

WOMEN VETERANS HEALTH CARE

*You served, you deserve
★ the best care anywhere.*



VA Services for Women Veterans in Oregon

Marcia Hall PhD

**Women Veterans Program Manager
Roseburg VA Healthcare System**

November 17, 2009

Objectives of Presentation

1. Identify the demographic and clinical characteristics of women Veterans using the VA Healthcare Services in Oregon.
2. Describe How Women Veterans 'Access' care and what care is available in Oregon.
3. Describe some current barriers for women Veterans accessing VA services.
4. Define VA priority initiatives to improve Women Veterans Health services based on VA Women's Health Research.

The New Face Of Our Women Veterans



New Considerations and Emerging Trends....
In Times of War the 'Aftermath' is in our Communities:
Veterans are Our Communities

- The Northwest Region has more returning veterans than other regions of the country.
- The majority of veterans are returning to rural communities.
- Many returning veterans, have Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), have Family Conflicts and too many are homeless.
- They are returning profoundly changed by their experiences of war and multiple deployments.

Embedded In this “Bigger Picture” of Returning Troops... **Are Women Veterans.**

- **Women Veterans serve honorably: “We are Soldiers First and Women Second.”**
- **Women Veterans have experienced, survived and carry both common and unique burdens from their service to our country.**
- **Too often, women veterans are *invisible*, and this *invisibility* is, in and of itself, a barrier to healthcare services.**
- **Women veterans face specific issues of violence (military sexual trauma and domestic violence) which are frequently hidden and stigmatized.**
- **Of homeless veterans from the Iraq and Afghanistan wars 11% are women.**
- **Roughly 40% of the homeless female Veterans of recent wars have said they were sexually assaulted while serving.**

Women Veterans: Background

- There are 1.7 Million Women Veterans in the U.S. .
Women Veterans are my 93 year old mother and your 19 year old niece.
- 200,000 women have served in the current wars in Iraq and Afghanistan.
- Women Comprise 14% of 230,000 Active Duty and 19.6 % of Reserve Troops serving overseas. They remain a 'Minority Population' in the military and in the VA.

Combat Roles?

All our troops in Iraq and Afghanistan are in Combat



Sgt. Lynn Kinney, Maj. Megan McClung and Staff Sgt. Amy Forsythe stand together on Camp Fallujah, Iraq, April 2006. All worked together at the Public Affairs Office for the 1st Marine Expeditionary Force serving in Al Anbar Province. McClung was killed in action Dec 6, 2006 by an IED while escorting media in Ramadi, Iraq.

Women will Double in the next 5 Years

The mass influx of women veterans that the VA faces would be a challenge for any health care system. It is particularly challenging for a system that has a history of caring for a predominantly male population. As recently as 1971, women constituted less than 1 percent of the U.S. military.



Female Enrollees FY 2007 = 255,324

Projected female enrollees 2008 = 481,054

Projected female enrollees 2010 = 533,208

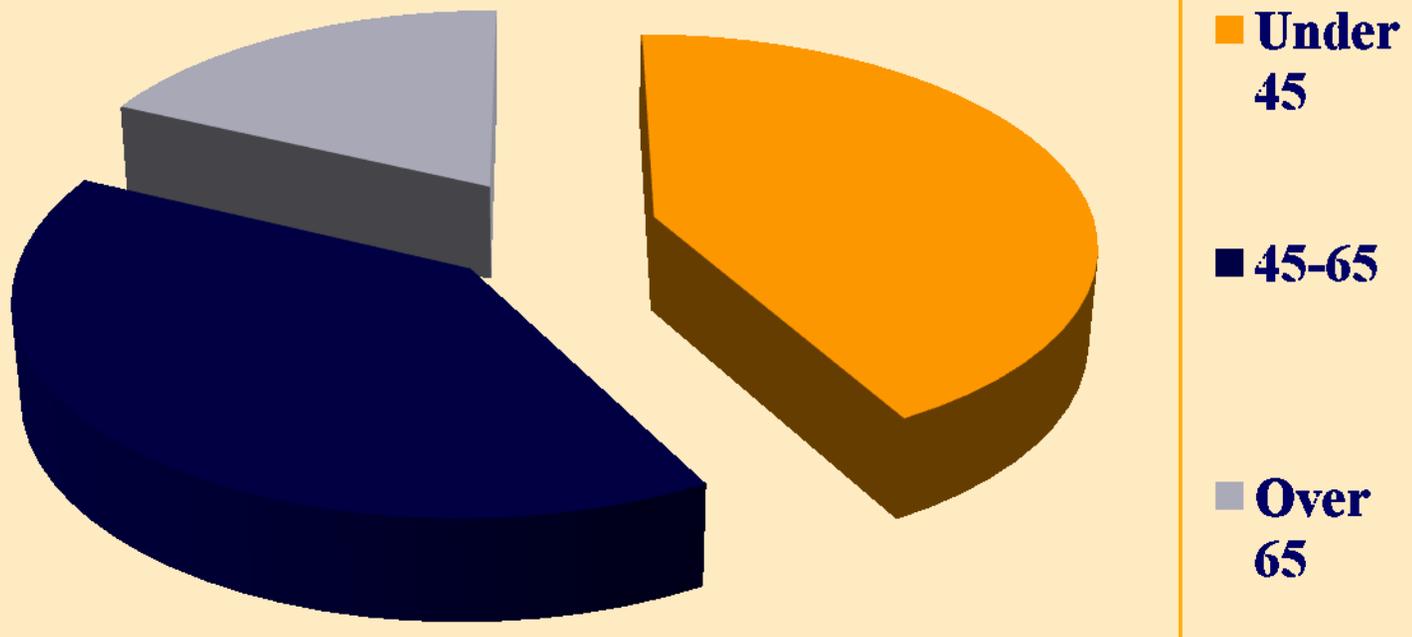
Projected female enrollees 2013 = 589,383

Utilization by Women Veterans

- Traditionally, women Veterans have under-utilized VA health care – many also receive VA and health care outside VA.
- Utilization data indicate current models of care delivery present barriers to women Veterans using VA.
- However, there is high utilization by women who served in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF):
 - Over **114,949** female OEF/OIF Veterans since 2002
 - 47.3% of women enroll; of these, 45% have used from 2-10 visits

VA Women Users: Age

AGE



Women Veterans Seeking Care:

How it Works

- First, women Veterans Enroll and Eligibility is determined. Care will vary dependent on eligibility status. *See pg. 81 of Gov. Task Force Report for Eligibility Categories 1-8.*
- ***Eligibility is a key point of miss-understanding among Veterans, Civilians, and between VA community partners.
- Veteran will request care at specific VA Facility – usually closest to their home.
- Veteran is assigned a Primary Care Provider who will coordinate and deliver necessary care. The current goal is a first new pt. appt. within 30 days.

Eligibility in Brief:

Requirements as Barriers for Women's Healthcare

- Time in service (a significant issue in MST cases).
- Service Connected Disability - r/t active duty. For women there tends to be less support (isolation), less precedence, and research identified gender biases i.e. PTSD).
- MST – Eligibility for services r/t MST aftermath. Current challenges with how MST is determined, and the extent of services covered remains controversial.

**** Not all women Veterans are eligible for care and some are eligible for 'only designated services'.*

VA Facilities and Services in Oregon

The Big Picture:

- Portland: Main Hospital and 4 CBOCs - clinics: Bend, Salem, E.PDX and Vancouver.
The highest level of care and services in State exist at PVAMC.
- Roseburg: Main Hospital, 2 CBOC and 2 outpatient clinics: Eugene, N. Bend, Brookings and Crescent City.
The intermediate level of care and some specialized services.
- White City: Main Domiciliary, 1 CBOC; Klamath Falls.
Domiciliary with out-patient care only.

Levels of Care - Distance from Care - Eligibility for Care -

- Not all VA facilities have the same level of care or services – transportation is a barrier...childcare is a barrier.
- Some Veterans live considerable distance from point of care – innovative technologies such as tele-medicine may help bridge the gap but not eliminate it.
- Not all Women Veterans are eligible for care.

Women Veterans in Oregon:

Demographics

- 25,000 Women Veterans in Oregon
- 17,673 do not receive healthcare from the VA.

2009	Portland VA	Roseburg VA	White City VA	Total Females In Oregon using VA
Female Users	4927	1511	823	7,361

Current Challenges Identified VA Women's Health Research:

- 1. Under-serving Women Veterans: Gender disparities in relative utilization of VA services (M = 22% F= 15%). In Oregon women Veteran utilization is 29%.
(i.e. The % of men versus the % of women who use the VA)
- 2. Increased need for service delivery: Women veterans using VA services are projected to double in the next 5 years with declining male veteran numbers. The case for “insufficient numbers” of women has now become obsolete.

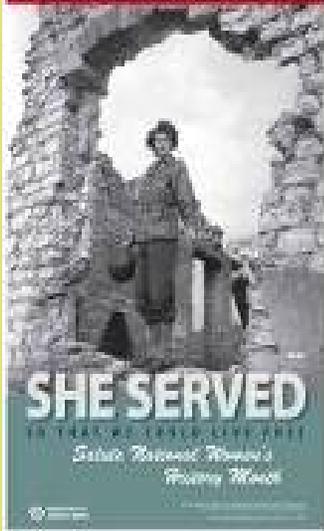
- 3. Demographic shifts and impacts on age-related concerns. Women veterans are significantly younger than male counterpart (M-61 F-48) with almost all new women using the VA now are under 40.
- 4. Gender Disparities in quality care. Despite improvements for women, there exists a significant difference in outpatient quality measures. From Diabetes management to colo-rectal screening, to influenza vaccination...we need to close the gap.
- 5. Fragmentation of health care delivery (how we deliver care) for women veterans. 67% of VA sites provide primary care in a “multi-visit, multi-provider model”: primary care at one visit and gender-specific primary care at another. This *has been* the predominant model of women’s care, and a model associated with lower quality and outcomes.

- 6. Insufficient numbers of clinicians in VHA with specific training and experience in women's health issues. The historical predominance of male Veterans in the VA has resulted in VA providers will little experience or exposure to women patients. ***Skills, CULTURE, Environment.
- 7. Inconsistent policy for women's health. Policy drives practice and in 2003 policy changed gender related care from "mandated" to "preferred". This change to 'preferred' fragmented care. Gender care has always been recognized as integral part of primary care for male veterans "you would never send a male veteran to a separate doctor for a prostate exam...but that is what has routinely happened for women veterans".

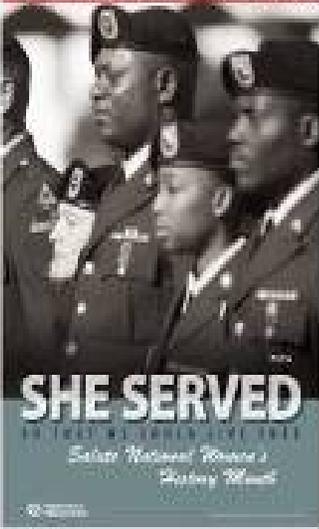
VA Priority and Plan For Women's Health

- To improve quality of healthcare for women veterans a new model of care - comprehensive primary care – is now the priority national effort. The new model will decrease fragmentation of care and increase quality of care outcomes.
- This singular focus has been the priority of funding and unprecedented efforts during the past year to improve women Veteran's health.
- Women Veterans Program Managers have been 'Mandated' for each VA facility 12-1-08.

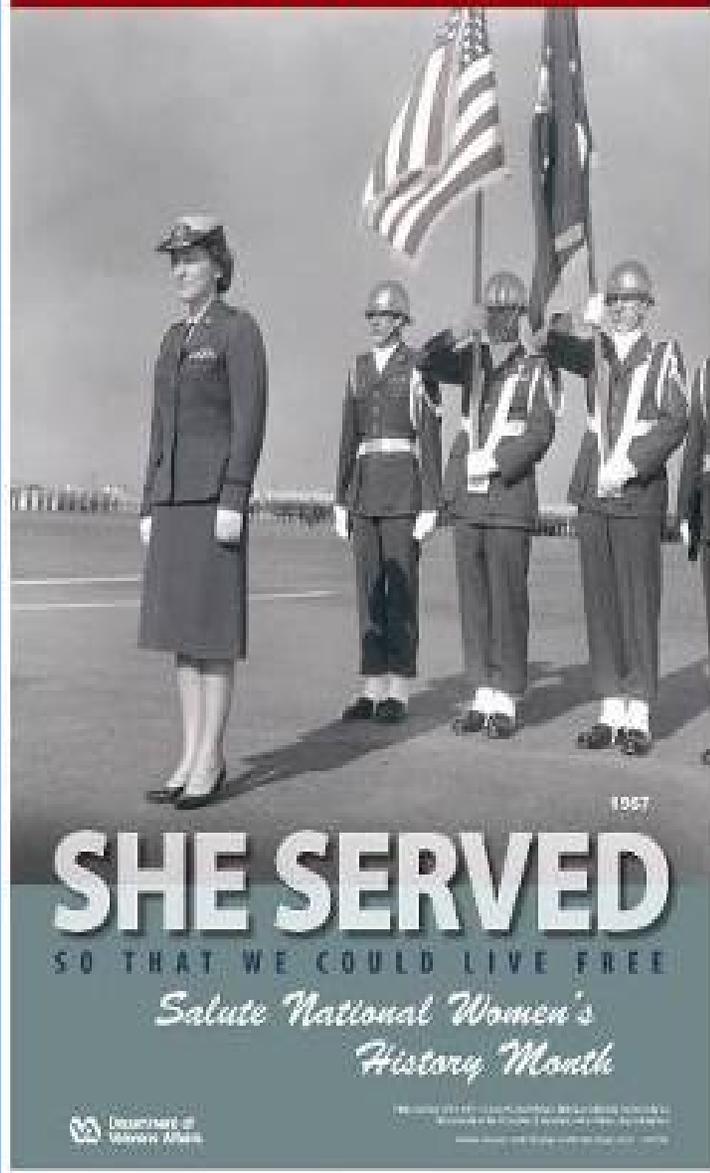
WOMEN VETERANS HEALTH CARE



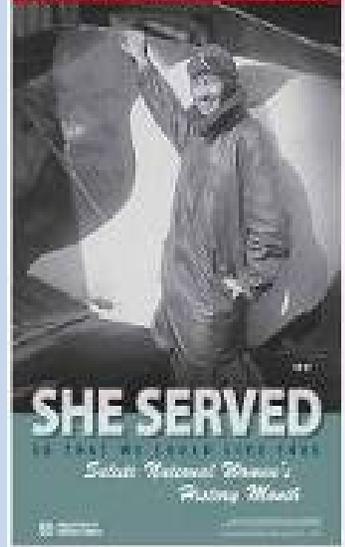
WOMEN VETERANS HEALTH CARE



WOMEN VETERANS HEALTH CARE



WOMEN VETERANS HEALTH CARE



WOMEN VETERANS HEALTH CARE



Healthcare Services

Top 2 Diagnosis for Women Using VA Services

- Posttraumatic Stress Disorder (PTSD)
- Hypertension

Primary Care Services

- Traditionally VA Primary Care Providers have served a predominant male population.
- Providing primary care to women Veterans by skilled providers has been, and continues to be a central focus of improvement.
- *We need to develop a cadre of professionals who are 'Proficient, Interested, and Engaged' in Womens Health.*

Nancy Sloan DNP Portland VAMC

Gender Specific Services Offered

- Healthy Living Guidance specific to women Veterans
- Nutrition & Weight Management
- Primary Care
- Family Planning/Birth Control
- Pregnancy Care – VA Maternity Benefits
- Tubal ligations/Surgical sterilization
- Infertility Evaluation
- Diagnosis and treatment of gynecologic problems,
• surgical interventions available
- Cervical Cancer Screening (e.g. pap smears, HPV
typing)
- Breast self-care
- Mammography
- Menopause Management
- Incontinence treatment
- Osteoporosis Evaluation & Treatment
- HIV/STD Testing

Mental Health Services

- Posttraumatic Stress Counseling
- Military Sexual Trauma Counseling
- Inpatient Psychiatric Treatment
- Substance Abuse residential and outpatient treatment (mixed gender only - no gender specific unit in our region).
- Psychological Evaluation
- Traumatic Brain Injury (TBI) evaluation and treatment.

Military Sexual Trauma (MST):

MST is the umbrella term used to describe physical assault, sexual assault, stalking or harassment that occurs while on active duty. Prevalence estimates of MST harassment are reported as high as 78% in female active duty personnel and rape prevalence range from 15% to 26% of women.

(Department of Defense).

MST is the “Sentinel Health Concern” of Women Veterans

Carole L. Turner, Veterans Affairs' National Director Women Veterans Health Program

- Sexual victimization that occurs in the military environment, especially during times of war...often means that victims are relying on their perpetrators (or associates of the perpetrator) to provide for basic needs including medical and psychological care...and for their survival.
- In addition, when sexual trauma occurs within the workplace, this form of victimization disrupts the career goals of many of its victims. When perpetrators are peers, supervisors, commanding officers responsible for making decisions about work-related evaluations and promotions...careers often end.
- *Entrapment, severe and often prolonged physical and emotional trauma, can create an enduring consequence for the individual survivor that eventually emerges in the context of VA Healthcare delivery.*

You cannot talk about MST without talking about “Unit Cohesion”.

- The ‘unit cohesion’ so central to” survival in times of war and an integral part of the ‘positive’ military experience becomes the compounding destructive factor complicating recovery from sexual violence in the military.
- The implied or stated threat of destroying “unit cohesion” functions to keep women silent even long after they leave the military.
- What exists as a primary ‘resiliency’ factor for many soldiers exists for MST survivors as a factor or mechanism of entrapment and terror.

Military Sexual Trauma and Women Veterans:

The VA is the first and only healthcare system which conducts universal screening for sexual violence.

- Portland VA = 856 MST with 5,714 female patient encounters last year.
- Roseburg VA = 319 MST with 2,483 female patient encounters last year
- White City VA = 208 MST with over 1019 female patient encounters last year.

We tend to think of Sexual Trauma as resulting in “Psychiatric Problems” ...both acute and chronic. This is how we as a society have come to comfortably conceptualize the aftermath.

Sexual Trauma Produces a Physiologic – A Biologic Imprint

Biologic Changes may Become
Chronic Health Consequences and
Exist as an Enduring ‘after effect’ of
Sexual Trauma.

“The Body Keeps Score”

Historically, beyond the immediate physical injuries that can be associated with the sexual assault... little attention has been given to an array of physical maladies and complaints persistent and consistent among survivors.

Sexual Trauma has Medical Consequences:

Increased prevalence of physical symptoms and disease.

- Sleep problems
- Diabetes
- Chronic pain
- Gastrointestinal Disorders
- Gynecological Problems
- Heart Disease
- Sexual problems and intimacy.
- Asthma and other respiratory problems
- Cancer (including breast and cervical)
- Dissociation/memory loss
- Non-specific immune-system disorders
 - (Lupus, Fibromyalgia, Chronic Fatigue Syndrome)
- ***Death , suicide, and homicide, and severe bodily injuries are also medical consequences of MST.

Women Veterans are at Increased Risk of Interpersonal Violence (MST, and Domestic Violence)

- Specific issues of experienced violence are often hidden and stigmatized...but commonly surface as healthcare problems.
- Increased interpersonal violence always associated with war, is frequently obscured...but exists as a predominant, and often intergenerational legacy...in families and specifically through children.

Substance Abuse and Trauma Frequently Co-occur. The Majority of Substance Abuse Patients have a History of Trauma.

Percentage of ALL Male and Female Outpatients Receiving Mental Health code for Substance Abuse.

		2008	↑ Women
PORTLAND	F	% 25.0	7%
	M	% 17.1	
ROSEBURG	F	% 26.4	12%
	M	% 14.6	
WHITE CITY	F	% 23.1	3%
	M	% 21.6	

The Greatest Need

Inpatient Treatment for Trauma and Substance Abuse for Our Women Veterans has been Identified as the Number #1 Mental Health Service Need in our Region by VA Women's Mental Health Providers.

Critical Success Factors for the VA Serving Women In Oregon

- Sufficient staff to service health needs of increasing women Veterans: Recruit, Train, and Support healthcare professionals.
- Educate interested Primary Care providers in women's health care.
- Establish designated providers at each site as point person in women's health
- Integrate Women's Health into overall Organizational Planning.
- Support a culture of dignified care for women Veterans.

Cross Cutting Issues: Women Veterans

- VA must increase recognition of women Veterans. Women Veterans report that they feel “invisible” in VA.
- VA must enhance privacy, respect, dignity, and sense of security for all Veterans. Women Veterans in particular express needs for privacy.
- Every level of VA, including program offices, VISN and facility leadership, and staff at every site need to be engaged in the enhancement of services to women Veterans

*Our Women Veterans
Healthcare Needs*

Feedback from Women Veterans
on VA Services



Needs of Women Veterans

- Clinics to serve the needs of young, working women.
 - Access, flexible hours, use of technology
 - Address reproductive health issues
- Many have childcare responsibilities and eldercare demands.
- Many are employed, difficult to get time off for appointments.
- Adjustment and depression issues
- Homelessness
- Age-related health effects
 - Cardiac risk, obesity and diabetes, lung cancer, colorectal cancer, breast and cervical cancer screening, osteoporosis screening

Childcare for Veterans

- Lack of childcare services is a barrier that prevents women from coming to appointments.
- Task force: different types of care needed
 - “Drop-off casual care” for medical outpatient appointments
 - Intermediate care, e.g. attending mental health intensive care
 - Daycare when Veteran is in polytrauma and rehabilitative care
- Due to recent VA General Counsel opinion, VA is examining what options might be feasible under current authority.

Dr. Patty Hayes

Newborn Care

- VA is not authorized to pay for newborn services.
- Follow-up in VA is often lost when women Veterans rely on newborn care coverage elsewhere (i.e. Medicaid).
- VA has supported legislation for newborn care.
 - Current VHA Legislative proposal for 96 hours of care is under review at Office of Management and Budget.
 - S 252 Proposes 7 days of newborn care.
 - HR 1211 Proposes 7 days of newborn care.

**A Time of Transformational
Change in VA Women's Healthcare
and
A Time of Tremendous Challenge**

The Taskforce is an Additional Opportunity to Build
and Link Efforts for
Improving Healthcare for Women Veterans
in Oregon





