Can Right-Sizing the Use of Virtual Care Improve Access to Equitable, Patient-Centered Care for Women Veterans?

Karen M. Goldstein, MD, MSPH[1,2], *Hayden B. Bosworth, PhD*[1,2,3,4,5], *and Jennifer M. Gierisch, PhD, MPH*[1,2,4]

[1]Center of Innovation to Accelerate Discovery and Practice Transformation, Durham VA Health Care System, Durham, NC, USA; [2]Division of General Internal Medicine, Duke University School of Medicine, Durham, NC, USA; [3]Duke University School of Nursing, Durham, NC, USA; [4]Department of Population Health Sciences, Duke University School of Medicine, Durham, NC, USA; [5]Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, NC, USA

J Gen Intern Med 38(Suppl 3):S868–S70
DOI: 10.1007/s11606-023-08113-7

There is a time-sensitive imperative to optimize health care access for women veterans (WVs). While WVs are a numerical minority within the Veterans Administration (VA), they are one of the fastest-growing populations seeking VA health care and are expected to more than double by 2040. Since the 1990s, VA has achieved tremendous advances in women's health care. Specifically, the VA has designated providers with expertise in women's health, formed women's health patient-aligned care teams, and created physically distinct comprehensive women's health clinics. These efforts have reduced gender-based disparities in quality of care metrics and improved the care experiences of WVs in VA. However, despite these system-level advances, WVs continue to face distinct logistical, cultural, and geographical barriers to accessing high-quality, patient-centered care.

Current access barriers faced by WVs include reverberations of overt and implicit bias against women in the context of military service and veteran status (e.g., gender-based stranger harassment on VA grounds), competing personal demands that marginalize self-care in favor of caring for others (e.g., caring for young children and/or aging parents), and sourcing of high-quality sex-specific care (e.g., gynecological care) in a health care system developed for a male-dominated patient population. In addition, WVs have disproportionate opportunity costs associated with attending in-person appointments during regular business hours as they are more likely to be of working age, earn less, and be single heads of households compared to male veterans. Within this context, the 2020 Congressional Deborah Sampson Act set a legislative imperative to continue to improve WVs' experience and access to VA care. One approach to advancing equitable access to high-quality care for WVs is the strategic deployment of existing virtual care modalities via synchronous modalities such as video and telephone, and asynchronous platforms such as automated SMS/text message algorithms.

Prior to the COVID-19 pandemic, WVs demonstrated ready uptake of telehealth modalities such as virtual diabetes support groups[1]. During the pandemic, WVs were more likely to become new users of video-based care compared to their male counterparts[2]. In fact, some veterans have indicated a preference for video-based care options over audio-only methods suggesting video-based platforms may be particularly acceptable and feasible for WVs care delivery. Moreover, the strategic deployment of video-based care could be realized across primary care, specialty care, and mental health pathways to provide comprehensive access beyond care needs typically identified as women's health (e.g., solely breast and gynecologic health). Below, we explore three key areas in which virtual care could overcome existing barriers to high-quality, comprehensive care for WVs.

First, virtual care could offer an alternative pathway for WVs to connect with VA care when otherwise deterred by an unwelcoming environment. A recent study by Klap et al.[3] found that 25% of WVs report experiencing inappropriate or unwanted comments or behaviors by male veterans while seeking care on VA grounds. While VA is actively working to reduce the occurrence of stranger harassment, WVs must be able to access care comfortably and reliably. This particular access barrier is likely to impact already disadvantaged WVs the most. Among WV receiving VA care, greater than 50% experienced sexual harassment while on active duty; these women may be particularly vulnerable to the impacts of ongoing threats to their safety and bodily integrity which may manifest in avoidance of needed preventative health care[4]. In addition, stranger harassment may also be particularly poignant for veterans from marginalized populations such as individuals who identify as racial, ethnic, or gender minorities; experiencing adverse treatment (e.g., harassment) by women with intersecting identities in a VA health care environment could have amplified effects by incurring additive new stressors atop past negative experiences and

Prior Presentation: none.

Received June 2, 2022
Accepted February 24, 2023
Published online March 15, 2023

accumulated racial and gender-based stress over a women's lifetime (i.e., the weathering hypothesis). For these WVs, in-person interactions with the medical system may be a deterrent to health care engagement. Affording marginalized patient populations the choice to receive some or most care virtually when clinically appropriate could improve both access and patient satisfaction and the establishment of continuity of care.

Second, virtual modalities can create ways to engage with health care when WVs may otherwise forgo care in the face of competing responsibilities. WVs are frequently racially/ethnically diverse, working age, and the single head of their household; all are factors that may compete with seeking health care and have implications for health care engagement. Moreover, WVs frequently report competing demands (e.g., dependent care, work obligations) as a barrier to health promotion and disease prevention activities. In order to encourage WV to engage in chronic disease management and health promotion, virtual modalities could help address this common barrier for women by offering flexible ways to track and share personal health data. Synchronous health care visits may be seen as more feasible while managing the multiple competing demands WVs experience. Developing a user-centered understanding of why women and their health care teams use virtual modalities in the health care setting could guide when and how to best incorporate them routinely.

A third opportunity for strategic virtual care implementation for WVs is around sex-specific health needs. Veterans with biologically female reproductive organs have medical care needs specific to both natural (e.g., pregnancy) and pathological (e.g., ovarian cancer) conditions stemming from that biology. Because WVs are a numerical minority population within any given VA health care system, facilities are challenged to maintain sufficient site-based facilities and skilled staffing to provide high-quality care for women with sex-specific health considerations. In addition, for some facilities in rural areas, clinical expertise "deserts" preclude the community-based purchasing of care for women-specific health needs[5]. Regionalization via telehealth hubs could supplement high-quality care for these women's health conditions and be readily integrated into local VA clinical services. The VA already has experience with successful regionalization of care provision using telehealth services. For example, genetic counseling and remote oncology are currently provided to many VA facilities via telehealth when not available in local facilities. VA also has experience providing e-consultation across facilities for certain sex-specific conditions[6]. Yet, there are unrealized opportunities to address women's health conditions with the expanded use of expert-delivered telephone or video-based care. Clinical needs such as emergency contraception provision, reproductive planning for women with complex health conditions, and lactation support are a few examples. In addition, the VA recently announced that it will provide abortion counseling and termination care in limited clinical situations creating a new opportunity to provide unmet essential reproductive health needs for women in areas of the country with increasingly limited access to termination options and support[7]. There is tremendous potential for telehealth and virtual modalities to provide care for sex-specific WVs health needs in a way that has not yet been realized.

If the VA is to achieve the goal of being the health care option of choice for *all* veterans, the next steps in improving access to care must be patient-centered and factor in patients' ability to, and preferences for, interacting with the health care system. A key step for all veterans is to ensure equitable access to broadband service which is most relevant for veterans living in rural areas and those with fewer financial resources; VA programs such as the digital divide consult are an important step in addressing this fundamental barrier to virtual care. For women veterans in particular, this also means identifying modalities of care delivery that overcome contextual, structural, and population-specific barriers to accessing care for each type of health care need and in each clinical context. We already have the resources of the well-established VA telehealth infrastructure. Our next steps are to identify how to integrate virtual care delivery within the daily context of care provision for women based on population-specific challenges, what resources are needed to support those population-tailored innovations, and which implementation strategies are optimal to support their uptake at the bedside. Employing VA telehealth modalities to expand access to excellent sex-specific care for women would not only improve the health of women veterans but could serve as an example for civilian health care systems to improve the reach of high-quality women's health care to underserved areas. Optimizing access to care for WVs warrants dedicated, swift action through the creative application of virtual care.

Corresponding Author: *Karen M. Goldstein, MD, MSPH; Center of Innovation to Accelerate Discovery and Practice Transformation, Durham VA Health Care System, Durham, NC, USA (e-mail: Karen.goldstein@va.gov).*

Funding *This work was supported by VA Health Services Research and Development grant IIR # 21–205 and the Durham Center of Innovation to Accelerate Discovery and Practice Transformation (ADAPT), (CIN 13–410) at the Durham VA Health Care System. Dr. Bosworth was also supported by VA Senior Career Scientist Award (VA HSR&D 08-027).*

Declarations

Conflict of Interest *KMG and JMG report no conflicts of interest related to this topic. HBB reports research funding through his institution from BeBetter Therapeutics, Boehringer Ingelheim, Improved Patient Outcomes, Merck, NHLBI, Novo Nordisk, Otsuka, Sanofi, VA, Elton John Foundation, Hilton Foundation, and Pfizer. He also provides consulting services for Abbott, Imatar, Novartis, Sanofi, Vidya, Walmart, and Webmed. He was also on the board of directors of Preventric Diagnostics.*

REFERENCES

1. **Moin T, Ertl K, Schneider J, et al.** Women veterans' experience with a web-based diabetes prevention program: a qualitative study to inform future practice. J Med Internet Res 2015;17:e127.
2. **Ferguson JM, Jacobs J, Yefimova M, Greene L, Heyworth L, Zulman DM**. Virtual care expansion in the Veterans Health Administration during the COVID-19 pandemic: clinical services and patient characteristics associated with utilization. J Am Med Inform Assoc 2021;28:453-62.
3. **Klap R, Darling JE, Hamilton AB, et al.** Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care. Women's health issues : official publication of the Jacobs Institute of Women's Health 2019;29:107-15.
4. **Skinner KM, Kressin N, Frayne S, et al.** The Prevalence of Military Sexual Assault Among Female Veterans' Administration Outpatients. Journal of Interpersonal Violence 2000;15:291-310.
5. **Friedman S, Shaw JG, Hamilton AB, et al.** Gynecologist Supply Deserts Across the VA and in the Community J Gen Intern Med 2022;37 (S3):690–697.
6. **Cordasco KM, Zuchowski JL, Hamilton AB, et al.** Early lessons learned in implementing a women's health educational and virtual consultation program in VA. Med Care 2015;53:S88-92.
7. VA will offer abortion counseling and - in certain cases - abortions to pregnant Veterans and VA beneficiaries. 2022. (Accessed 9/22/22, 2022, at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5820#:~:text=Specifically%2C%20VA%20will%20provide%20access,have%20access%20to%20this%20care.)