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Commentary

The Health Needs of Rural Veterans

Mary Beth Skupien, Ph.D., M.S., R.N., Director, Office of Rural Health, Washington, D.C.

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Of the 23 million Veterans in this country, roughly 8 million are enrolled in the Veterans Health Administration (VHA), and approximately 40 percent of these Veterans live in rural and highly rural areas. Rural Veterans face unique health care challenges for a variety of reasons, including disparate access to higher quality services, shortages in qualified health professionals, and limited transportation options. On average, these rural Veterans travel between 60-120 minutes for inpatient care, and 30-90 minutes for primary care. This population also has fewer financial resources compared to urban Veterans. One-third of OEF/OIF Veterans live in rural or highly rural areas; three-fourths of rural Veterans are over the age of 55.

Office of Rural Health

The health needs of rural Veterans receive more attention now due to greater commitment and new resources within the VHA. The Office of Rural Health (ORH) was established in March 2007 in response to The Veterans Benefits, Health Care and Information Technology Act of 2006. ORH is part of the Office of the Assistant Deputy Under Secretary for Health (ADUSH) for Policy and Planning (10A5), led by Patricia Vandenberg. ORH's mission is to improve access to and quality of care for enrolled rural Veterans by developing evidence-based policies and innovative practices that support the unique needs of those residing in geographically rural areas. ORH carries out its mission by working closely with internal VA program offices, field units, rural health experts, and partners to develop new

methods to provide the best possible solutions to the challenges faced by Veterans living in rural areas.

In fiscal year 2009, Public Law 110-329 appropriated \$250 million for new rural health initiatives. Key major initiatives for this funding include: national and local telehealth expansion, Home Based Primary Care, local outreach clinic expansion, community outreach, rural provider outreach and education, rural Veteran education, geriatric care, mental health programs, women's health initiatives, and local transportation programs. Many of these initiatives are designed at the local level to target the needs of specific rural and highly rural Veteran populations. Also in 2009, Public Law 110-387 contained provisions for the development of rural health pilot programs to further focus on peer outreach and support for Veterans, improved access to community mental health centers and Indian Health Service facilities, and enhanced contract care authority to better involve private providers in the care of highly rural Veterans.

Access and Quality for Rural Veterans

An additional \$250 million in rural health appropriations was provided to ORH in fiscal year 2010 to continue improving access to and quality of care. These funds support a wide variety of existing and new initiatives, including the hiring of much needed health care professionals in underserved areas, evaluating new models and sites of care, purchasing telehealth



Director's Letter

Veterans choose VA as their primary source of health care largely because it provides high quality, comprehensive, integrated care at relatively little or no cost. Access to health care, however, can be a vexing issue for Veterans, since the approximately 1,000 hospitals and free-standing outpatient clinics and other facilities do not nearly cover Veterans' health services needs across the expanse of the United States. This explains, in part, why a substantial majority of VA patients currently receives at least some health care from non-VA providers.

The implementation of health care reform during the next several years will facilitate access for all Americans (including Veterans) to a broad array of health services. VA patients may therefore find non-VA care increasingly attractive, reinforced by the convenience of Veterans' family members receiving services from those same non-VA sources.

In September 2010, some of the nation's leading VA and non-VA investigators participated in a State of the Art (SOTA) conference that addressed access to VA care for Veterans. Access was defined broadly, including directly observable and measurable access, and more difficult to measure patient perceived access. Research issues that were discussed included defining and measuring access; identifying access issues for special populations; characterizing the impact of access on utilization, quality, outcomes, and satisfaction; challenges associated with matching medically appropriate levels of access to patient perceptions of access needs; the impact of policy and organization on access; and identifying, evaluating, and implementing innovative approaches to improving access (emphasizing roles of computer technology and informatics). Manuscripts addressing access related topics commissioned as background papers for the SOTA or developed as a result of SOTA deliberations will be published in a special issue of the *Journal of General Internal Medicine* by summer 2011.

Investigators interested in pursuing access related issues are encouraged to thoughtfully align their research with VA objectives. Equally important, investigators must engage clinical, operations, and policy leadership in research concepts to help ensure that research objectives being addressed are likely to be relevant not only today, but several years in the future when results will be available.

Seth Eisen, M.D., M. Sc.
Director, HSR&D

and other equipment, initiating new mobile care units, providing education sessions for VA and non-VA health professionals on local rural Veteran needs, fee-based and contracted care, and new rural Community-Based Outpatient Clinics (CBOCs).

To assist in the implementation, maintenance, and oversight of these initiatives, a network

of 21 regionally based VISN Rural Health Consultants (VRCs) works directly with ORH staff to support each VISN in managing their rural health funded projects. In addition to the VRCs, ORH established three Veterans Rural Health Resource Centers located in Salt Lake City, Utah; Iowa City, Iowa; and White River Junction, Vermont. The Centers' goals include conducting, coordinating, and disseminat-

ing studies and analysis related to issues that impact Veterans living in rural areas. Finally, a 16-member Veterans' Rural Health Advisory Committee evaluates program activities, identifies barriers to receiving services, and offers recommendations for ORH policies that impact rural Veteran care.

National Rural Measurement Strategy

In order to demonstrate the impact of ORH funding, in conjunction with other VA program offices, ORH staff members are finalizing a nationwide rural measurement strategy that will include national measures and VISN-level project measures. Links with relevant HSR&D Centers of Excellence and Quality Enhancement Research Initiative (QUERI) groups will be an important part of this process.

In my new role as Director of ORH, I plan to continue these collaborative efforts by building on 28 years of federal service at the Indian Health Service (IHS) and with Tribal programs, where I most recently served as Deputy Director of the Office of Public Health Support. I also worked in a variety of rural settings as a nurse practitioner and public health nurse, and had progressive leadership roles in the field as well as at IHS headquarters. I received my doctoral degree from The Johns Hopkins University, with an emphasis in public health management and policy. In addition to my recent arrival, Sheila Warren, M.P.H., joined ORH as Deputy Director this fall, and additional staff members are coming on board to help implement the goals and activities of the office to meet the mission of ORH.

Our nation's rural and highly rural Veteran population is large, dispersed, and racially, ethnically, and culturally diverse. ORH will continue to collaborate with numerous areas of the VA, along with other government offices and private organizations and partners, to increase access to safe, effective, efficient, and compassionate health care for this unique group of Veterans.

Response to Commentary

Improving Access and Quality of Care for Rural Veterans – An Imperative

Peter J. Kaboli, M.D., M.S., Director, Veterans Rural Health Resource Center—Central Region, Iowa City VAMC

Understanding and addressing the needs of rural Veterans requires complementary perspectives including VA Central Office and local administration, policymakers, clinicians, researchers, and most importantly, the patient. For example, one of the fundamental challenges in the care of rural Veterans is distance. However, distance can mean different things to different people with a variety of ways to overcome it. For some Veterans, traveling two hours for a clinic visit can be a welcome social event; for others, it is a barrier to obtaining care. Policies and programs exist to bring care closer to the Veteran including Home Based Primary Care (HBPC), a group effort between the Veteran, family caregiver, VA, and the community. Other policies and programs include telehealth, mobile clinics, and fee-basis care. Yet each of these and other programs has their pros and cons: HBPC may not be cost-effective in highly rural settings; not all Veterans have adequate connectivity for telehealth; mobile clinics have distance, weather, and other limitations; and fee-basis care in the community may contribute to fragmented care.

Access

Even defining “access” is challenging. From a patient perspective, traveling two hours for a simple blood test can be onerous, especially if the service is available close to home. Yet two hours of travel for highly specialized care like a neurosurgeon may not be a barrier if these services are not available closer to home. Thus, different access standards can exist for different services. Access barriers can manifest in other ways such as waits and delays for care, health professional shortages, limits in specialty services such as mental health, and even identifying eligible benefits.

Once access barriers have been defined, the next step is overcoming these barriers with strategies to meet the patient-centered needs of the Veteran. One size does not fit all and thus these strategies need to be combined with adequate evaluation and analyses to better understand

both program effectiveness and barriers to implementation.

Quality

Another aspect of rural health is determining whether disparities in quality of care exist for rural Veterans. To date, results of studies appear to be mixed. VA-based research has suggested that rural Veterans have lower health-related quality of life, yet clinical outcomes for a condition like acute myocardial infarction appear to be no different for rural versus non-rural Veterans. Further, studies and analyses are critical to help define quality disparities and then to propose interventions to overcome them.

Addressing the Issues

In an effort to understand the challenges of access and quality, and test strategies to improve these, the Office of Rural Health established three field-based Veterans Rural Health Resource

Centers (VRHRC). The VRHRCs bring together rural health experts, clinicians, researchers, administrators, and the patient to evaluate the care of rural Veterans and perform pilot studies to address issues identified. The VRHRCs work collaboratively to identify access and quality gaps and best practices to overcome them, and then disseminate the findings throughout VA.

SOTA Conference

The recent September 2010 State of the Art (SOTA) conference examined issues related to access. This HSR&D sponsored conference brought together VA and non-VA experts in health care access to better define the problem and identify proven and potential future interventions to overcome access barriers for all Veterans—whether urban or rural. Please see accompanying text box with information regarding the SOTA conference.

As outlined by Dr. Skupien, ORH has the charge and the resources to improve access and quality of care for rural Veterans. It is thus the responsibility of the VRHRCs, program offices, researchers, clinicians, and facilities to understand how we are meeting the real and perceived needs of rural Veterans. The imperative is to then test and implement the most cost-effective strategies to improve access and quality of care for all Veterans.

SOTA Conference: Improving Access to VA Care

The “Improving Access to VA Care” State of the Art (SOTA) conference was held in Arlington, Va., from September 21 to September 22, 2010. Access to care is one of VA’s priority transformational initiatives, making this SOTA particularly timely. While access to care is a consideration for all Veterans, it is particularly important given the needs of Veterans returning from the conflicts in Iraq and Afghanistan, many of whom are returning to rural areas and/or returning with severe injuries that will require long-term care. Both Under Secretary for Health, Dr. Robert Petzel and Principal Deputy Under Secretary for Health, Robert Jesse, M.D., Ph.D., spoke at the SOTA, providing an overview of VHA’s priorities and challenges regarding access and the importance of improving access to VA health care for Veterans. With the advent of health care reform, one particular challenge for VA will be to successfully compete with the many non-VA health care options that will become available to Veterans.

The 70 invited attendees, including VA and non-VA clinicians, researchers, and policymakers with special expertise in access to health care, worked to identify what we know and what we need to know to improve access to health care for Veterans. SOTA participants discussed resources, relationships, policies, and infrastructure related to accessing quality health care.

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Research Highlight

Health Care Access and Quality for Rural Veterans

Alan West, Ph.D., Deputy Director, Veterans Rural Health Resource Center—Eastern Region, White River Junction VA Medical Center, VT

About two in five VA health care enrollees are rural residents (including the 1.5 percent that VA defines as “highly rural”). Rural enrollees are slightly more likely than urban ones to use VA care (68 percent vs. 65 percent), and from 2006 through 2009 the number of rural enrollees grew faster (by 11 percent) than the number of urban enrollees (2 percent). Over-representation of rural residents among OEF/OIF troops, and casualties, will likely increase rural Veterans’ health care needs further.

Rural Veterans’ Use of VA and Non-VA Health Care

Fully understanding Veterans’ access to health care requires much more nuance than utilization alone can reveal. Nevertheless, utilization sheds light on major aspects, such as the availability of financial resources to pay for services and the burden of traveling to reach them. VA provides a “safety net” of health care that many Veterans might not otherwise obtain for financial reasons. But because VA’s specialized and high-technology treatment is centralized, many rural Veterans must travel far to reach it. Many current VA patients obtain much of their health care from non-VA providers. Comparing rural and urban enrollees on their use of VA services, and to other Veterans and non-Veterans on the use of non-VA health care, provides contextual information on rural Veterans’ medical needs as well as their provider options, travel demands, insurance coverage, out-of-pocket medical expenses, and reliance on VA and other government support such as Medicare/Medicaid.

Total medical expenditures incurred by male Veterans, rural or urban, who use VA for any of their health care, are much higher, on average, than for other health care using men. Most of the treatment received by these VA users, however, is non-VA care: for those 65 or older, the largest payer is Medicare, and for those younger, it is commercial insurance; in either age group, average out-of-pocket payments for services also are substantial. Despite similar

co-morbidities and worse health self-ratings, adjusted medical expenditures for working-age rural VA users average 20 percent lower than for urban users; the difference is largely due to rural users receiving less inpatient care and having less private insurance coverage and lower incomes.¹

For a current HSR&D-funded project, we have acquired administrative data for all VA and non-VA hospitalizations obtained in recent years by any VA enrollees living in eight states (Arizona, Iowa, Louisiana, Florida, Tennessee, South Carolina, Pennsylvania, and New York). These data permit analyses of regional variations in urban-rural VA/non-VA utilization for common medical conditions and procedures. The eight states vary greatly in “ruralness,” from Florida, where one in five enrollees is rural, to Iowa, where two in three are

“Over-representation of rural residents among OEF/OIF troops, and casualties, will likely increase rural Veterans’ health care needs further.”

rural. The states also vary in how much rural enrollees relied on non-VA care: non-VA hospitalizations outnumbered VA Medical Center (VAMC) admissions by 2 to 12 times for those 65 or older (mostly paid by Medicare), and by 1 to 3 times for younger enrollees. In either age-group, reliance on the VA was less for rural than urban enrollees in six states, but greater in Florida and Louisiana. In the more rural states (Iowa, Louisiana, Tennessee, South Carolina), rural and urban enrollees were hospitalized at similar rates; for elderly rural enrollees in Florida there was a trade-off—these enrollees use non-VA care less and VAMCs more than expected. In Arizona, Pennsylvania, and New York, however, rural enrollees had fewer admissions, either VA or non-VA, than might be expected from their numbers alone. This finding suggests that rural residents in states with concentrated population centers might have

less referral access to urban hospitals in addition to greater travel burden.

Travel Distances for Rural Veterans

Across the eight states, most urban patients lived within a half hour and most rural patients lived within an hour of the nearest non-VA hospital. For VAMC inpatients the nearest VAMC averaged more than a half hour away if they were urban residents, and one to one and a half hours if rural. For enrollees who used non-VA hospitals instead, driving to the VAMC would have averaged at least one half to one and a quarter hours for urban residents and one and a quarter to two hours for rural. Patients with multiple admissions over time who used VAMCs exclusively lived about a half hour closer to those hospitals than those who used non-VA hospitals only. Such findings suggest that greater distance to VA inpatient care has some dampening effect on its use by both urban and rural enrollees; average travel time, however, is considerably higher for rural than urban residents, in effect establishing a different threshold for normative, perhaps acceptable, distances. Rural Veterans must travel a long way to hospitals anyway, so quality considerations should outweigh relative convenience in their treatment choices; we have shown elsewhere,² for example, that those who need high-risk surgeries could be redirected from lower to higher performance non-VA hospitals with minimal impact on their travel burden.

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The 28th National Meeting of VA’s Health Services Research and Development Service (HSR&D) has been approved and is being planned for February 2011 (dates and location are pending). To check for the most current meeting information go to: <http://www.hsrd.research.va.gov/meetings/2011/>

Research Highlight

Access to VA Health Care in the Digital Age

John Fortney, Ph.D., Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas

The U.S. health care system has been characterized as fragmented, delivering acute episodic treatment with little information sharing across providers and minimal care coordination over time.¹ The U.S. health care system also relies predominantly on face-to-face encounters between patients and providers, with hardly any communication in between encounters. In contrast, the VHA health care system is an integrated system of care that has an assortment of e-health technologies that promote patient-provider communication outside the context of a face-to-face clinical encounter, and an electronic medical record that facilitates provider-to-provider communication.² VHA is also embracing the patient centered medical home model with its emphasis on care teams and enhanced patient access through digital channels of communication.³ One can envision a future VHA health care system that relies less on the episodic delivery of treatment during face-to-face encounters between Veterans and their providers, and more on proactive non-encounter-based digital communications between Veterans and their care teams. With access being one of Secretary Shinseki's three major themes, the VHA health care system should be an exemplar for how to deliver continuous and coordinated health care in the digital age.

Digital Health Care Utilization

Digital communication modalities include cell phones, smart phones, interactive voice response, text messages, emails, clinic-based interactive video, home-based webcams, personal monitoring devices, kiosks, dashboards, electronic medical records, personal health records, Web-based portals, social networking sites, secure chat rooms, and online forums. There are at least five cat-

egories of digital health care utilization that use these communication modalities as an alternative to face-to-face interactions. *Synchronous digital patient-to-provider encounters* include encounters in real time where the Veteran and the provider are located in different geographic locations. *Asynchronous digital patient-to-provider communications* include interactions between the Veteran and the provider where there are time lags in communication. *Digital provider-to-provider communications* include synchronous and asynchronous discussions between the members of a virtual caregiver team (including informal caregivers). *Digital peer-to-peer communications* include synchronous and asynchronous discussions among Veterans to share information and practical advice, and to provide mutual support. *Synchronous digital interactions between patients and computers* include personal computer- and smart-phone-based applications that present information or deliver therapeutic treatments.

Digital Access

The traditional conceptualizations and measures of access (e.g., providers per population, travel times, usual source of care, out-of-pocket costs) focus exclusively on face-to-face, patient-to-provider encounters and are not well suited to measuring access to digital encounterless communications. As the paradigm of VHA health care delivery evolves, it is imperative that our conceptualization of access undergoes a concurrent paradigm shift to make it more relevant for the digital age. For the digital age, access to care should be redefined more broadly as the opportunity and potential ease of having face-to-face and virtual interactions among a care team (including a patient and their formal providers, informal caregivers, peers, and computer applications). Access is a multidimensional concept that

includes the following domains: geographical, temporal, financial, cultural, and digital. Digital access represents the connectivity that enables synchronous or asynchronous digital communications with providers, peers and computerized health applications, and the connectivity that enables communications among the caregiver team and the sharing of relevant clinical information. Improvements in digital access could drastically diminish the geographical, temporal, and cultural access problems faced by many Veterans. Synchronous digital communications can alleviate the travel burden associated with utilizing many—but not all—types of health care services. Asynchronous digital communication can diminish the time burden, as Veterans upload and download clinical information at times that are convenient to them. Computer applications can be designed to educate Veterans in order to help them better understand their treatment options/plans, thereby improving the cultural acceptability of treatment. On the other hand, a growing digital divide for low income, minority, rural, and elderly Veterans could create greater access disparities for these Veteran populations.

Access Research

To address these important issues, the 2010 VA State of the Art (SOTA) conference focused on Veterans' access to the VHA health care system. The objectives of the conference were to synthesize the literature on access in order to summarize accumulated knowledge and make policy recommendations, and to identify gaps in knowledge and make recommendations about HSR&D research priorities. Just as improving access is a priority for Secretary Shinseki, enhancing access *research* must be a priority for HSR&D. HSR&D investigators need to develop and evaluate interventions that improve digital access to care, including programs designed to improve connectivity and the usability of digital communication modalities. In addition, HSR&D investigators need to develop and validate access measures that are relevant in the

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Research Highlight

Telehealth Technologies for the Delivery of Mental Health Services

Daniel F. Gros, Ph.D., Ron Acierno, Ph.D., Kenneth J. Ruggiero, Ph.D., Anouk L. Grubaugh, Ph.D., and Leonard E. Egede, M.D., M.S., all with the Ralph H. Johnson VA Medical Center and the Medical University of South Carolina, Charleston, South Carolina, and B. Christopher Frueh, Ph.D., University of Hawai'i at Hilo, Hilo, Hawaii

Over the past decade, rural health disparities and access to quality health care in rural settings have been major priority areas in both Veteran and civilian populations. Persons in rural settings generally have fewer health care options and face a number of barriers to care, such as limited financial resources and long travel distances relative to their urban counterparts. Disparities in rural communities are particularly problematic with regard to the receipt of mental health care services. Recent research demonstrates that, relative to those in rural areas, residents in metropolitan areas are 47 percent more likely to receive general mental health services and 72 percent more likely to receive specialized services (Richardson et al., 2009). In response to these and similar data, a number of initiatives have been launched within the VA and other large health care agencies to address disparities in access to mental health care.

Use of Telehealth Technology to Overcome Barriers to Treatment

One proposed method to overcome barriers to mental health care access in rural settings is with the use of telehealth technologies to provide assessment and treatment services from metropolitan areas to patients in underserved rural or geographically remote areas. Telehealth has several advantages for patients over traditional treatment approaches, including decreased patient cost (e.g., lower cost of transportation, travel time, and missed work), decreased provider costs, and increased system coverage area. In addition, telehealth may be useful in overcoming several other barriers to mental health treatments, such as perceived stigma associated with mental health care in active military service personnel and Veterans, by providing services directly in patients' homes.

Preliminary Findings

Telehealth has received preliminary support in a number of treatment settings and with a range of patient populations, including patients in rural areas, older adults, racial/ethnic minorities, patients adjudicated by the courts, and Veterans (for review, see Richardson et al., 2009). In addition, there is strong evidence for both high patient and moderately high provider satisfaction with mental health services delivered via telehealth. Of particular relevance to mental health services in the VA, recent studies support the effectiveness of telehealth for delivering evidence-based psychotherapies to rural Veterans with post-traumatic stress disorder (PTSD) (Tuerk et al., 2010). Similar beneficial effects of mental health care delivered via telehealth also have been demonstrated for other psychiatric conditions (e.g., obsessive compulsive disorder, panic disorder, and anger management).

Ongoing Research

To better understand the effectiveness of mental health services delivered via telehealth to rural Veterans, HSR&D, the U.S. Department of Defense (DoD), and other agencies have recently funded several treatment outcome studies within the Charleston Veterans Affairs Medical Center (VAMC) and its associated VA Health Services Research and Development Research Enhancement Award Program (REAP). These studies include: 1) a randomized controlled trial (RCT) of Behavioral Activation for depression delivered via telehealth or in-person in elderly Veterans (n=224) (Egede et al, 2009); 2) a RCT of Behavioral Activation and Therapeutic Exposure delivered via telehealth or in-person in OEF/OIF Veterans with PTSD (n=220); and 3) a RCT of Prolonged Exposure delivered via telehealth or in-person in OEF/OIF Veterans

with PTSD (n=226). In addition to the above, the Charleston VAMC recently received funding from the Office of Rural Health to initiate a two-year clinical treatment program to provide evidence-based psychotherapies and pharmacotherapies to rural VAMCs and their associated community-based outpatient clinics across three states. The program provided funding for five psychiatrists, five psychologists, and two support staff in addition to telehealth equipment. Together, these projects will greatly improve and

“...there is strong evidence for both high patient and moderately high provider satisfaction with mental health services delivered via telehealth.”

expand our understanding of use of telehealth services in the treatment of a wide range of mental health conditions for rural Veterans or Veterans who may simply prefer telehealth services over face-to-face care.

Conclusions

Telehealth services can overcome many of the current obstacles to quality mental health care in rural settings, including lack of local providers, transportation barriers, lost time from work, and stigma. Preliminary findings suggest that telehealth services are both effective and are received favorably by patients and providers alike. Together with ongoing research and clinical initiatives of the VA, telehealth services stand to bridge longstanding gaps in access and mental health care delivery to rural and underserved Veterans, ultimately resulting in improved mental health outcomes, health care-related costs, and overall quality of life in our nation's Veterans.

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Organizational Profile

VA's New Women's Health Research Consortium

Seth Eisen, M.D., M.Sc., HSR&D Director and Linda Lipson, M.A., Scientific Program Manager, both from HSR&D Central Office, Washington, D.C.

Because many more women are serving in the military, being deployed to Iraq and Afghanistan, and enrolling in VA care, VA clinicians are treating twice as many women Veterans as they did a decade ago. This increase poses challenges for a system historically designed to see predominantly men. VA is responding by accelerating changes in practice and policy initiatives, such as the recently revised VHA Handbook on Care for Women Veterans.

In response to the demand for research to inform evidence-based approaches to improving access to high quality care for women Veterans, the VA HSR&D Service has funded a new VA Women's Health Research Consortium (WHRC, pronounced "WORK"). WHRC is designed to build capacity in women Veterans' health services research, with an emphasis on accelerating movement to interventions, quality improvement, and implementation research. A cornerstone of this effort was the establishment in 2004 of the first-ever national VA Women's Health Research agenda and the publication of a systematic review that demonstrated that the women Veterans' health literature is principally descriptive and observational rather than evidence-based.^{1,2} Since 2004, the number of VA investigators explicitly interested in Women's Health Research has tripled, with more than 150 M.D. and Ph.D. researchers expressing interest in tackling research in a wide array of critically important areas relevant to VA operational concerns. Further, the number of women Veterans' research peer-reviewed papers published in the past five years outstrips the volume published in the previous 25 years combined, and has both dramatically extended our knowledge and simultaneously identified important knowledge gaps.

The goals of the Consortium are therefore to systematically arm this burgeoning and motivated cadre of VA investigators with knowledge, skills, and collegial VA leadership relationships necessary to generate relevant scientific knowledge regarding

evidence-based care models, interventions, and strategies for transforming VA care for women Veterans. The Consortium will provide: (1) methodological and content-related education and training through Web-based and other seminars; (2) technical consultation and mentorship through one-on-one consults and building collaborative communities of practice around key topical areas (e.g., access to care, reproductive health); and (3) accelerated dissemination and implementation of VA women's health research into evidence-based practice and policy. A special focus of the Consortium's efforts will be on fostering investigators' capabilities and readiness to translate current and emerging evidence into testable interventions among women Veterans.³ The Consortium, led by Elizabeth Yano, Ph.D. (VA Greater Los Angeles & UCLA) and Susan Frayne, M.D. (VA Palo Alto & Stanford), is also partnering with the VA Quality Enhancement Research Initiative (QUERI) Center for Implementation Practice & Research Support (CIPRS) to promote implementation of wom-

en's health research into routine practice.

The Consortium recently organized a VA Women's Health Services Research Conference in Arlington, VA, which attracted not only a large number of researchers but also senior VA leaders from almost every major office. The Conference also drew representatives from the U.S. Departments of Defense, Health & Human Services and Labor, the Institute of Medicine, and National Institutes of Health among other agencies (for more information go to www.research.va.gov/programs/womens_health/default.cfm). The Consortium is also coordinating a special VA Supplement to the journal, *Women's Health Issues*, with manuscripts due November 15, 2010 (see call for papers on same website). For more information about the VA Women's Health Research Consortium please contact Dr. Ruth Klap, VA WHRC Program Manager, at ruth.klap@va.gov.

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SOTA Conference: Improving Access to VA Care continued from page 3

Conference participants were divided into work groups focusing on the following topics:

- Defining access and constructs;
- Identifying access issues for special populations;
- Impact of access on utilization, quality, outcomes, and satisfaction;
- Impact of policy and organization of care on access; and
- Adoption and implementation of information technology.

Each of the groups worked to develop recommendations for policy strategies to assist VA and the larger health care community to improve access to care. They also developed research questions to target strategies that will improve access for Veterans, which will be refined for several SOTA products. The research agenda and policy recommendations will be reviewed and synthesized for presentation to VA leadership as appropriate. Also, a supplement to the *Journal of General Internal Medicine* is planned for publication in the summer of 2011. Papers are due to the journal for peer review by December 1. In addition, the SOTA planners will discuss and plan for other possible SOTA products which might include an RFA, a white paper(s) for leadership, and one or more cyber seminars to inform the research community about access research priorities.

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digital age so that the VHA can monitor and adapt itself to better accommodate the needs of Veterans in the 21st century.

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Performance Officer, VA
Central Office, Washington DC

Rodney A. Hayward, M.D.,
Co-Director, VA HSR&D
Center of Excellence,
Ann Arbor, MI

Alan S. Perry, M.P.A., M.H.A.,
FACHE, Director, VA
Central California Health Care
System, Fresno, CA

Frances Weaver, Ph.D.,
Director, VA HSR&D Center
of Excellence, Hines, IL