



**DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington, DC 20420**

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In Reply Refer To: 10P4W

April 15, 2014

**UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER
GUIDANCE ON EMERGENCY MEDICAL SERVICES FOR WOMEN**

1. PURPOSE: This information letter provides guidance for Emergency Departments (ED) and Urgent Care Clinics (UCC) to ensure delivery of quality care to all women Veterans when accessing Department of Veterans Affairs (VA) emergency services.

2. BACKGROUND: VA is providing health care to increasing numbers of women Veterans. In fiscal year 2012, 20 percent of women Veterans had at least one ED visit. Previous work has shown that many VA EDs have limited resources for female gender-specific medical conditions, such as access to specialty consultation. When resources are not available on-site, they are often provided off-site (i.e. through Non-VA Medical Care or contracting agreements). This may impact timely access, care coordination, and follow-up care. ED Directors, ED Women's Health (WH) Champions, Women Veterans Program Managers (WVPM) and, when applicable, Maternity Care Coordinators (MCC), Patient Aligned Care Team (PACT) Coordinators, and Associate Chiefs of Staff for Mental Health, or their designees, should work together to develop processes to assist VA ED and UCC in providing and arranging care for women Veterans.

3. OVERVIEW:

a. Veterans Health Administration (VHA) has an obligation to ensure quality emergency medical services for all Veterans including women Veterans. One of the main objectives of this information letter is to recommend facilities develop robust policies in advance of need to facilitate rapid transfer of patients with potentially catastrophic conditions that cannot be managed at the local VA site of care. For example, on-site stabilization and treatment strategies for patients presenting to a VA ED in hemorrhagic shock due to a ruptured ectopic pregnancy should be developed in advance. (See Attachment A for a list of relevant VHA policies that address care for women Veterans and provide guidance when the care needs of the patient exceed the capabilities of the VA health care system).

b. All women Veterans of child-bearing age (age \leq 52 years) triaged in VA ED or UCC should be asked about pregnancy status and last menstrual period. Nursing triage documentation should include this information. (See Attachment B for sample questions to assess for pregnancy

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status). Screening for Domestic Violence (DV)/Intimate Partner Violence (IPV) is also recommended for women Veterans at high risk (e.g. case finding approach). (See Attachment C for a list of risk factors for DV/IPV, a sample validated interpersonal violence screening questionnaire and the Women's Mental Health SharePoint site at

<https://vaww.portal.va.gov/sites/OMHS/WMH/default.aspx> for additional tools and references.

NOTE: This is an internal VA website, not available to the public).

c. All staff providing emergent/urgent care treatment to women Veterans should have the opportunity to receive ongoing professional education/training in women's health to maintain proficiency in topics such as, but not limited to, documenting a menstrual and obstetric history; evaluation of acute abdominal/pelvic pain; evaluating gender-based differences in presentation (i.e. myocardial infarction presentation), vaginal bleeding in early pregnancy, acute sexual assault, and DV/IPV. Simulation equipment and training materials have been made available to VA facilities for training.

d. VA EDs and UCCs should consider using care coordination tools and resources (e.g. clinical order sets, clinical pathways, note templates, clinical guidelines) to standardize and efficiently manage the evaluation and treatment of gender-specific clinical presentations (e.g. vaginal bleeding).

4. PREGNANCY TESTING IN VA ED AND UCC FACILITIES:

a. VA EDs and UCCs should have "stat" qualitative (urine and/or serum) and "stat" quantitative human chorionic gonadotropin (hCG) testing available 24 hours per day and 7 days per week (24/7) with results available to the patient's ED or UCC clinician within 1 hour of order. Immediate access to point of care qualitative urine pregnancy testing at triage is ideal for initial assessment in women of child-bearing age. Quantitative serum pregnancy testing is critical for managing certain cases (e.g. possible ectopic pregnancy).

b. All women Veterans of child-bearing age (≤ 52 years) who come to the ED or UCC should have a pregnancy test (urine or serum) if evaluation of the presenting complaint and any potential treatment could be affected by pregnancy or could adversely affect the well-being or outcome of a pregnancy. (See Attachment D for common obstetrics and gynecology (Ob/Gyn) related presentations to VA ED and UCC).

c. Blood type evaluation (i.e. Type and Screen) should be part of the evaluation of every pregnant woman who presents to an ED or UCC with vaginal bleeding. In EDs that treat pregnancy related vaginal bleeding; Rho (D) immune globulin (e.g. Rhogam) should be available 24/7.

5. EQUIPMENT AND SUPPLIES:

a. Every VA ED and UCC should have the ability to perform a gynecologic examination at all times and should have at least one gynecologic examination table or a stretcher that is adaptable for a gynecologic exam (i.e. stirrup availability).

b. Necessary gynecologic examination supplies should be available 24/7 (see Attachment E for a list of suggested VA ED and UCC gynecology equipment and supplies).

c. All VA EDs and UCCs should stock an obstetric delivery kit (see Attachment E, paragraph 6).

d. Fetal heart rate hand held dopplers: Fetal heart rate assessment is an important tool used by obstetric consultants (e.g. obstetricians/gynecologists, certified nurse midwives, family practitioners, or those trained in obstetric care) to assess the state of the fetus in a pregnant patient. This, however, is not an expected standard of care in every ED nation-wide or a mandated competency for all ED providers. VA medical facilities should not have hand held fetal heart rate dopplers available without local policy to support their use to evaluate fetal heart rates by obstetric consultants.

6. OBSTETRIC AND GYNECOLOGICAL EMERGENCIES:

a. VA EDs should ensure that processes (including local policies and agreements) are in place to provide standard emergency care to all pregnant women Veterans including stabilization and preparation for emergent maternal transport when facility capabilities are exceeded.

b. VA medical facilities should develop and implement written policies and processes (i.e. standard operating procedures) for managing obstetric and gynecologic emergencies that clearly describe on-site capabilities and processes/protocols for emergent patient transfer.

c. Processes for addressing obstetric and gynecologic emergencies will differ by facility depending on the availability of:

(1) Obstetricians and gynecologists on-site, off-site through transfer to another facility, or via tele-gynecology consultation;

(2) On-site diagnostic and treatment resources (e.g. pelvic ultrasound, operating room capacity); and

(3) Other community resources.

d. VA medical facilities should have a process in place to follow-up on cases transferred off-site to ensure appropriate quality assurance and integration of that care with ongoing care in VA.

7. DOMESTIC VIOLENCE/INTIMATE PARTNER VIOLENCE AND SEXUAL ASSAULT:

a. Screening for DV/IPV is recommended for women Veterans at high risk. (See Attachment C for a list of risk factors for DV/IPV, a sample validated interpersonal violence screening questionnaire and the Women's Mental Health SharePoint site at <https://vaww.portal.va.gov/sites/OMHS/WMH/default.aspx> for additional tools and references.

NOTE: This is a VA internal website, not available to the public).

b. Women Veterans who are at immediate safety risk should be referred to the mental health point of contact for follow-up and safety planning.

c. Clinical guidance for Alleged Acute Sexual Assault can be found in VHA Directive 2010-014, Assessment and Management of Veterans Who Have Been Victims of Alleged Acute Sexual Assault http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2177.

8. SPECIAL CONSIDERATIONS FOR PREGNANT WOMEN VETERANS:

a. Pregnant women Veterans may present to a VA medical facility for routine care; for a pregnancy-related issue; or, for a medical issue not directly related to pregnancy. Medical facilities should have information available that providers (i.e. Primary Care, PACTs, etc.) can give to pregnant women Veterans in advance. Such information should outline the patient's plan for their prenatal care and other medical care over the course of their pregnancy, and clearly define the offerings and limitations of the VA medical facility's ED or UCC as it pertains to the pregnant patient.

b. The MCC or their designees (i.e. PACT Coordinators, WVPM, etc.) should be involved in assisting pregnant women Veterans with arrangements for prenatal care and for providing resources to help them obtain the care they need (VHA Handbook 1330.03). This should also include information related to non-VA maternity care.

(1) Resources for pregnant women Veterans receiving maternity benefits through VA should include guidance describing where the pregnant Veteran should go in case of an emergency during her pregnancy (which is typically not to a VA ED or UCC).

c. **Care of the Pregnant Patient.** A systematic approach to ED or UCC triage and initial assessment of the pregnant or potentially pregnant patient is essential. In particular, it is fundamental to ascertain clinically whether the presenting emergency problem:

- (1) Is due to the pregnancy (e.g. vaginal bleeding, abdominal/pelvic pain, preeclampsia);
- (2) Is unrelated to the pregnancy (e.g. sprained ankle, ear infection); or
- (3) Could affect the pregnancy (e.g. asthma, seizure, pyelonephritis, and hypertension).

***NOTE:** See Attachment F for a treatment algorithm that outlines a suggested planned approach to care for pregnant patients.*

d. Transvaginal Pelvic Ultrasound.

(1) Transvaginal pelvic ultrasound is an essential diagnostic tool to provide comprehensive and safe care of women Veterans presenting with a myriad of pelvic conditions, especially ovarian torsion and ectopic pregnancy. VA medical facilities caring for pregnant patients on-site should have:

- (a) Pelvic ultrasound (transvaginal) capability;

- (b) Radiologist skilled to interpret transvaginal ultrasound;
- (c) Quantitative and qualitative pregnancy testing; and
- (d) Access to specialty care providers (i.e. Ob/Gyn) available through consultation to assist with diagnosis and treatment.

(2) Focused ultrasonography performed by duly credentialed emergency physicians to diagnose an intrauterine pregnancy is acceptable only if the interpretation of the results is formally entered into the medical record of the patient, and an appropriate quality assurance process is in place consistent with the American College of Emergency Physicians policy on ED Ultrasonography <http://www.acep.org/WorkArea/linkit.aspx?LinkIdentifier=ID&ItemID=32878>.

(3) VA medical facilities should have a written plan that describes when these ultrasonography services are available on-site (i.e. 24/7), during normal business hours, nights, and weekends) and options for providing care when these services are not available on-site.

9. MEDICATION AVAILABILITY:

- a. Emergency contraception should be available to women Veterans at the time of the patient's visit to the VA ED and UCC when indicated 24/7.
- b. Locally, VA medical facilities should develop a process to ensure availability of Rho(D) Immunoglobulin to prevent Rh Isoimmunization in female patients who are pregnant, Rh negative, and have a bleeding event (i.e. miscarriage). These processes should be in place in advance of need.
- c. Methotrexate and misoprostol are medications that are commonly used to manage complications of early pregnancy such as ectopic pregnancy and miscarriage. VA medical facilities systems should have processes in place to make these medications available to appropriate specialty providers (i.e. consulting Ob/Gyn) when caring for pregnant women Veterans in the ED or UCC. Written policies or processes should also identify how care will be provided when emergent surgical management is needed for the conditions these medications treat, such as ruptured ectopic or incomplete miscarriage.

10. REFERENCES:

- a. 2012 Emergency Services for Women Survey Report
<http://vaww.infoshare.va.gov/sites/womenshealth/grants/Emergency%20Services%20For%20Women%20Grant%20Information/Emergency%20Services%20for%20Women%20Survey%20Report%207208412.pdf>.
- b. Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy, August 24, 2012
<http://www.acep.org/WorkArea/DownloadAsset.aspx?id=8810>.

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c. VHA Directive 2010-011, Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2173.

d. VHA Directive 2007-015, Inter- Facility Transfer Policy
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1561.

e. VHA Directive 2010-014, Assessment and Management of Veterans Who Have Been Victims of Alleged Acute Sexual Assault
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2177.

f. VHA Handbook 1101.5, VHA's Emergency Medicine
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2231.

g. VHA Handbook 1330.01, Health Care Services for Women Veterans
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2246.

h. VHA Handbook 1330.03, Maternity Health Care and Coordination Handbook
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2246.

11. INQUIRIES: Questions concerning the contents of this Information Letter should be directed to the National Director, Emergency Services, Office of Patient Care Services at 315-425-4400 ext. 54417, or to the Director, Reproductive Health, Women's Health Services at 202-461-0373.

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Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List on 4/16/2014.

RELEVANT VETERANS HEALTH ADMINISTRATION (VHA) POLICIES

Topic	Policy source
Equipment and Supplies	Handbook 1101.05, Section 13b; VHA Handbook 1330.01, Section 20
Point of Care Tests Availability	VHA Handbook 1330.01, Section 20; July 13, 2011 Memo Clarification of VHA Handbook 1330.01
Laboratory Tests Availability	VHA Handbook 1101.05, Appendix C; VHA Handbook 1330.01, Section 20
Medication Availability	VHA Handbook 1101.05, Appendix D
Radiologic Studies Availability	VHA Handbook 1101.05, Appendix E
Consultative Services	VHA Handbook 1101.05, Section 13; VHA Directive 2010-008, Section 4
ED Layout	VHA Handbook 1101.05, Section 13
Consultative Services	VHA Handbook 1101.05, Section 13
Transferring Patients to Other Sites	VHA Handbook 1101.05, Section 14; VHA Handbook 1330.01, Section 20
Sexual Assault Services	VHA Directive 2010-014; VHA Handbook 1330.01, Section 20; VHA Directive 2010-008, Section 4
Follow-up Care	VHA Handbook 1101.05, Section 13
Obstetrical Emergencies	VHA Handbook 1330.03, Section 11

SAMPLE QUESTIONS TO ASSESS FOR PREGNANCY STATUS IN TRIAGE

General questions	<ul style="list-style-type: none">• When was the first day of your Last Menstrual Period (LMP) (Month/Date/Year)• Are you pregnant? (Yes, No, Maybe)• Are you having sex with a male partner?• Are you currently trying to get pregnant?• Are you using contraception (birth control)?
Possible exclusions to LMP/pregnancy questions or pregnancy testing	<ul style="list-style-type: none">• Women over age 52• Known Hysterectomy

DOMESTIC VIOLENCE/INTERPERSONAL VIOLENCE (DV/IPV) RISK FACTORS

1. RISK FACTORS FOR DOMESTIC VIOLENCE (DV)/INTERPERSONAL VIOLENCE (IPV): Risk factors include but are not limited to:

- a. Disability, pregnancy, recent separation from violent partner;
- b. Child abuse;
- c. Child witness to violence;
- d. Younger age (18-24);
- e. Separated, divorced, or cohabitating;
- f. Marital discord;
- g. Psychiatric illness;
- h. Financial instability; or
- i. Low social support.

2. EXTENDED-HURT, INSULT, THREATEN, SCREAM (E-HITS) SCREENING

TOOL: Women Veterans who are identified as being at high risk can be screened using the Extended – Hurt, Insult, Threaten, Scream (E-HITS) screening tool.

Sample validated interpersonal violence screening questionnaire

Extended – Hurt, Insult, Threaten, Scream (E-HITS)	The E-HITS is an extension of the HITS (Chan, Chan, Au, & Cheung, 2010; Sherin et al., 1998), a tool that is recommended as a front-line IPV screening tool by the United States Preventive Services Task Force (USPTF, 2012) and has been validated in a variety of settings and diverse patient populations, including women Veteran patients (Iverson et al., 2013). This brief tool allows providers to briefly and sensitively identify women who would likely benefit from further assessment of IPV and associated health care needs.
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a. For additional tools and references, see the Women’s Mental Health SharePoint site at <https://vaww.portal.va.gov/sites/OMHS/WMH/default.aspx>. *NOTE: This is a VA internal website, not available to the public*

b. Any Veteran who screens positive on the Danger Assessment Tool should be referred immediately to their VA health care system’s mental health point of contact for follow-up and safety planning. Veterans who screen positive on the E-HITS, but not the Danger Assessment Tool should be provided with a referral to mental health within 24 hours.

c. For details on the Danger Assessment Tool, see the Women's Mental Health SharePoint site at <https://vaww.portal.va.gov/sites/OMHS/WMH/default.aspx>. ***NOTE:** This is a VA internal website, not available to the public.*

COMMON OB/GYN RELATED PRESENTATIONS TO VA ED AND UCC

Ob/Gyn conditions	Life-threatening vaginal hemorrhage
	Ovarian torsion
	Ectopic pregnancy
	Sepsis related to uterine/ovarian pathology
	Eclampsia/pre-eclampsia
	Acute sexual assault
	Non-sepsis gynecologic infections (vaginitis, cervicitis)
	Pelvic inflammatory disease
	Ruptured ovarian cyst

SUGGESTED VA ED AND UCC GYNECOLOGY EQUIPMENT, TESTS AND SUPPLIES

NOTE: It is recommended that all gynecologic examination supplies are stored together (i.e. assembled into a kit, on a dedicated cart, or in a designated supply location). Most commonly used supplies and instruments (e.g. speculums, ring clamp, 4x4 gauze pads, large cotton applicators) can be assembled into pre-packaged kits. A focused light source for speculum examinations is essential.

1. EQUIPMENT:

- a. Mobile cart to hold equipment and supplies for easy provider access during exam
- b. Table/stretcher with footrests.
 - (1) The stretcher should have a bottom that lowers or footrests at the end.
 - (2) Note: The exam table/stretcher should face away from the door or area of foot traffic.
- c. Focused standing light source:
 - (1) standing or
 - (2) speculum light

2. INSTRUMENTS:

- a. Speculums in several sizes (small, medium, large, and pediatric size).
 - (1) The speculums should be of several types and styles (e.g. Pedersen, Graves, and pediatric).
 - (2) Lighted speculums are recommended however, if unavailable, an external focused standing light source is necessary.
- b. Forceps (i.e. Ring, Kelly, Adson; long alligator; long, curved uterine dressing).
- c. Scissors (i.e. regular and long Mayo).
- d. Suture kit (needle driver, curved and straight hemostats, forceps with teeth).
- e. Single and or double tooth tenaculum.
- f. Word catheters (for management of Bartholin cyst).
- g. Scalpels (i.e. blades #15, #10, and #11).

3. TESTS: DNA probe for gonorrhea and chlamydia testing:

- a. Probe or wet prep (Clinical Laboratory Improvement Amendment (CLIA) waived) for evaluation of vaginitis (e.g. Affirm®).
- b. Point of care pregnancy test kits (CLIA waived).

4. SUPPLIES:

- a. Sterile boxes of 4x4 gauze.
- b. Betadine and non-iodine antimicrobial solutions.
- c. Silver nitrate sticks.
- d. Dermal biopsy punches (various sizes).
- e. Chux pads or equivalent.
- f. Feminine pads and tampons (regular and super-size).
- g. Lubricant (e.g. in packets, water-based lubricant as Surgilube®).
- h. Extra-large cotton applicators (e.g. Phoenix Rayon Swabs).
- i. Single cotton tip applicators.
- j. Female patient gowns (regular and large sizes).

5. MEDICATIONS THAT REQUIRE ACCESS 24 HOURS PER DAY AND SEVEN DAYS PER WEEK: Access is possible via dispenser in ED and UCC or an on-site pharmacy.

- a. Emergency contraception, at least one: Levonorgestrel (e.g. Plan B One-Step® and equivalents) or uliprisal (e.g. ella®).
- b. Misoprostol and/or Methergine.
- c. Rho(D) immune globulin (e.g. Rhogam) from Blood bank for Rh-negative pregnant women who have vaginal bleeding or abdominal/pelvic trauma (if not available on-site, design process for obtaining).
- d. Hormones to treat dysfunctional uterine bleeding.
- e. Antibiotics.
- f. If applicable, processes should be established for methotrexate use for ectopic pregnancy.

6. SUPPLIES IN OBSTETRIC DELIVERY KIT:

- a. Bulb syringe.
- b. Sterile scissors.
- c. Cord clamps (four on hand at all times).
- d. Container for placenta.

SUGGESTED PLANNED APPROACH TO CARE FOR PREGNANT PATIENTS

1. The following treatment algorithm outlines a suggested planned approach to care for pregnant patients:

a. Pregnant patients who present to the Emergency Department (ED) or Urgent Care Clinic (UCC) at less than 20 weeks gestation, by dates or by history, should be evaluated by the Department of Veterans Affairs (VA) ED or UCC provider, and either treated in the ED or UCC or assessed for potential transfer for treatment, if appropriate.

b. Pregnant patients who present to the ED or UCC at 20 or more weeks gestation, by dates or by history, with pregnancy threatening symptoms such as abdominal/pelvic pain, vaginal bleeding, or lack of fetal movement should be evaluated by the emergency physician (EP) immediately. These patients should be taken directly to OB triage, if it exists at the VA medical facilities, or transferred emergently to a facility that can manage such cases. The patient must be stabilized prior to transfer unless delays would result in more significant problems.

c. Pregnant patients who present to the ED or UCC at 20 or more weeks of greater gestation, by dates or by history, with a life-threatening event including trauma-induced events, should be evaluated by the EP immediately and stabilized. The EP should consult with an obstetrics provider (in person or by phone) to determine whether or not the patient should be transported to a facility that can provide appropriate emergent obstetrical management and other necessary emergent care. Stabilization of the pregnant patient is critical in a life-threatening situation.

d. Pregnant patients who present to the ED or UCC with a non-obstetrical complaint that is non-threatening to maternal/fetal well-being (e.g. broken arm, laceration requiring stitches) should be evaluated and treated in the ED or UCC.

e. Consultation with the patient's obstetric provider is important in all cases to assist in care management and arrange timely outpatient follow-up. Such consultation should be used if there are questions about the safety and/or appropriateness of particular tests or treatments.

f. Pregnant patients may present to a VA ED or UCC facility in labor, some with imminent delivery. Most VA ED and UCC facilities do not have labor and delivery capabilities. However, they may need to provide emergency care during the delivery (i.e. precipitous delivery) and prepare for transfer of the patient and infant as soon as possible post-delivery. Transfer processes for such should be in place in advance.

2. Emergency departments and urgent care clinic providers should ensure that all pregnant patients who present to the ED or UCC have appropriate follow-up arrangements. Processes for notifying the Maternity Care Coordinators, or their designee, or Patient Aligned Care Team Coordinators to facilitate care coordination and follow-up needs should be identified.