Cyberseminar Transcript

Date: September 9, 2020

Series: Spotlight on Women's Health

Session: Sourcebook Volume 4: Women Veterans in the Veterans Health Administration

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HEIDI: Again, thank you everyone, for joining us for today's Spotlight on Women's Health Cyberseminar. I am sorry, I am stumbling over all my words, here. Today's session is Sourcebook Volume 4: Women Veterans in the Veterans Health Administration. Our presenters today, we'll be starting with Dr. Susan Frayne, she's a Core Investigator with VA HSR&D Center for Innovation to Implementation. She is joined by Fay Saechao. Fay is a Research Health Scientist with the VA Palo Alto Healthcare System. Our discussants today, we are joined by Dr. Patricia Hayes, who is the Chief Consultant with the Women's Health Services Office of Patient Care Services, and Dr. Sally Haskell, the Deputy Chief Consultant for Clinical Operations, Director of Comprehensive Women's Health Services Patient Care Services with the VHA, and an Associate Professor at the Yale School of Medicine. Dr. Hayes, can I turn things over to you?

DR. PATRICIA HAYES: Absolutely, and thank you very much Heidi, for getting us started. Checking my sound, we okay?

HEIDI: You sound great, yes. Thank you.

DR. HAYES: Okay. Today we're welcoming an audience to hear all about Sourcebook Volume 4: The Key Findings, which is really about our trends, over time. And time is kind of what this is all about. I want to first make sure that I thank Susan Frayne and Ciaran Phibbs, the Directors of the Women's Health Evaluation Initiative, which we started a way long time ago back around 2008, because of the fact that there was not data available by gender. It's kind of hard to believe today, but when I arrived in VA Central Office, we had really very, very, very limited data by gender. And so I engaged with Susan Frayne as the Director, and Karen and a number of excellent researchers and statisticians over time to develop the Women's Health Evaluation Initiative which began, in fact, by cleaning up the Austin Database Set for the factors of male and female, and when you think back on it, it sounds like a simple thing to do, but maintaining the entire VA database for the gender variable has been critical to our work. And I can tell you that I see them as the authoritative source for Veteran identity birth sex and of course now we see what we would probably earlier have seen as noise in the system, which is our transgender or transitioning population which does create a several thousand person difference each year, but when we look to how many women are we serving, the source book begins with that. My office sets policy across VHA for the delivery of healthcare to women and in that role, we’ve been very involved in trying to look at what are the most appropriate ways to do the care, what are some of the most common conditions in women, how do we look at race and ethnicity, what are the rural and urban factors?

Certainly age, gender, and all of these divides the subpopulations of women. And so that’s why we started. Now, along the way, because we are a group of operations folks from VA Central Office, and what at core, I think in their hearts are researchers, we’ve continued to work together to find ways in which program evaluation—which I call little R research—and big R research, works together both to inform our policy and our practice and also work in the policy or the research area works together to develop research ideas. So an example of that might be that we’re very interested in patterns of women and who was accessing women’s healthcare and what their conditions were. And we also, we’re paying attention, when we think about access, to the issue of attrition. So this group has worked to set up a definition of what is attrition in Veterans and how can we look at women versus men. And then, among the women, what are some of the factors that predict attrition or what, for us was important, what would help women stay in VA after they first arrived on our shores. Just some examples of how our emphasis on evidence-based practice has been a particularly rich working environment to work with the Women’s Health Evaluation Initiative. And now we’re going to turn to Sourcebook 4, which as the name says, is number four of the sourcebooks. They’re all available on our website. And as you’ll also see on the website, there’s a tremendous amount of technical assistance behind the scenes on this, and Susan Frayne and Fay Saechao are the experts. So as researchers, I think you’re going to be very interested in all of the variables and how we define some of these things. And they’re the go-to people to understand technically, what the sourcebook means. But with that note, I'd like to turn it over to Susan to go forward with what is really a very powerful set of slides we’re going to look at today about Sourcebook four.

DR. SUSAN FRAYNE: Well, thank you so much, Dr. Hayes. So Fay Saechao and I are going to be sharing with you some highlights of Sourcebook Volume 4 data, covering women Veteran sociodemographic characteristics, utilization patterns, health profile, and geographic distribution. This work is based on Program Evaluation Funding from women’s health.

But first of all, we wanted to do just two quick poll questions. And Heidi can quickly help us with the poll.

ROB: Hi everyone, this is Rob, Heidi’s colleague. I will be running the polls today, and that poll is open. Question being: Do you provide clinical care to women Veterans? Simply put, answer options yes and no. Susan, we have quite a few of your viewers having made their choices, but I'll leave it open for a few more moments to give people a chance to make their choices.

DR. FRAYNE: Okay, great. And I can’t see it, so if you’re able to tell me what the answer is at the end, that would be great.

ROB: I will. And I will show you the results when I close the poll.

DR. FRAYNE: Oh, great.

ROB: And it has leveled off, so I'm going to go ahead and close the poll. And show you the results. And what you have is that 33% of your viewers who answered, answered yes. And 60% answered no.

DR. FRAYNE: Okay.

ROB: Would you like to move on to the second poll?

DR. FRAYNE: Yes, please. Thank you. So, wonderful. We have a lot of clinical expertise on the call.

ROB: And that poll is running. The question being: Do you conduct research that includes women Veterans? And that poll is open. Answers are streaming in, rapidly. I am going to leave it open just for a few more moments. It does look like it’s leveled off, so I'll close this poll, share the results and read them to you; 70% answered yes, and 28% answered no. And you can go ahead with your slides.

DR. FRAYNE: Great. Well, that’s wonderful. We have a mix of clinical and research expertise on the call, which will make for a rich discussion in the last part of the call.

Okay, so we’re only going to be giving you a sampling of Sourcebook findings today. If you want to get more details, you can go directly to the link, here, for the full online Sourcebook. The second link here, has a bunch of related documents, like a detailed technical appendix and detailed data tables, and I wanted to express my deep appreciation to not only the Women’s Health Services, which funded this work, but also to everyone on the Sourcebook team, whose names are listed here in the citation, including WHEI’s Associate Director, Ciaran Phibbs, of the Health Economics Resource Center in Palo Alto. I’m also grateful to the many other people who made contributions to this work who are acknowledged in this Sourcebook, and as usual, the findings and conclusions in this presentation are ours, and do not necessarily reflect the views of the U.S. Government.

So first, a little bit of background. Women’s Health Services at VA Central Office oversees a lot of initiatives that are designed to improve access and quality of care for the growing women Veteran population, and one such initiative is the Women’s Health Evaluation Initiative, which we call WHEI, at VA Palo Alto, where we analyze National VA Databases to inform Women’s Health Services strategic policy development and program planning. WHEI has been making a series of Sourcebooks, and most recently Volume 4, which is the focus for today. So now I'm going to turn it over to Fay Saechao. And Fay will need to unmute.

MS. FAY SAECHAO: Okay, great. Thank you so much, Susan. The data presented in this Sourcebook are derived from National VA Databases. The report is divided into four sections that describe the sociodemographic characteristics, utilization of VA care, and health profile, as well as the geographic distribution of women Veteran patients. Unlike previous Sourcebooks, this volume presents longitudinal trends across a 16-year time horizon, focusing on different cohorts of women Veteran patients who use the VA at four different timepoints. So women who used the VA in fiscal year 2000, women who used in FY05, and FY10, and FY15. And individual women can be in multiple cohorts, if she continued to use the VA over time. The Sourcebook presents data on women Veterans overall and by age group and also compares women to men. You can find the technical and supplemental appendices online in the links Susan presented in the previous slide, and these contain information about all the variable specifications, the full data for all the exhibits, and other supplementary materials.

Turning to the findings, we’ll first present some of the key sociodemographics of women Veterans across a 16-year timeframe. Most of the findings in this presentation are from Sourcebook Volume 4 and thus focus on FY00 through FY15, but you’ll see in some places we’ve included updated findings from the FY19 WHEI Master Database.

This slide shows the growth in number of women and men Veteran patients over time, with women in yellow in the left panel and men in blue on the right panel, but with a different Y-axis scale. Over time, over the 16-year timeframe, the number of women in the VA grew 2.8-fold, whereas the number of men only grew 1.7-fold, so women in the VA are growing at a much faster pace than men.

This slide is similar to the previous slide, but focuses only on women Veterans and expands the time horizon out to 20 years, to include data through FY19, and here we can see that the number of women Veterans has now more than tripled from 159,000 using the VA in fiscal year 2000, to over half a million women Veterans using the VA in FY19.

While the Sourcebook mostly focuses on Veterans who use the VA, this slide puts VA users into the broader context of all Veterans in the United States. Over time, we’re seeing an increasing proportion of the entire U.S. women Veteran population who are coming to the VA for care.

In FY00, looking at the top red circle here, there were an estimated 1,593,000 women Veterans living in the United States. That same year, in the bottom red circle, 159,000 women Veterans received care in the VA. So in FY00, 10% of all women Veterans in the United States used the VA for care.

That proportion more than doubled, such that in FY15 22% of U.S. women Veterans used the VA. While not shown on this slide, market penetration continued to increase, reaching 27% in FY19. Data for men are also presented on this slide, in blue on the right panel, but again, with a different Y-axis scale. Although we do see a pattern of increasing market penetration for men, it’s most notably due to the declining U.S. male Veteran population over time. And throughout this presentation, we’ve noted key implications of the data in purple text, and here for this finding, is the observed trends in growth of the number of women Veterans using VA and if the increases in market penetration continue, then we can expect to have accelerated demands on VHA delivery systems for women.

This slide illustrates how a Veteran’s age in each of the fiscal year cohorts could reflect the different war eras in which they might have served in the military, depending on when they joined or left the military. So for example, a woman who was aged 65 in the FY15 cohort, would have turned 18 in 1968. If she joined the military when she turned 18, then she would have served during the Vietnam War era.

The distribution of women and men in each of the three age groups, so 18-44, 45-64, and 65+, are presented on this slide. Comparing women to men, women Veteran VHA patients are substantially younger than men. Eighty-six percent of women were age 65 or younger compared to 44% of men. Conversely, 14% of women and 56% of men were age 65 or older in FY19.

This slide shows the age distribution of women in each of the four fiscal year cohorts, plus an update with FY19 data in dark gray. The X-axis shows the age in 10-year intervals and the Y-axis shows the number of women Veterans with that age in the cohort year. Comparing FY00 to FY19, so looking at the bottom red line, and going up to the top dark gray line, we see a shifting of the peaks to the right as women Veterans from the various war eras age, and we also see increases in the total area under the curve, so the peaks are getting taller over time, as more women come to the VA for care. In FY19, so focusing only on the dark gray line, there is a peak of women Veterans at age 35, and this most likely represents women who served in the OEF/OIF/OND era. We see another big peak with two maxima at ages 57 and 62, and these are probably largely women who served in the Vietnam/post-Vietnam era. The last peak that we see is at age 95, and this most likely represents women who served in World War II. Unlike the other peaks that have grown taller over time, this peak is smaller in size than the previous fiscal years, and most presumably due to death or transfer to long-term care facilities. These shifts in age distribution over time have important implications. First, the cohort of young women have greatly increased. VA needs to ensure capacity to provide care such as reproductive health services for women in childbearing years. Additionally, between FY00 to FY19, the number of women in the 55 to 64-year-old cohort increased tenfold. As they continue to age, we expect to see a rapid growth over the coming decade in the number of women age 65 or older who may require more intensive chronic disease care.

Women Veterans in the VA are more racially ethnically diverse than men. In FY19, 41% of women, compared to only 25% of men, belonged to a racial and ethnic minority group. For both sexes, the two largest racial ethnic minority groups were African-American Veterans, shown in yellow, and both bars, and Hispanic Veterans, shown in blue.

Looking at longitudinal trends, women in all age groups are becoming progressively more diverse, with those in the younger age groups consistently having greater racial/ethnic heterogeneity than older women. The key implication here is that consistent with VA’s commitment to equity, women’s growing diversity in all age groups supports the importance of efforts to ensure services are not only sensitive to gender, but also to culture and what is referred to as intersectionality or the interactions between gender/age and race/ethnicity.

Relevant to considerations around intersectionality of gender, race, ethnicity, and other factors, another resource for you to be aware of is the VA Office of Health-Equity’s National Veteran Health Equity Report, which is available on the web link in this slide. This product of the OHE-QUERI Partnered Evaluation Center, directed by Dr. Donna Washington at VA Greater Los Angeles draws in part upon WHEI data.

Okay, turning to urban/rural residence, three out of four women Veterans live in an urban area. That being said, there are also a substantial group of women Veterans who live in rural areas and their absolute number is growing. This raises an important challenge in women’s healthcare. The need to provide high-quality, equitable gender-specific services, gender-specific VA services, in remote areas where there could be very few women. It also highlights the potential relevance of programs that extent access to primary care and specialty care such as telemedicine and mobile clinics.

We also see that the proportion of women Veterans with a service-connected disability rating is growing over time. Based on FY19 data, 71% of women Veterans in the VA carried a service-connected disability rating. Many of these women who carry a service-connected disability rating are very young and will be eligible for lifelong VA care for their service-connected conditions. And now I'll pass it back to Dr. Susan Frayne.

DR. FRAYNE: Wonderful. Thank you, Fay, for that wonderful demographics summary. So now we’re going to shift gears, and I’ll move the slide, and we’ll talk about women Veterans use of various types of VA services. Primary care, mental health care, purchased care, and OB/GYN care.

Okay, so first, primary care. Here you again have one bar for each year, FY00 to FY15. The top wedge of each bar is the percent of women Veteran patients from that year who had no primary care encounters in the year. The next wedge down is the percent with exactly one primary care visit, then two visits, three to five, six to 11, and at the very bottom is the percent of women with 12 or more visits to primary care in that year. You can see that in FY15, 41% of women Veterans had at least primary care visits in the one-year period. We saw previously that the number of women Veterans had increased markedly since FY00, so this means that the absolute number of women Veterans using primary care services has been growing rapidly. The size of our women’s health primary care provider workforce needs to keep pace with this rapid growth in women Veteran primary care users, many of whom use primary care services heavily.

Comparing women to men, in every age group, more women than men had three or more primary care visits in FY15. Women were using primary care services more heavily than men, despite the fact that women are, on average, younger than men. This supports the idea that clinicians whose primary care panels are enriched with women need to have their panel size and scheduling profiles adjusted accordingly, to be sure they can offer sufficient access to care.

Many VA facilities around the country have separate women’s clinics, which are typically interdisciplinary and often located in the facility’s flagship VA Medical Center. As we detail in the Sourcebook, there’s some limitations with the data that impede our ability to fully characterize whether women received their in the women’s clinic versus general primary care clinic, but with that caveat in mind, I'll share some FY19 WHEI data with you, which showed that 32% of women Veterans used the women’s clinic for primary care at least once in FY19. Although only 17% of women Veterans used a women’s clinic exclusively for their primary care services.

Turning next to mental health and substance use disorder care, both the proportion and absolute number of women using these services has been increasing markedly. In fact, there’s a five-fold increase from FY00 to FY15 in the number of women Veterans who are using mental health or SUD care. We don’t know if the increase in proportion of women using mental health/substance use services is because we’re doing a better job of connecting women with VA services after they leave the military or because women look upon VA mental health/substance use services more favorably now, or because need as increased as a result of greater prevalence of mental health and substance use conditions or some other factors.

Gender differences are pronounced for mental health/substance use disorder care. So using updated data from FY19, 43% of women Veterans—versus only 26% of men Veterans—received mental health/substance use services.

In light of women’s markedly higher use of mental health/substance use care compared to men, recent research looking at the potential promise of gender tailoring mental health/substance use services in VA is particularly timely. Women with mental health substance use conditions often have an excess burden of medical illness as well, and so another key issue is the importance of ensuring that there is good coordination between medical and mental health/substance use services for women Veterans.

In Sourcebook Volume 4, we refer to VA Community Care as purchased care. The Sourcebook examines care longitudinally, and this type of care has taken on many names over the years from fee-basis care, to CHOICE, to MISSION Act care. Regardless of what you call this type of care that VA purchases in the community, the absolute number of women Veterans using purchased care increased four-fold from FY00 to FY15.

One very consistent finding is that a higher proportion of women than men received purchased care. This was true across all age groups and across all years. In FY15, 37% of women versus only 23% of men had at least one encounter through purchased care. This implies that all the efforts that are going in to try to look at the quality of outsourced care and to try to figure out what are good approaches to coordination between VA and purchased care providers are really important, especially for women, as they try to navigate between these distinct care providers. It’s also especially important right now, because purchased care use has been escalating after passage of first the CHOICE Act, and now more recently, the MISSION Act.

The final type of care we’ll look at today is for reproductive health. In FY19, 12% of women Veterans received OB/GYN care in VA, whereas only 3% of women received OB/GYN care exclusively through purchased care in that year. While I'm not sure the figure is absolute, the number of women Veterans using OB/GYN specialty care more than doubled from FY00 to FY15. This points to the importance of efforts VA has been making to expand its OB/GYN provider workforce and to ensure good geographic distribution of OB/GYN providers in VA facilities across the country.

Drilling down to one specific type of OB/GYN care, the OB complement, there’s been a dramatic 14-fold increase in deliveries since FY00, which far outpaces the rate of growth in women of childbearing age, suggesting that women are choosing VA for their deliveries. If we keep seeing such increases, it’s going to be even more crucial to be sure that we have good coordination of services between VA and Community Care settings for maternity care. This supports the key role of Maternity Care Coordinators at every VA facility.

In the same vein, I also want to highlight that the number of women Veterans in the 35+ year age group with deliveries increased 16-fold from FY00 to FY15, so we’re seeing a lot of older, and therefore higher-risk, women having deliveries. In addition to advanced maternal age as a risk factor for adverse pregnancy outcomes, serious comorbidities like PTSD that are common among women Veterans can also increase perinatal risk. This further highlights the importance of Maternity Care Coordinators.

Now we’ll switch gears and focus on the health profile of women Veterans, in terms of their most common condition. One caveat for this section is that the conditions we describe here are based on ICD diagnosis codes that are entered by clinicians as the reason for a visit or the reason for an inpatient stay. In this section, we present condition frequencies by age group, since the types of conditions that afflict women vary across the lifespan.

That being said, one subtle caveat for when we look at time trends and condition frequencies by age group is that age distribution of women Veterans varies over time within an age group, as shown here. That might be of particular interest for the researchers on the call. Therefore, when we see cross-year changes in the frequency of a specific condition within a specific age group, part of the reason for these changes can be demographic shifts as the age distribution changes over time.

Okay, so first, in terms of a high-level view, in FY15, the top five broad domains of conditions in women, 18-44 years old, were musculoskeletal, mental health/substance use, reproductive health, endocrine/metabolic/nutritional, and neurologic. In those 45-64, they were musculoskeletal and endocrine/metabolic/nutritional, mental health/substance use, cardiovascular, and sense organ. And for those 65+, they were endocrine/metabolic/nutritional, cardiovascular, musculoskeletal, sense organ, and gastrointestinal conditions. So you can see that women Veterans health profiles clearly changes across the lifespan.

Here’s a snapshot of part of Exhibit 3.F in the Sourcebook. This exhibit shows the frequency of all 202 specific conditions that we examined. So it’s a good reference, if you’re interested in a specific condition, and the online appendices have even more details. I’m only showing you the top part of the table here, just to orient you to how this exhibit is set up. In the first column, you’ll see the specific condition grouped by broad domain, shown in yellow. So here you see that under the musculoskeletal broad domain, we have connective tissue disease as a specific condition, rheumatoid arthritis as a specific condition, etcetera. The next set of columns gives the frequency of these conditions among women Veterans in FY00 and in FY15. First overall, and then by age group. And then the final two columns give the age-adjusted odds ratio for women versus men for that condition. You can consult the Sourcebook for the details of this table.

So focusing on which of those 202 conditions are most common in each group, I'll start with the 18-44-year-old age group, and show conditions in rank order. In FY15, the top five specific conditions in 18-44-year-old women in VA were depression, anxiety disorders, headache, PTSD, and lumbosacral spine disorders.

So in the 18-44-year-old age group, mental health conditions were quite common. The higher rate of PTSD and anxiety diagnoses that we saw in FY15 compared to FY00 could be related in part to many of the FY15 cohort, having been deployed to war post-9/11 and could also be related to improved screening or more women seeking treatment. Musculoskeletal conditions were also common in this age group. We don’t know how much of that is related to military service, but we do know that polytrauma and focal injuries are common in deployed populations. Along those lines, traumatic brain injury increased five-fold over time, perhaps reflecting injuries sustained during OEF/OIF/OND, or enhanced detection. To address reproductive health needs, like contraception and treatment of other gender-specific conditions, we need clinicians knowledgeable about modern approaches to treatment. The women’s health primary care provider workforce in VA receives training in these issues through women’s health mini-residencies. As I mentioned, there’s a high rate of PTSD in this age group, and so skill in trauma-sensitive pelvic examination is one of the key competencies needed in clinicians who are caring for reproductive-aged women.

Among women 45-64 years old, in FY15, the top five conditions were hypertension, lipid disorders, depression, lower extremity joint disorders, lumbosacral spine disorders and refraction disorders.

And so in the 45-64-year-old age group, we see a shift to more cardiovascular risk factors, representing an opportunity for population health intervention. It’s important to intervene at this stage before women older age and experience irreversible end-organ damage like myocardial infarction, one of the leading causes of death in women. Musculoskeletal conditions are also very common in this age group and can have major impact on quality of life. The number of women 45 to 64-year-old with a musculoskeletal condition has increased six-fold over time. This means that VA pain services should take the needs of women into account, whether it’s rheumatology clinics, ortho, pain clinics, complementary and integrative health programs, rehabilitative care, or prosthetics. Mental health symptoms like depression are also very common in this group, again, with impacts on quality of life. VA facilities are working to ensure that women Veterans feel welcome and safe at all mental health points of care, from waiting rooms to group therapy visits, to inpatient wards. Treatment of mental health conditions needs to account for gendered issues, such as the fact that depression, PTSD, anxiety disorder, and substance use disorders are common sequalae of military sexual trauma. Which is far more common among women Veterans than among men.

In the 65+ age group, the most common specific conditions in FY15 were hypertension, lipid disorders, eye disorders, cataracts, and diabetes.

So in this oldest age group of women Veterans, cardiovascular risk factors like hypertension, hyperlipidemia, and diabetes are even more common than in the middle-age group. VA’s PACT model in primary care has design characteristics relevant to management of chronic diseases like diabetes, such as team-based care, panel management tools, and embedded behavioral health providers. With the rising prevalence of mental health conditions in this age-group, we also anticipate increasingly seen comorbidity between medical and mental health conditions, which will add to case complexity as women Veterans age. Given how much older women prioritize maintenance of their independence, addressing their musculoskeletal conditions also needs to be a target of treatment to reduce pain and to improve sleep, functional status, deconditioning, falls risk, mobility, and mental health status. And likewise, rehabilitative services, home-based care, and treatment of vision and hearing deficits may be pathways for preventing or delaying the need for transitions to long-term care settings.

The last bit of data we’ll share with you is about geography—where women Veterans are going for their care.

This slide shows the absolute number of women Veterans in each VISN or VA Region, in FY00, the yellow bars, and in FY15, the blue bars. You can see that there was growth over time in the number of women Veterans in every VISN in the country, and in five VISNs there was actually huge growth with at least a tripling of the number of women Veterans over the 16-year period.

Drilling down to the individual healthcare system level, the top map shows FY00 and the bottom map shows FY15. There’s a dot for each healthcare system in the country and the size of each dot reflects the number of women Veterans at that healthcare system. The number of women Veterans grew from FY00 to FY15 at every healthcare system in the whole country. The red dots in the bottom map indicate the FY15 facilities where the number of women Veterans grew by at least 5,000 between FY00 and FY15. Two healthcare systems were new in FY15 and are shown as gray dots because growth can’t be assessed there.

So there’s multiple implications of these geographic findings. We saw that the rapid growth in the number of women Veterans using VA really touched every single VISN and every single healthcare system VA-wide. So that means that we need to deliver augmented women’s health services at every point of care across VA. Growth was especially dramatic at some facilities, which could strain their capacity to provide timely access to women. If anything, we would expect this type of expansion and increasing demand to continue, given the growth of women in military service and increasing market penetration over time. For each of us, at every VA facility, our long-range strategic planning should account for the capacity needed to provide care for the growing population of women Veterans. This can include, for example, making sure that we have sufficient staffing with designated women’s health primary care providers, initiatives to reduce burnout in the women’s health workforce, development of gender-tailored services for women, and measures to ensure that our environment of care and our VA culture is welcoming to women Veterans and acknowledges their military services.

We hope this taste of the data available in Sourcebook Volume 4 helps to ensure that women Veterans needs are factored in to your clinical care, strategic local clinical program development, and research. Now I'll turn it over to Dr. Hayes and Dr. Haskell for any concluding comments from VA Central Office and then respond to any questions and comments that you have in the final portion of the hour. Thank you.

DR. SALLY HASKELL: Hi, this is Sally Haskell, can you hear me?

DR. FRAYNE: Yes.

DR: HAYES: Yes, Sally, we hear you. I wanted to encourage everyone to—this is Patty Hayes--I wanted to encourage everyone to go ahead and start entering your questions in the chat box, which you can find over on the upper right, hopefully. And Dr. Haskell, we welcome you. Deputy Chief Consultant for Clinical Operations and Deputy Director. And I should correct and say she’s a full Professor of Medicine at Yale University and a Researcher in the Women Veterans Cohort Study at VA Connecticut. So Sally, I'm going to turn it over to you for comments and any particular things that you’d like to highlight.

DR. HASKELL: Yeah, thank you. Yes, I just wanted to thank the whole WHEI team for your amazing presentation, Susan and Fay, and for all the great work that you have done for us over all these years. You know, I think that the way data has really impacted just about everything we’ve done in women’s health services, you know, I was thinking starting out with just being able to sort of accurately document the population growth, the rate of growth, the age of the population, how it differs between women and men—I mean, that has just really had a substantial impact on our ability to request resources when we’re able to say things like the population has tripled or 30% of new Veterans are women and these types of statements that we gather from your data are just highly impactful. Then I think, again, thinking about population growth, that last data you presented about the rates of growth at some specific facilities where over the last few years they’ve had 5,000 new women, it really enhances our understanding of access challenges, as we’ve looked at sites that we consider sort of hot-spots, you know, why are women waiting for care at these sites? When we see there have been 5,000 new women, we can understand that sites really haven’t been able to keep up with their hiring and training of women’s health providers to meet this need. So those things are super important. And then focusing on the women Veteran population, thinking first of all about utilization, the numbers of visits that women make compared to men, that has really—you know, impacted our policy in terms of designated women’s health providers, and the need for panel size reduction because of the increased numbers of visits. So that data has been extremely helpful, there. And that’s just—I think, in general, as we think about understanding the health conditions of women Veterans, the complexity of the population, it has impacted our ability to be able to advocate or increase that support, for things like care coordination. And in fact, just recently, of course, we’ve been able to get additional funding of this 50 million dollars that has gone out to the field and the fact that we know that we have this complex population where over 30% of them are receiving care in the community, really is sort of reflected in our ask for sites to apply for women’s health care coordinators. So I could go on and on but I'll probably stop there and let Dr. Hayes take over and make a few comments.

DR. HAYES: Okay. I think that if nothing else, this data should be having researchers be thinking about how you need to present by gender and by race/ethnicity, that this very diverse group of women that we serve is also diverse by age and that you see some of the conditions and ways in which women present is going to be affected. So we look to your research to make sure that A—first of all, by gender. And if you don’t—if you already have projects underway that don’t include analysis by gender, you know, there’s still some supplemental HSR&D money to do that. We’ve worked long and hard with HSR&D to set the research agenda and to make sure that we’re covering some of the key issues for women. I think you can just really already see as we’ve talked about ways in which the findings are used by us, but they are also very much part of the social culture, Congress pays attention, a lot of this data feeds into research which is reported to Congress and probably should put a shoutout as well, if you don’t know about the women’s health research network, you can see how this data helps us tune folks in to where the numbers of women are that they need to produce their research and to include gender, and also for the researchers who are working at various sites to work together without having to do a cooperative study to get sufficient numbers of women to do the power of the study that you want to produce. So I'm going to let our moderator, see if there’s some things in the chat box and also continue to ask or comment on things that you’d like to be able to see in the future from this enterprise.

HEIDI: Fantastic.

MS. SAECHAO: This is Fay, and I thought I’d just—I’d jump in for one second on the point that Dr. Hayes just made about the women’s health research network. So that has three—the women’s health research network has three complements of consortium of researchers interested in women’s health. It’s led by Beth Yano in Los Angeles, and a multi-level engagement component that’s led by Alison Hamilton in Los Angeles, and a women’s health practice-based research network that’s led by me and we’re called PBRN, or Practice-Based Research Network, if you are interested in doing—trying to include more women in your research. Dr. Hayes just was talking about you can call upon the women’s health PBRN at 61 sites to help promote your multi-site research. And we’re also right in the process of expanding the PBRN right now with the applications for being a new site due at the end of this month, so if your site is not part of the PBRN and you’re interested, this is a plug for also trying to consider that as well. So I'll pass it back it Heidi. Thank you.

HEIDI: Great. Thank you. And we do have a couple pending questions here, but we do also probably have a little bit more time available than these questions will fill, so for the audience, if you do have any pending questions, please submit those in the QA screen and I will ask those on the call for our presenters. Okay, our first question here: Once again, the team has produced an invaluable resource for VA. I am wondering about findings related to the intersection of race/ethnicity and gender, particularly given the differences in race/ethnicity in women of Veteran age groups.

DR. FRAYNE: Hi, this is Susan. I can comment. Thank you so much for that question, Paula. So the Sourcebook actually provides information that is broken down by sex, by race/ethnicity, by age group, all together. Because all three of those factors are so important as introspections. And then by year. So it’s a four-way, four-dimensional comparison. We do also send WHEI data to Dr. Donna Washington, who is Los Angeles, who leads the Office of Health Equity-QUERI Partnered Evaluation Center. And they are definitely also looking at health intersectionality issues as well. So yes, thank you. And I hope everyone on the call who is researchers will continue looking at those issues.

HEIDI: Great. Thank you. The next question here: Hi, thank you all for the Sourcebook and presentation. Dr. Frayne mentioned researchers looking into quality of purchased care. Would you be able to describe what these VA researchers are doing, and how to connect with them?

DR. FRAYNE: Okay, great. You know, the person I would recommend that you connect with is Dr. Kristin Mattocks, who is leading the, I believe it’s called the CREEK, C-R-E-E-K now, which is collecting information from all the researchers around the country in collaboration with the Office of Community Care to find out what are the resources, who is doing what, and how could we all learn from each other. So Kristin Mattocks, M-A-T-T-O-C-K-S, would be I think a really good resource to connect with for that.

HEIDI: Great. Thank you. The next question here: Is there information about mortality in women Veterans compared to men, and based on race?

DR. FRAYNE: So Donna Washington in Los Angeles for the Office of Health Equity has actually been looking at mortality information and probably has the most updated information about that. And I don’t remember—I think there is also by gender, by race as well, I just don’t have the numbers off the top of my head, but you could connect with us, and with Donna, and we can give you more information. That’s a great question, thanks.

HEIDI: Okay, great. Thank you. That is all of the pending questions that we have at this time. I don’t know if anyone has any final remarks you’d like to make. We can see if anyone has anything else that they’re typing in at the moment.

DR. HAYES: This is Patty Hayes. I just wanted to mention, in the issues of quality care, when you separate out maternity care, we are engaged in a couple of efforts, both the program office in terms of evaluation, and also some other work that if you have a specific dataset or interest in that, we would be very interested in hearing from you. I think there’s going to be parallel work on specific conditions. So it is difficult to do quality of care for the purchased care and anyone who wants to do it, we welcome and support you in that work. The other thing I just wanted to say is apart from the issues of mortality where there obviously are comparisons in men versus women because of the age groups, one of the things you’ll hear as an over-arching long-term theme of ours is that it’s often more meaningful to compare subgroups of women Veterans than to compare women Veterans just as a whole to non-Veterans. And so we continue to encourage work that is getting enough women into the set of data that you’re looking at to be able to make some of those comparisons by gender, by race, ethnicity, within that subgroup. If you can do it by rurality, if you can do it by certain other geographic components. Any of these kinds of things are very interesting to us and very helpful to making sure that we’re getting the right services for women out there in the right places in a timely manner. And so we encourage you to reach out to us when you have ideas or to reach out to reach out to the Practice-Based Research Network, who can also kind of help not only mentor and support you but kind of work on brainstorming and other ways in which we can make the information make—make the research really effective. So, thank you.

DR. FRAYNE: Yeah, and this is Susan again. I do definitely really encourage that researchers, that we separate out gender information and make it so that it’s possible to actually see results by gender in the work that we do, because the women in the study cohort can tend to be swamped by a larger number of men and you may not be able to see kind of how differences are—how results are different in those groups.

HEIDI: Great. Thank you. We have not received any other incoming questions, so we can probably wrap things up here, unless anyone has any quick final remarks they would like to make. Sounds like we are at a good stopping point, then. I want to thank all of our presenters and discussions today. We really appreciate all of the time and energy that you put into presenting the session today. To our audience, thank you everyone for joining us today. When you leave the session, you will prompted with a feedback form. Please take a few moments to fill that out, we really do appreciate all of your feedback. Thank you, everyone, for joining us for today’s HSR&D Cyberseminar, and we look forward to seeing you at a future session. Thank you.

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