%	25%	27%
Active Duty, 18-24	Number of Appointments	175	154	180	176	157	157	199	212	211	193	194	224
Active Duty, 18-24	Percentage of Total	25%	22%	27%	27%	20%	21%	22%	25%	26%	25%	25%	27%





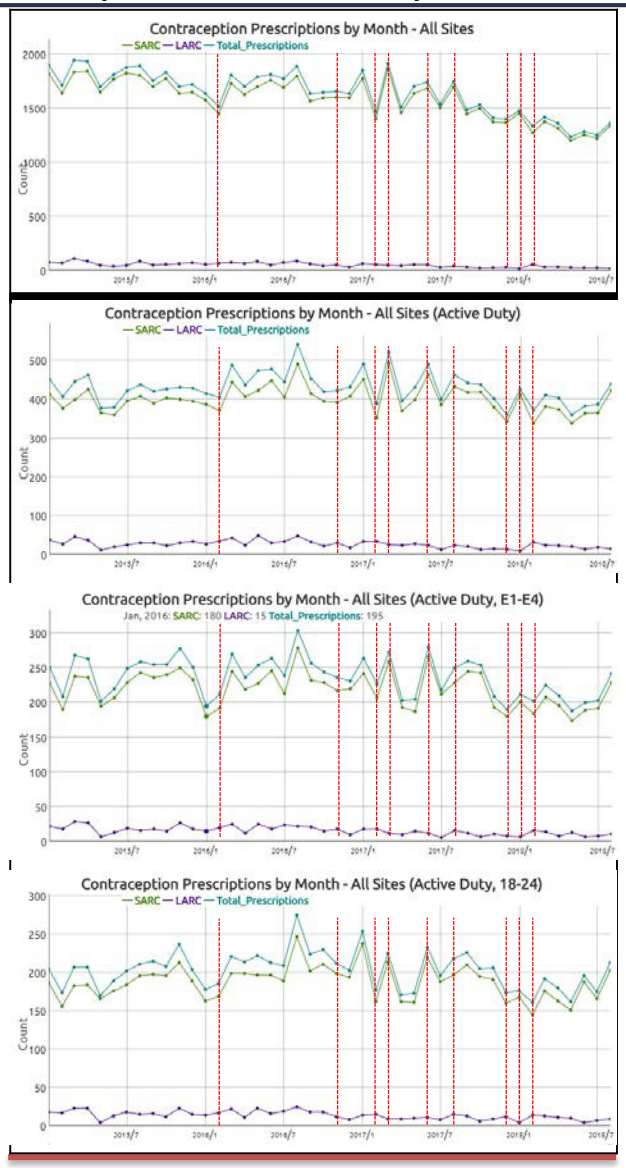




- Steady increase in contraception appointments as additional sites start
- Almost 50% appointments by AD
  - ~25% of total appointments by At Risk group

Contraception Prescriptions (11 MTFs)

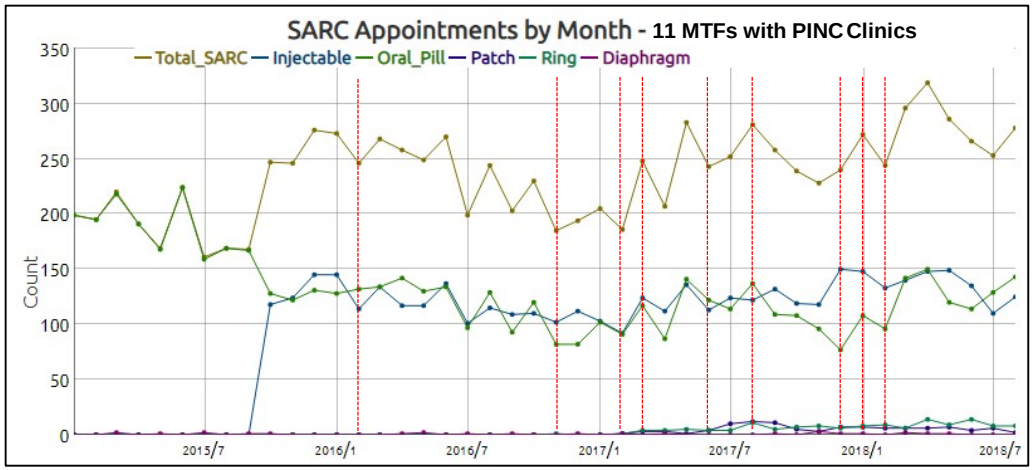
Category	Type	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Total	Number of Prescriptions	1487	1535	1413	1403	1479	1338	1421	1362	1237	1287	1253	1364
Active Duty	Number of Prescriptions	442	438	402	360	426	372	411	404	360	383	387	440
Active Duty	Percentage of Total	30%	29%	28%	26%	29%	28%	29%	30%	29%	30%	31%	32%
Active Duty, E1- E4	Number of Prescriptions	228	233	195	168	188	184	211	196	170	181	178	227
Active Duty, E1- E4	Percentage of Total	15%	15%	14%	12%	13%	14%	15%	14%	14%	14%	14%	17%
Active Duty, 18-24	Number of Prescriptions	226	205	206	174	176	161	192	180	162	196	175	213
Active Duty, 18-24	Percentage of Total	15%	13%	15%	12%	12%	12%	14%	13%	13%	15%	14%	16%

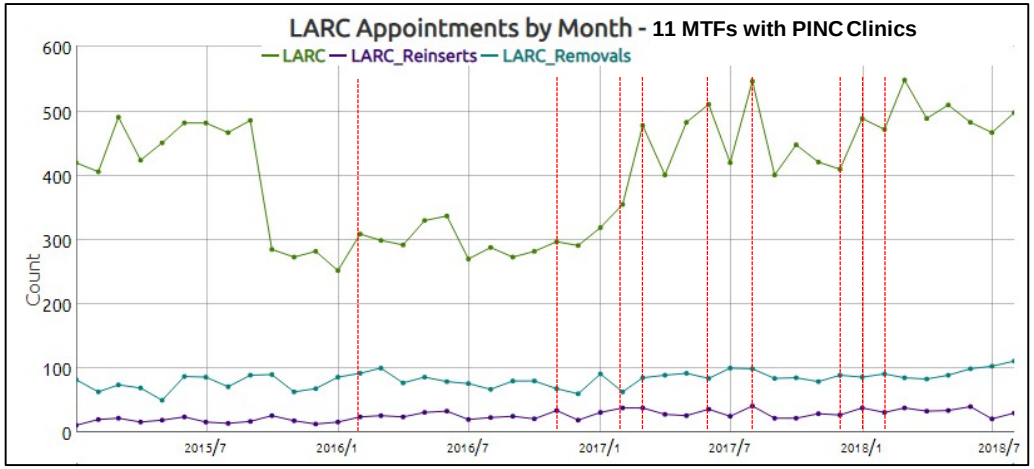


- Steady decrease in overall prescriptions
- Minor increase in prescriptions for At Risk group

Contraception Appointment (11 MTFs)

- Of the MTFs included in this analysis:
  - Overall increasing trend in SARC prior to PINC clinics
    - Oral pill decrease in 2016 and 2017
    - Large injectable increase in late 2015
  - Significant drop in LARC in 2015 but has rebounded since Jan 2017



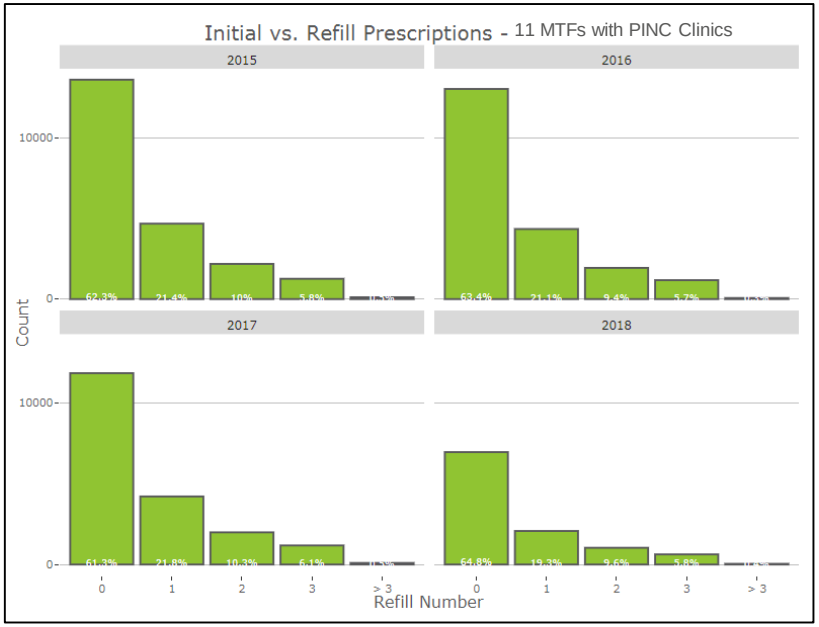


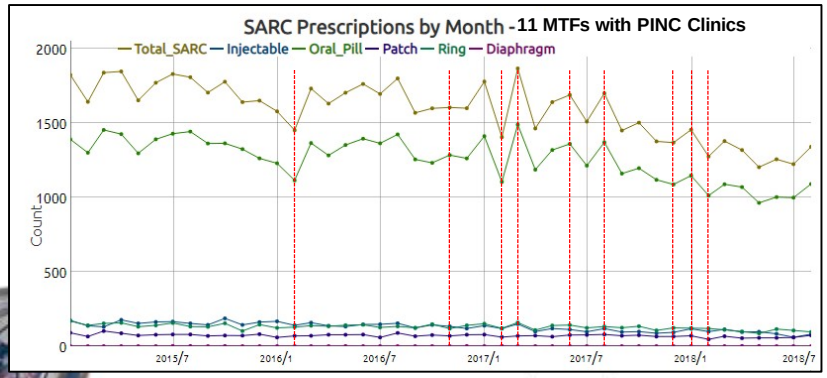
MILITARY HEALTH SYSTEM (MHS)

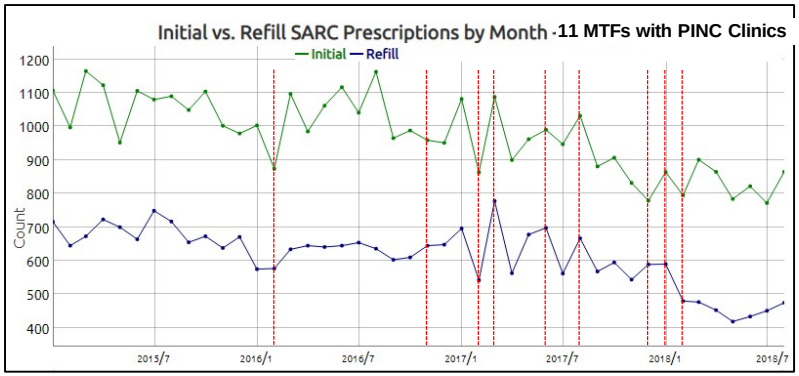
PINC Start

SARC (11 MTFs)

- SARC prescriptions have steadily decreased
  - Most significant drop appears from 2017 to 2018
- Changes in SARC prescription similar for initial and refills

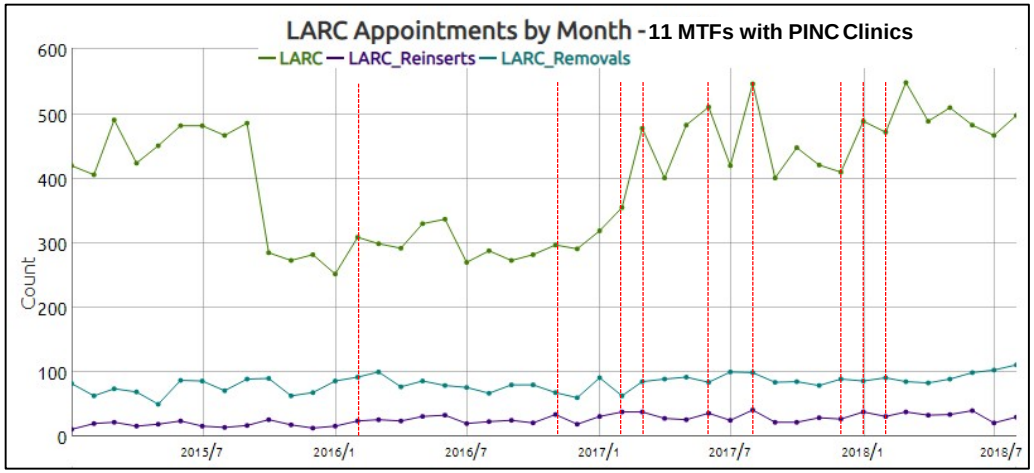


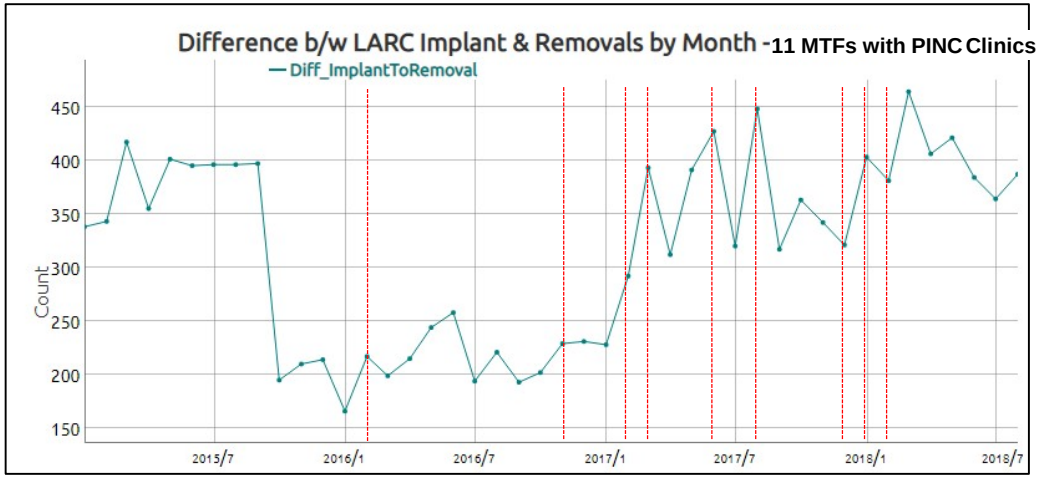




LARC (11 MTFs)

- Significant drop in LARC in 2015 but has rebounded since Jan 2017
- LARC reinserts and removals has stayed steady
  - LARC volume changes due to new placements

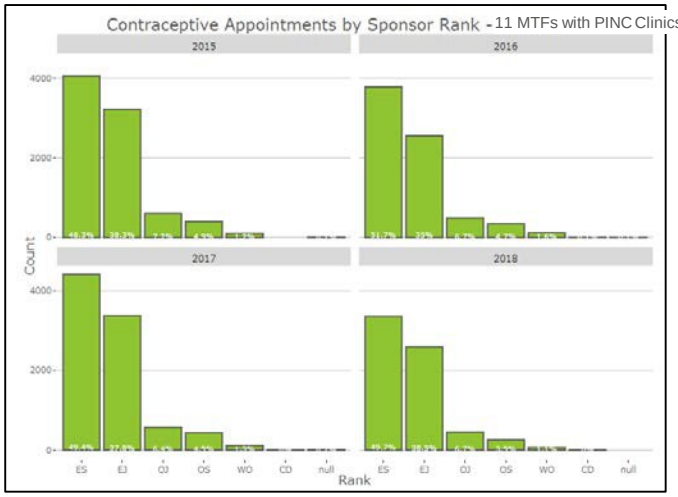




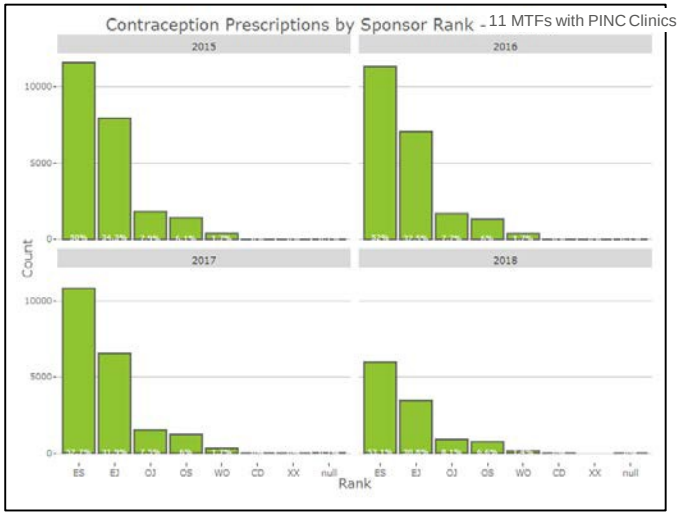
MILITARY HEALTH SYSTEM (MHS)

Contraception Access by Sponsor Rank (11 MTFs)

- Most appointments and prescriptions by enlisted or enlisted dependent women
  - >48% senior enlisted sponsor rank
  - >30% junior enlisted sponsor rank



- Contraception prescription for junior enlisted population shows minor decline



Sponsor Rank Group:

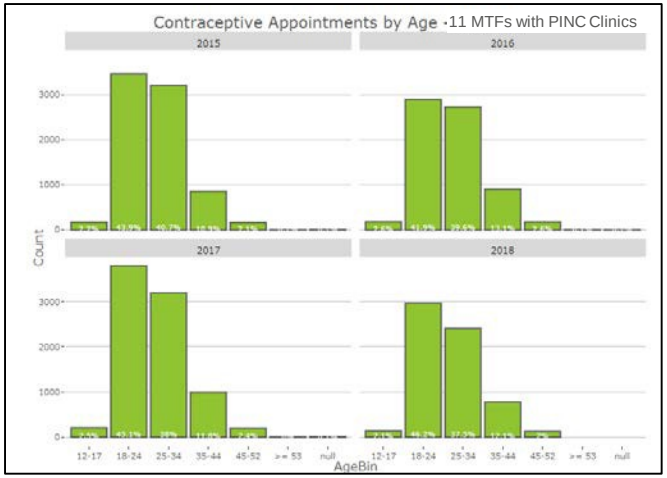
- CD = Cadet
- EJ = Enlisted, Junior (E1-E4)
- ES = Enlisted, Senior (E5-E9)
- OJ = Officer, Junior (O1-O3)
- OS = Officer, Senior (O4-O9, 10, 11)
- WO = Warrant Officer (W1-W5)
- XX = All Others

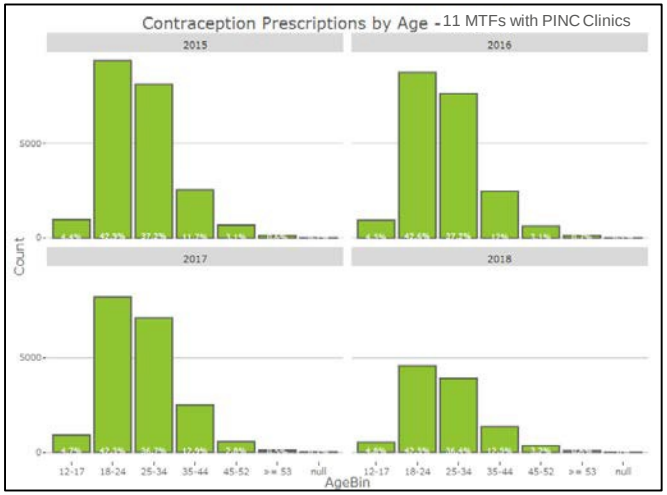
Note: 2018 data only contains January – August data

Contraception Access by Age Group (11 MTFs)

- >80% of contraceptive appointments are for females between 18-34 across all beneficiary categories

- >90% of contraception prescriptions are for females 18-44 across all beneficiary categories



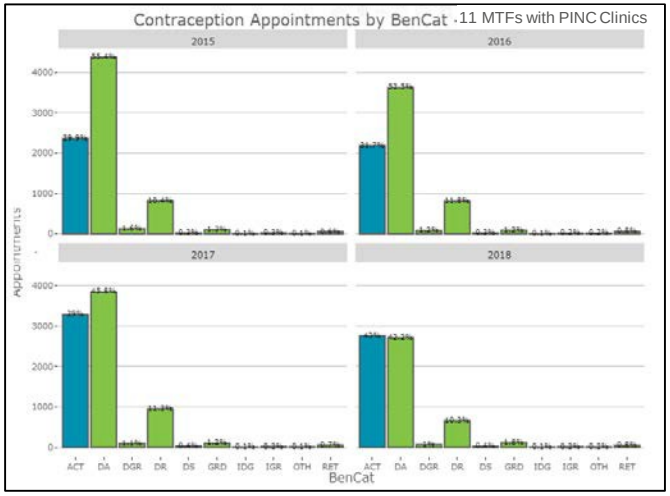


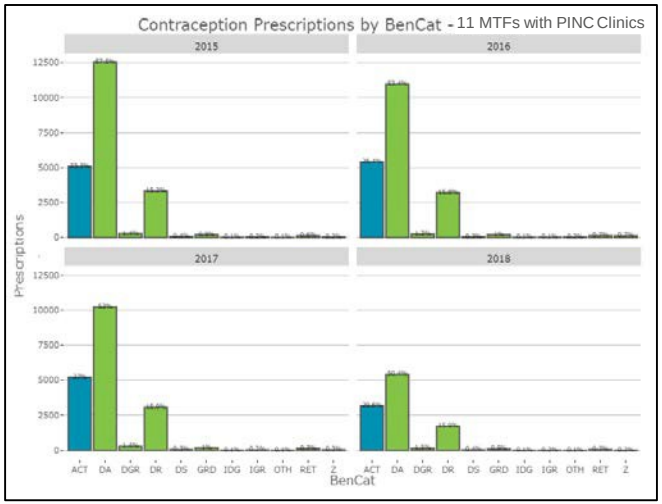
Note: 2018 data only contains January – August data

MILITARY HEALTH SYSTEM (MHS)

Contraception Access by Beneficiary Category

- Increasing number of contraceptive appointments for active duty over past 4 years
- >80% of contraceptive prescriptions are for active duty and their dependents
  - >23% active duty





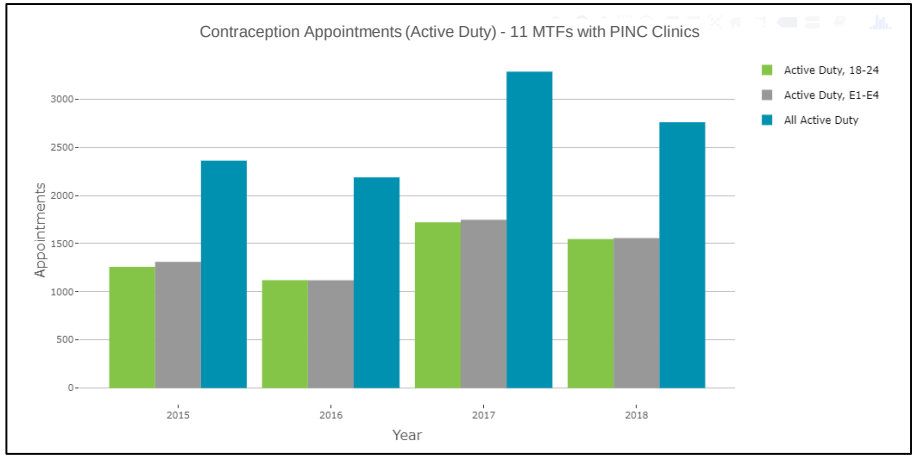
Beneficiary Category:

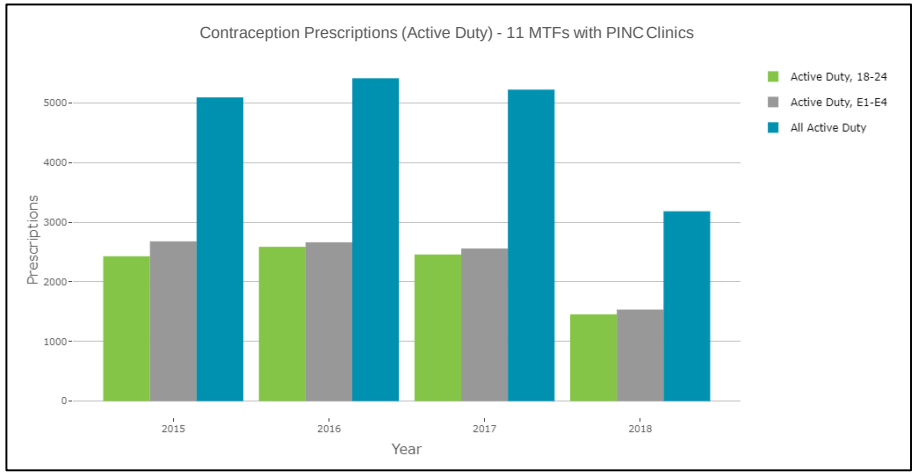
- ACT = Active Duty
- RET = Retirees
- GRD = Guard/Reserve on Active Duty
- IGR = Inactive Guard/Reserve
- DA = Dependents of Active Duty
- DR = Dependents of Retiree
- DS = Dependent Survivor
- DGR = Dependent of Guard/Reserve on Active Duty
- IDG = Dependent of Inactive Guard/Reserve
- OTH = Other
- UNK = Unknown
- DCO = Direct Care Only
- NAT = NATO

Note: 2018 data only contains January – August data

Contraception Access by Active Duty (11 MTFs)

- Contraception appointments for AD groups increase after opening of PINC clinics
- Overall contraception prescriptions consistent
  - – Lower 2018 rates may be due to incomplete data





Note: 2018 data only contains January – August data

MILITARY HEALTH SYSTEM (MHS)

Key Takeaways

- Unplanned pregnancy rates have historically been higher among Active Duty women compared to civilians, with ages 18-24 being at the highest risk.

- Following the opening of the PINC clinics, both the average provider RVU per visit and average number of provider total RVUs per month increased. The percent of LARCs used and the number of contraception appointments also significantly increased.

- The increase in visits for contraception helps increase readiness of Active Duty female Service members (ADFSM).

References

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Health Analysis Department, Navy and Marine Corps Public Health Center. (2019). *Relative Value Units (RVU) Analysis.* Data Sources: MDR CAPER, GENESIS Basic Encounter, and PDTS Tables October 2019. Unpublished.

QUESTIONS?

How to Obtain Continuing Education Credits

To receive CE/CME credit, you must register by 0745 ET on 24 January 2020 to qualify for the receipt of CE/CME credit or certificate of attendance. You must complete the program posttest and evaluation before collecting your certificate. The posttest and evaluation will be available through 6 February 2020 at 2359 ET. Please complete the following steps to obtain CE/CME credit:

1. Go to URL https://www.dhaj7-cepo.com/content/clinical-communities-speaker-series-23-jan-2020
2. Click on the REGISTER/TAKE COURSE tab
   a. If you have previously used the CEPO CMS, click login.
   b. If you have not previously used the CEPO CMS, click register to create a new account.
3. Click "ENROLL."
4. Follow the onscreen prompts to complete the following for each session you wish to claim CE/CME Credit:
   a. Read the Accreditation Statement
   b. Select the CE/CME credit type(s) you are seeking
   c. Complete the Evaluation
   d. Take the Posttest
   e. Download your Certificate(s)
   f. Complete the Commitment to Change survey (optional)
5. After completing the posttest at 80% or above, your certificate will be available for print or download.
6. You can return to the site at any time in the future to print your certificate and transcripts at https://www.dhaj7-cepo.com/
7. If you require further support, please contact us at dha.ncr.j7.mbx.cepo-cms-support@mail.mil