

Allocate, Innovate, Educate
How Addressing the Health Needs of Rural Women Veterans
Makes the U.S. Department of Veterans Affairs Stronger

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The proportion of enrolled Veterans who are women increased from 4.7% in fiscal year (FY) 2000 to 7.5% in FY 2015, and will reach 13.1% *at a minimum*,¹ and perhaps as high as 15-20%, by 2035 – if not sooner. Twenty-five percent of these women live in rural areas,² where provider shortages, geographic distances to care, and other factors make it more difficult to get the care they need. This growing cohort of women Veterans utilizes more – and different – services from the U.S. Department of Veterans Affairs (VA), and VA must adapt to accomplish its mission of caring for those who served our nation. The VA’s Veterans Rural Health Advisory Committee (VRHAC) will take a focused look at the situation of rural women Veterans throughout FY2020-2021. The VA’s Office of Rural Health developed this report to prompt the Committee’s thinking and action on this critical topic.

The report draws upon interviews with nine women’s health leaders from inside and outside VA, as well as a review of available literature and data, to understand the scope of women’s health issues, and how they manifest in rural women Veterans’ lives in particular. The report explores three different situations, each requiring VA to take a different approach. Specifically:

- Women need a level of access to gender-specific services that is equivalent to the access that already exists for their male counterparts. For example, women need obstetric and gynecologic services, and these should be as easy for women Veterans to access as it is to get any other kind of care. The challenge to VA in these cases is to **allocate** resources appropriately and equitably to address health needs that are unique to women.
- In other cases, women and men face the same general types of health issues – such as mental health disorders, musculoskeletal issues, or chronic pain – but women’s symptoms may present differently from male patients or be more

¹ This is the proportion of enrolled Veterans age 65 or younger who are women, since in 2035 today’s Veterans age 65+ will have reached today’s average life expectancy at 65, which is 84 for men and 86.5 for women (see <https://www.ssa.gov/planners/lifeexpectancy.html>). Of course, the actual proportion of enrolled Veterans who are women will likely be even higher given that younger Veterans are more likely to be women than in older generations.

² U.S. Department of Veterans Affairs’ Women’s Health Evaluation Initiative and Women’s Health Services. Sourcebook Volume 4: Women Veterans in the Veterans Health Administration. Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution. February 2018, 30. https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WHS_Sourcebook_Vol-IV_508c.pdf.

complex. For example, while VA may have experience treating chronic illness, VA has less experience due to its historic patient population in treating women with chronic illness who also suffer from traumatic brain injury (TBI) and have been diagnosed with breast cancer. Providing care to women Veterans with more complex health needs requires **innovation** that could improve care for Veterans of all genders, if the innovations are spread throughout VA’s health care system.

- In still other cases, men may face the same challenges as women, albeit in smaller numbers. For example, both men and women can experience intimate partner violence (IPV), whether physical, mental, emotional, verbal, or sexual. This suggests that a large-scale effort to address IPV could also help men Veterans whose needs may have been overlooked in the past. The third challenge is to **educate** political leaders and the general public about health and life issues, especially those related to military service and combat, that men and women share so greater action can be taken to meet the need.

Each situation is presented in greater detail below, with specific implications for rural implementation. A framework of questions for VRHAC and other VA leaders to ask in each situation is provided as **Appendix A**.

Allocate

The growing presence of women Veterans enrolled in VA’s health care system requires VA to provide health services that would have seemed unimaginable 50 years ago. Pregnancy care, breast cancer screening, gynecologic care – this is new ground for VA. VA’s challenge here is to allocate resources appropriately and equitably to ensure that women have a level of access to the services they need that is equivalent to the level of access men have to the services they need. VA is moving in this direction by training its existing workforce on women’s health, by building out its workforce to provide women’s health services, and in pioneering new roles. VA is also outsourcing some care to community providers through mechanisms enacted in the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, but in many rural areas the needed providers are not available in the community either.

VA has made great strides in addressing the gap in care for women Veterans through its Women’s Health Primary Care Provider (WH-PCP) program, which trains and designates VA’s primary care providers to offer gender-specific services to women patients. As Dr. Sally Haskell, Deputy Chief Consultant for VA Women’s Health Services, notes, “We have designated women’s health primary care providers at all of our Health Care Systems.” However, some Community-Based Outpatient Clinics within those Health Care Systems may not have a designated women’s health provider. This may be because there is only one provider with very few women patients (and thus,

perhaps, little perceived need or interest in completing the training), or because the Community-Based Outpatient Clinic has been unable to send a provider to the training.

To address this latter situation, VA Women’s Health Services partners with VA’s Office of Rural Health to provide “mini-residencies” that travel to rural areas to train the providers there on women’s health topics. These programs differ from the traditional program in that participants can complete much of the didactic training online, and then participate in practical sessions face-to-face. The goal is to have at least one designated women’s health primary care provider program in each VA facility; otherwise, women patients need to be referred out into the community for gender-specific care, and in some rural areas those services may also be unavailable in the community.

For specialty care (e.g., obstetrics and gynecology) and sub-specialty care (e.g., infertility and gynecologic oncology), VA will need to seek out and hire more providers of these women-specific services so that women Veterans can receive the services they need within VA. **This requires VA to look ahead and consider women’s health needs throughout their lifespans—from reproductive health to geriatrics.** As VA Women’s Health Services Senior Program Analyst Nancy Maher, PhD, notes, “The current median age is around 45-50 for women Veterans, and around 65 for men. In 10 years, these women will be experiencing issues of older life and aging,” including menopause, gender-specific cancers, and assisted living.

In rural areas, VA’s capacity to address the need for these gender-specific health services, even through community care, is severely constrained by provider shortages. As VA Deputy Director of Reproductive Health Dr. Alicia Christy noted, “In some states, there’s only one gynecologic oncologist in the entire state.” To some extent, these local provider shortages can be addressed with technology, such as tele-gynecology programs that offer initial assessments, post-operative care, and other remote services, or tele-group health for women suffering from postpartum depression.

VA will need to pioneer new roles as well, as in the case of maternity care coordinators who help pregnant Veterans coordinate the care they receive in VA and in the community; because VA does not deliver babies, effective coordination between different providers is key. Again, this need is particularly acute in rural areas; maternal mortality and severe maternal morbidity have been increasing and are more prevalent among women in rural areas.³ Joan Combellick, a Women’s Health Research Fellow at

³ Kozhimannil, Katy et al. “Rural Focus and Representation in State Maternal Mortality Review Committees: Review of Policy and Legislation.” *Women’s Health Issues* 29:5 (2019). 357-363. <https://doi.org/10.1016/j.whi.2019.07.001>.

the VA Connecticut Healthcare System, conducted chart review research that indicates rural women are overrepresented in severe maternal morbidity and mortality events. Pregnancies of women Veterans enrolled in VA health care have skyrocketed in recent years, from 1,902 in FY 2010 to 3,756 in FY 2015 (an increase of 97.5% over five years), suggesting that additional staffing will likely be required in this maternity care coordinator role. As Dr. Haskell notes, “Care coordination is complicated for women Veterans, because we have to coordinate additional screening programs such as cervical and breast cancer screening, and coordinate maternity care.” As the current cohort of women Veterans ages, similar roles may be required to coordinate care in the areas of gender-specific cancers and long-term care.

Providing care for women is just one piece of health services – the site of care must also be a comfortable and welcoming environment. Currently one in four women Veterans report having experienced harassment on VA premises.⁴ VA will need to continue allocating resources to ensure that VA facilities are welcoming and respectful to women Veterans. VA currently has a campaign to heighten awareness of this harassment and to train staff and Veterans so that women Veterans will feel safer and more comfortable at VA. Further, VA has undergone an effort to offer increased privacy for women Veterans waiting for appointments, for example with separate entrances to women’s health clinics. However, such efforts depend on the space available, so are more likely in new construction than in existing facilities.

As VA’s population of women Veterans expands over the next five years, demands on the system will change. From reimagined staff roles to expansion of services, VA will need to allocate its resources differently to fulfill its mission of serving its entire patient population.

Innovate

There are some conditions that are exclusive to women’s health, others that are more common for women, and others that may be less common in women but present differently or with greater complexity. These conditions require greater innovation to meet women Veterans’ needs. Of course, those innovations can then be disseminated, as appropriate, to improve VA’s care for all Veterans. **By addressing a challenge in the most complex cases, the VA will learn how to address it in other cases as well.**

One source of complexity is that a greater proportion of women Veterans than male Veterans (40 percent vs. 25 percent in FY 2015) use mental health services, including

⁴ Klap, Ruth et al. “Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care.” *Women’s Health Issues* 29:2 (2019). 107-115. <https://doi.org/10.1016/j.whi.2018.12.002>.

for substance use disorders.⁵ Further, research on women Veterans generally (that is, including those not enrolled in VA for health care) found that 61 percent of female Veterans have a diagnosis of clinical depression, and that women Veterans commit suicide at rates 2.2 times higher than non-Veteran women.⁶

Eileen Goode, CEO of the New Mexico Primary Care Association, notes that gendered social stigma can complicate mental health or substance use disorder treatment. For example, she highlights that women of child bearing age with substance use disorder can be more heavily stigmatized than men in similar situations. Researchers identify stigma as a barrier to access and quality care.⁷

As Maher notes, “Many rural women Veterans face challenges that can make their health care delivery more complex. Because of residing in in a rural area they may have less social support, less access to primary or specialized medical care (even including access to maternity care and delivery for pregnant women), and/or reduced access to accessible mental health care due to geographic isolation and/or stigma associated with having a mental health condition.”

Women also suffer from musculoskeletal issues at greater rates than men, often related to injuries during military service and ill-fitting combat gear designed for men. Women Veterans who presented at a 2019 VRHAC meeting shared stories of how standard military equipment may not be designed with their bodies in mind. One noted that the smallest size of sunglasses issued for a tour in the desert were far too big for her face; she needed to buy civilian sunglasses to protect her eyes. Another referenced her difficulty in finding a Kevlar system that fit her torso. To prevent the male-designed vest from fitting too loosely, she had to remove the side pieces, which reduced her safety. Several of the panelists said they now face back problems, possibly due to ill-fitting equipment. Further, women may not disclose such injuries to medical providers for fear of looking weak, so their injuries may go untreated for long periods of time and compound other issues.

⁵ U.S. Department of Veterans Affairs’ Women’s Health Evaluation Initiative and Women’s Health Services. *Sourcebook Volume 4: Women Veterans in the Veterans Health Administration. Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution*. February 2018. https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WHS_Sourcebook_Vol-IV_508c.pdf.

⁶ U.S. Department of Veterans Affairs’ Office of Mental Health and Suicide Prevention. 2019 National Veteran Suicide Prevention Annual Report. September 2019. https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf.

⁷ Knaak, Stephanie et al. “Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions.” *Healthcare Management Forum* 30:2 (2017). 111-116. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5347358/>.

Innovating to deliver the appropriate care to women Veterans will require a new approach to research in which women are appropriately represented. The National Institutes of Health, recognizing that sex and gender were often not included as variables in health research, implemented a strategic policy to ensure that NIH-funded research discovers and addresses biological differences in the prevention, presentation, management, and outcomes related to various diseases.⁸ VA will need to take similar steps to ensure that research activities appropriately and equitably represent women in their research design and in their findings.

Educate

Some issues typically considered “women’s health issues” also affect people of other genders, albeit in smaller numbers. For example, intimate partner violence is becoming a more significant concern within VA due to the growing number of women enrolled in VA for health care, and due to the prevalence of mental health disorders and post-traumatic stress disorder (PTSD), which are risk factors for IPV.⁹

However, men too can suffer from IPV. According to LeAnn Bruce, National Program Manager of VA’s Intimate Partner Violence Assistance Program, “People have a lot of stereotypical views about IPV and domestic violence – that is, the man as the ‘perpetrator’ and the woman as the ‘victim.’¹⁰ In the VA, we do see cases like that. But we tend to see more cases where relationship stress or ineffective communication patterns result in many forms of bidirectional IPV.” For this reason, the IPV Assistance Program is rolling out a process to screen all Veterans who are enrolled in VA’s health care system for IPV.

But as Dr. Megan Gerber, Medical Director for Women’s Health at the VA Boston Healthcare System, notes, women are much more likely than men to be injured by IPV, or to be killed by IPV. **In fact, the largest cause of traumatic brain injury among women Veterans is not a combat-related injury but rather IPV – that is, being struck or asphyxiated by an intimate partner.** So, it is essential that VA support women’s – as well as all Veterans’ – health by addressing the issue of IPV.

Veterans in rural areas who experience IPV face additional challenges. First, as with other types of services, social workers and shelters may be less available. Second,

⁸ Clayton, Janine Austin. “Applying the new SABV (sex as a biological variable) policy to research and clinical care.” *Physiology & Behavior* 187 (2018), 2-5. <https://doi.org/10.1016/j.physbeh.2017.08.012>.

⁹ Misca, Gabriela and Forgey, Mary Ann. “The Role of PTSD in Bi-directional Intimate Partner Violence in Military and Veteran Populations: A Research Review.” *Frontiers in Psychology*. August 2017.

¹⁰ Consistent with its mandate to be recovery-oriented, trauma-informed, Veteran-centered, and to use people-first language, the VA IPV program does not use terms like “perpetrator,” “batterer,” or “victim.” Instead, the program addresses people who “experience IPV” or “use IPV.”

geographical isolation may cut those experiencing IPV off from support, for example a neighbor who might hear an episode and call for help in an urban setting.

Addressing IPV will require VA not just to allocate and innovate, but also to educate political leaders and the general public about what IPV really is. As Bruce notes, “It’s often really about the breakdown of the relationship itself. We believe that helping people develop healthy relationships is the key to prevention – not only of IPV, but also health and mental health concerns, and many social factors such as homelessness and poverty. Further, having one good, healthy relationship in their life can help a Veteran cope with everything else that they’re dealing with.”

Another issue typically viewed in the context of women’s health is reproductive care. However, same-sex male couples may also benefit from services related to childbirth, such as in vitro fertilization (IVF) and surrogacy. These services are currently only covered by VA under certain conditions, which include a male-female relationship. As the VA increasingly recognizes women Veterans’ desire to have children, it may recognize same-sex male couples’ desire to have children as well. In this way, addressing women’s health implies a greater interaction with all aspects of a Veteran’s life, beyond what would have been considered relevant when Veterans were virtually all men.

Conclusion

The growing numbers of women Veterans enrolled in and who obtain care from VA offer VA a greater opportunity to live into its mission of caring for those who served this nation. The challenge of doing so is greater when it comes to rural women Veterans. In some cases, what is required is simply to allocate resources to ensure the appropriateness and equity of services provided to its ever-changing enrolled population, with particular attention to rural areas where provider shortages are often severe. **In other cases, women’s biology, experiences and needs can prompt innovation that will help VA deliver women-centered care, as well as possibly improve VA’s care for men Veterans.** In still other cases, issues typically viewed as women’s health issues may also apply to other genders, albeit in different numbers, and VA’s efforts to educate on the broader relevance of these issues will improve the health and well-being of all Veterans.

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Appendix A

Women’s Health Care Equity Framework

To help VA’s Veterans Rural Health Advisory Committee and other VA leaders track VA’s efforts to allocate, innovate, and educate on behalf of women Veteran’s health care as described in this report, we offer the following framework of questions to be asked on a regular basis to evaluate current efforts and to guide future activities.

Allocate

- Does VA policy and planning prioritize the services of greatest importance to women’s health?
- Does the allocation of resources to women’s health apply the same criteria and weights as when prioritizing the needs of men Veterans?
- Has VA anticipated the future needs of this first large cohort of women Veterans (now in middle age) as they move along the life course?
- Is VA actively putting in place the services and resources that these women Veterans will need in the coming years?
- Is VA maximizing the use of technology to increase access to women’s health services, particularly for rural women Veterans?
- Is VA taking sufficient action to help rural women Veterans access needed care when providers do not exist locally, either at the VA or in the community?
- Are sufficient resources and staffing in place to coordinate women’s more complex care across VA and community care?
- Is VA allocating sufficient resources to ensure that VA facilities and services are welcoming, safe, and respectful for women Veterans?

Innovate

- Do databases used by VA clearly differentiate by sex, gender, rurality, and Veteran status across the full U.S. population?
- Do databases used by VA capture the medical and non-medical factors most likely to shape a woman Veteran’s health and well-being?
- Does VA health research appropriately and equitably address sex- or gender-specific prevention, presentation, management, and outcomes of health conditions?
- Does VA seek out and apply learning from other entities’ research and innovation related to women’s health?
- Does VA health data capture the complexity of women Veterans’ health and well-being across multiple areas of health?

Educate

- Are health issues defined in ways that are inclusive of all those affected?
- Are resources related to a given issue made equitably available to all who might benefit?
- Is the language used by the VA respectful of all concerned?
- Are policies inclusive of all who might benefit from a given service provided by VA?