

DNP Portfolio Executive Summary
Nancy Sloan
Doctor in Nursing Practice Candidate, OHSU School of Nursing
May 2, 2009

The contents of this portfolio demonstrate the accomplishments achieved throughout the Doctor in Nursing Practice program. Over the course of the past two years I have concentrated on the needs of women veterans who are seeking health care at the Portland VA Medical Center (PVAMC). The reason this is currently a critical focus is due to the increase in women serving in the military and consequently the increase in women veterans who are now accessing health care at the Veteran Administration Medical Centers (VAMC) nationally. My focus for the Clinical Inquiry Project is the implications of this increase for delivery of health care to this population and the ways the PVAMC can address gaps and barriers that women may feel exist in trying to access health care at this facility. To evaluate the current status of women veterans I pulled data for a twelve month period spanning 2007 to 2008 and analyzed the demographic and clinical characteristics of women veterans using the Portland VA Medical Center. I also conducted three focus groups for women veterans, inviting them to express themselves on their views of services and their preferences related to health care choices.

During the DNP program policy issues were also addressed. I analyzed Public Policy 262-211, enacted in 1995. This policy changed the manner in which health care is delivered throughout the Veterans Administration. The implementation of this policy and the resulting changes enlightened my knowledge of VAMC history and made me aware of the vast changes experienced in health care delivery within the VA. These policies caused a major shift from an acute care health model to a focus on ambulatory care. The fact that policy can have such a great impact on health care delivery encouraged me to press forward and take the lead in advocating for women veterans who are currently an underserved population within the PVAMC.

The DNP program has emphasized methods for organizational change and the leadership responsibilities that are a major part of the role of the DNP. The portfolio paper on organizational change highlights DNP class instruction that coincided with the organizational changes I was seeking to make within the PVAMC. These changes included improving health care services for women and including that these services were offered in a gender-sensitive manner. This proved to be a challenge due to VA medical centers historically serving male patients. With the increased understanding of organizational structure and the importance of identifying key stakeholders within the organization, I was able to improve health services for women veterans. These changes include the appropriation of space and funding for a new Comprehensive Women Veterans Health Center. The build out of this Center is scheduled for fall 2009.

Numerous case studies are also included in this portfolio. These serve to highlight how my clinical expertise grew as I applied research to clinical practice. My knowledge of how best to help women veterans seeking health care at the PVAMC grew dramatically. I learned the importance of clinical environments, access and perceived barriers that create real roadblocks for women veterans receiving quality health care. Perhaps most importantly, I learned how leadership is an essential component to championing the rights of health care for groups experiencing health care disparities.

Having taken the DNP coursework and applied my newly learned skills to practice I feel that I am now equipped to affect change within a health care system, be a leader to influence health care

outcomes for individuals, groups and populations, and influence health policy on a local, regional and international level.

Running Head: WOMEN VETERANS HEALTH CARE

Status of Women Veterans' Health Care in the Portland Veterans Administration Health Center

Oregon Health & Science University

Nancy Sloan

The recent increased deployment of women in the U.S. military is creating a sharp rise in women accessing Veterans Administration (VA) for health care. Historically, the majority of patients using VA services have been male. This sudden increase by female users has created multiple challenges that may potentially affect the quality of health care they receive (Washington, Yano, & Simon, 2006). These challenges include a lack of data on the women who qualify for and need services, clinical environments designed for the needs of a women, inadequate staffing, both in terms of appropriate skill sets to address the special needs of women veterans (e.g., gynecological knowledge, sequelae of sexual trauma, post traumatic stress disorder, etc.) and also the numbers of skilled personnel.

Women veterans now comprise 42% of veterans using one or more VA services. Of these, 86% are under age 40 and of child bearing age (U.S. Department of Veterans Affairs, 2007). Women now constitute 9% of the patients currently accessing health care through the Portland VA Medical Center (PVAMC). This is 3% higher than the current national average. The current numbers are already taxing the local VA health system, yet it is projected that the women veteran population will double within the next five years (U.S. Department of Veterans Affairs, 2007).

There is a new sense of urgency and attention being given this phenomenon via the media because of this projected growth in the number of women veterans. This heightened public attention has highly politicized the issue of VA healthcare for women. There is little research available on the clinical needs of this emerging population due to the relative newness of these challenges. Researchers (Bean-Mayberry, Chung-Chou, McNeil & Scholle, 2003) suggest that the lack of available information limits our knowledge to adequately address these issues. Yano, a leading researcher in this area, also confirms that there remains a deficit of information about

women veterans and factors that affect their access to the VA health system (E. Yano, personal communication, 2008).

The PVAMC has recently become acutely aware of the needs of women veterans who use the facility. The Director of Primary Care has chosen to address the current disparities by communicating with national and local Women Veteran Program Managers and affiliated committees to develop a dedicated space for a Comprehensive Women's Health Clinic within the PVAMC (J. Moore, personal communication, 2007).

The Advanced Practice Nurse (APN) is a strong advocate for all populations experiencing inadequacies within health care delivery systems. Using knowledge of policy and applying theoretical concepts to practice enables the Doctor of Nursing Practice (DNP) to be a leader who will affect change in health care systems thus insuring equal access and quality of care for populations experiencing health care disparities.

In my role as Women Veterans' Program Manager (WVPM) at the PVAMC I advocate for quality services for women veterans. In this role I started a multi-disciplinary Women Veterans Advisory Committee to evaluate the current status of health care delivery and address the gaps that exist within the PVAMC. I met with PVAMC executives and provided them with national statistics which project that the women veteran population accessing the VAMCs will double within the next five years. Due to the close proximity of military bases and the high level of active participants within the reservist population in the Pacific Northwest these numbers are likely to be even higher than the national figures (U.S. Department of Veterans Affairs, 2007).

Desired outcomes

Intermediate:

1. Evidence-based recommendations for the PVAMC to improve healthcare outcomes for women veterans.

Long-term:

1. Implementation and evaluation of programmatic and clinical changes in the PVAMC that improve health care outcomes for women veterans.
2. Development and dissemination of needed services for women veterans throughout the PVAMC.
3. Dissemination of information to the women veteran community on available services and access.
4. Evidence-based guide for other local, regional, and national VAs for women veterans' health care.

Purpose statement

The purpose of this clinical inquiry project is to complete a program evaluation that describes the current status of women veterans health care at the PVAMC and provide evidence-based recommendations that improve health care outcomes for women veterans. The development of a model that reflects these recommendations can then be applied to multiple clinical settings which currently experience gaps in the quality of health care being provided for women veterans.

The Clinical Inquiry Question(s) are:

1. What are the clinical characteristics (demographics and most common diagnosis) of women veterans using the PVAMC?

2. What are the current barriers that women veterans experience in accessing health care at the PVAMC?

Conceptual Framework

The conceptual framework for this inquiry has three components: Population Needs, Existing Services, and Population Outcomes. The analysis will explore how Population Outcomes (such as patient services provided along with the numbers of women served) are related to the nature of Existing Services and the extent to which Population Needs are met.

Needs

It is critical to note that the population of women veterans is rapidly changing. For example, these women are likely to have experienced mental health challenges from serving in combat zones, and may have suffered from trauma imposed by military colleagues in what is termed as military sexual trauma (MST) (Department of Veterans Affairs, 2004). This reality has important implications for delivery of health care to women veterans, requiring that service providers be sensitive to the possible experienced trauma while in the military. Clinical settings need to enhance the veterans' feelings of safety and privacy to ensure that they feel comfortable to pursue VA health care throughout their lifetime (Yano et al., 2006).

New challenges related to women veterans' physical health concerns also need to be considered. With this younger cohort, maternity services and birth control must be addressed. Along with the physical and mental challenges experienced by young women, these women veterans are more likely to be single, raising children and pursuing an education when compared to their male counterparts (Hayes, 2008).

Gynecological services, which historically have not been a part of the VA medical structure, are now needed on a regular basis. Research has found that women veterans use the VA health

services more frequently than do males (Hayes, 2008). In fact, due to their need for gynecological exams, women are routinely advised to use the VA services annually. Yet it has been shown that women veterans often times do not access the VA for their health care needs due to a lack of awareness about the services the VA provides (M. Martin, veteran representative, personal communication, 2008). For example, in Oregon there are over 25,000 women veterans – most in the Portland catchment area – and to date only 3,972 use PVAMC services (U.S. Department of Veterans Affairs, 2007).

Existing Services

Research surveys have shown that women who have had negative experiences related to health care at the VA are unlikely to return. Often, lack of access to gender-sensitive women providers is cited as the reason (Lee, Westrup, Ruzek, Keller & Weitlauf, 2007).

Educational conferences called “mini-residencies” that address basic primary care women’s health issues have been sponsored by the national VA to address this need within the VAMCs, but few providers have yet taken advantage of this education (U.S. Department of Veterans Affairs, 2007). Until there is an applied model which functionally addresses these concerns, it may be difficult to convince women veterans to use their health benefits at the PVAMC.

Outcomes

The degree to which existing services correspond to needs and provide appropriate clinical environments and professionally competent care influences patient satisfaction and ultimately affects the number of women served. The following diagram depicts how an evaluation of the current women’s health care services can lead to beneficial health outcomes for women veterans.

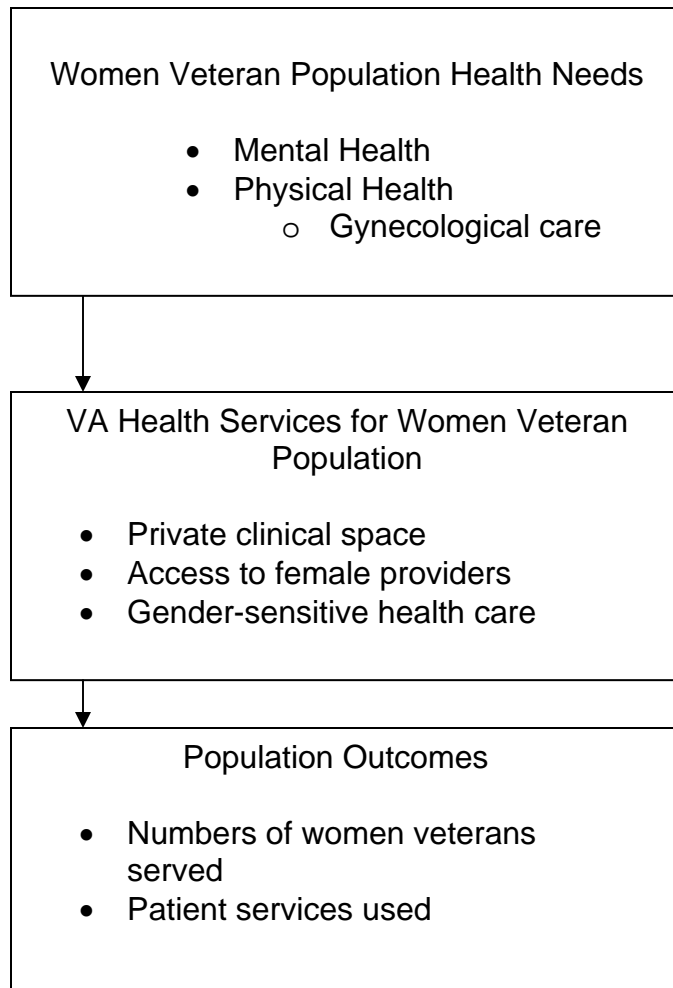


Figure 1. Women Veteran Care Needs, Health Services, and Population Outcomes

Review of Literature

There is little research on the health care needs of women veterans. The lack of research is at least partially due to the fact that the increase in women veterans within the military is a relatively new phenomenon. The growing number of women in the military is reshaping the veteran population. The Department of Defense collects data at the inception of military duty for women, but little information about these women exists after they become veterans (Yano et al., 2006). The research that does exist consistently suggests the need for more study. Furthermore, the situation is intensified due to the fact that women generally seek medical care more frequently than males (possibly due to socialization to seek health care throughout their life span) (Parkman, 2004).

Statistics indicate that 87% of women veterans do not access the VA health care services to which they are entitled (Washington et al., 2006). There is much speculation as to why this gap exists and research is beginning to assess productive ways of changing this trend (Ouimette, Wolfe, Daley, & Gima, 2003).

The VA Office of Research & Development (as of 2004) commissioned a research team to conduct a systematic literature review to assess what current research exists related to best treatment practices for women veterans. A profile of potential users of the VA system was established based upon 1500 women veterans surveyed from the Department of Veterans Affairs National Registry of Women Veterans. Users are most likely younger women without medical insurance, ethnically diverse and having less financial resources than male veterans (Ouimette et al., 2003). How to best serve these veterans and the appropriate clinical model with which to serve them is still not determined (Yano, personal communication, 2008). Consequently,

vigorous debate continues at the national level of the VA on how best to deliver care to this growing population.

One of the reasons for the lack of specific information relevant to the topic of this clinical inquiry is related to obstacles in studying women veterans. Five barriers to conducting research on women veterans have been identified (Yano, 2006):

- The lack of a network for recruiting women for research
- Identifying and accessing women in the community who do not use the VA
- Lack of coordination with the Department of Defense to track these veterans after demobilization
- Lack of centralized databases containing contact and demographic information for women veterans.

The research to date breaks roughly into two categories. First, what are women veterans' needs and what is their health care experience? Second, what services do women veterans need and what is the gap between the ideal and those services that currently exists?

Women's Needs and VAMC Environment

It has been shown that generally women attempt to create a "network of care" involving all of their health care providers; this allows them to be part of the decision making process in relationship to their treatment and health care outcomes (Parkman, 2004). These conditions for women currently do not exist within most VAMCs due to a relative dearth of available services and trained providers (Lui, Yano, Ranson & Maciejewski, 2004). Numerous anecdotal reports suggest that women experience indifference and discomfort with the standard environments they experience when seeking health care at VA facilities (Fontana & Rosenbeck, 2006). Some women veterans have voiced these concerns to local representatives of the women veteran

population (C. Holt, personal communication, September 15, 2007; D. Benjamin, personal communication, October 23, 2007).

A study on women's health provided in the private sector concluded that women preferred their care to be provided by women providers (U.S. Department of Health and Human Services, 2007). The research suggested this was due to women physicians typically spending more time with their patients than male physicians, and engaged in more active partnership behaviors. This was defined as being more talkative, disclosing more medical and psychosocial information, and making positive statements about health outcomes (Roter & Hall, 2004).

Few studies have researched how PTSD and MST affect women veterans use of the VA health system (Kelly, Vogt, Ouimette, Daley & Wolfe, 2008). Vogt (2006) suggests that women veterans with PTSD and MST are generally less healthy than their non-veteran women counterparts, yet have emotional and physical impairments that hinder them from using the VA (Vogt et al., 2006).

A survey of women veterans revealed their need to feel the VA provides is safe and accessible (Goldzweig et al., 2006.) Women veterans who have experienced MST are reluctant to seek health care where patients in the waiting rooms are predominantly male (Vogt et al., 2006 and Polusny, Dickinson, Murdoch & Thuras, 2007). Women reported that embarrassment and lack of privacy in the VA clinical setting were reasons for avoiding the VA (Federman, Kravetz, Fancgchao, & Kirsner, 2007).

Available care versus women veterans' needs

As previously mentioned, the needs of women veterans in general are changing due to new military roles. Women are increasingly deployed in combat zones that expose them to increased risks of multiple forms of trauma (Murdoch et al., 2006). These conditions range from

orthopedic complications to mental health issues. MST is reported by over half of the women returning from active duty (Goldzweig, Balekian, Rolon, Yano & Shekelle, 2006). This trauma coupled with low social support from family, friends, and institutions on homecoming are factors that contribute to women veterans' inability to initiate positive health seeking behaviors (Yano, Goldzweig & Washington, 2006). Research indicates that additional study of treatment programs for women veterans suffering from PTSD as related to MST is needed (Goldzweig et al., 2006.)

It is thought that lack of information about VA services including breadth and access of care, along with negative perceptions of VA quality and perceived inconvenience of VA care, may explain why many women veterans are not using the VA for health services. Further, Goldzweig (2006) states that little research has been done to evaluate the type of clinical programs that would best meet the needs of this population.

The sequelae of MST present further challenges to treatment. Studies indicate that MST causes women to avoid annual healthcare such as breast, pelvic and rectal examinations (Lee et al., 2007). Due to their trauma, a number of these females have additional symptoms such as depression, substance abuse, chronic pain, and eating disorders (Monnier, Grubaugh, Magruder & Frudha, 2004).

The research to date also indicates that women veterans need mental health services provided in combination with general medical care (Burger, 2005). Having these services in one main health care area is a model that has gained increased acceptance and has shown an increase in use by women veterans (Yano et al., 2006).

Summary

Serving the needs of women veterans is vital to the mission of the VA. Multiple challenges inherent to the PVAMC need to be addressed as the numbers of women using the VA

health care system increases. The women veteran population is now largely under the age of 40, single, and often pursuing additional or higher education. Many of these women have been physically and sexually traumatized while serving in the military, complicating their needs and desire to use VA services.

Attempts have been made to mandate general standards of care, but wide discrepancies exist in application of these mandates. In some instances, cost considerations prevent implementation within VA medical centers (Yano et al., 2003). Efforts geared toward mediating these gaps, standardizing best practice guidelines, and training gender proficient health care providers are viewed as having the potential to greatly improve conditions for women veterans seeking health care at VAMCs (Ouimette et al., 2003).

The available research indicates that the VA medical centers are largely unable to meet the physical, psychosocial and emotional needs of these females. It's critical to the health and wellbeing of women veterans that the medical community diligently identifies and implements needed care and best practice guidelines to ensure that the needs of this population are met. Further research is needed to understand clearly how to best meet the needs of this cohort. This research project will identify the services needed and the appropriate delivery of those services at PVAMC to meet the growing needs of women veterans.

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Clinical Evidence Table

Synopsis			Findings		Clinical Applicability
Citation	Clinical Question	Design	Credibility	Significance	Applicability
Author & Year	Hypothesis, Variables under study	Design Sample Population Would you change anything?	Rigor in data collection & analysis	Statistical & clinical significance Level of Evidence	To whom and under what situations could findings apply? Can these be applied to your inquiry?
1 Bean-Mayberry, et al., 2006	Do women receive a lower quality of outpatient care due to gender?	Randomized section of 86,000 patients across the US looking at quality of care in seven common health concerns. Would focus on environment specific to psychosocial needs of women veterans.	Qualitative study; data collection. Good sample, reliable data.	R= reliable; sample size adequate to reach statistical significance, would consider using data for my research. Level of Evidence=I (Melnyk).	Would apply to women patients in my research arena; can be applied to my clinical inquiry.
2 Saldago, et al., 2002.	Do findings suggest that negative health outcomes occur due to gender inequities within the VA health system?	VA women patient care contrasted with non-veteran women patient care in private sector. Establishes benchmark for comparison.	Abundant study comparisons, rich resource material	R= reliable; Would use data for comparative research links in my research paper. Melnyk level II.	Applies to my clinical inquiry question in regard to standard quality of services which should be offered women patients.
3 Ashish, et al., 2005.	Do gender differences within the VA healthcare	Wide random sample of women VA patients and	Wide sampling with generalized	R=reliable study. Melnyk level IV.	Large general population of womens studied –

	system over 2 years show significant findings?	their purpose for accessing VA healthcare system.	sampling questions		general information useful in a descriptive and qualitative application
4 Washington, 2007.	What are the challenges of conducting research of women veterans? What needs exist for studies which focus on perspectives and experiences of women veterans?	This is more of a discussion of the challenge of research design and the various models used for study currently. Is not directly related to an evaluation of clinical adequacy in VA.	Well written and thoughtful article. Showed breadth of experience in this research area.	NR= not reliable; great article but not useful for data analysis. Melnyk level V.	Could be useful for design ideas which have been tried and succeeded or failed.
5 Duggal, et al., 2005.	What has been the experience of women returning from Iraq and Afghanistan in relationship to their ability to access quality healthcare ?	Analysis of clinical utilization data from the VA's electronic medical record for returning veterans. Useful for understanding access to information within the VA for purpose of comparison with current data to be collected for CIQ.	Clinically significant data collection with significant outcomes.	R= Reliable; evidence based on systematic review of relevant controlled research. Melnyk level I.	Useful research and comparisons of groups addressed in clinical inquiry.
6 Lurie, et al, 1993.	Does sex of the physician factor into the utilization of VA womens in	Examination of rates of cancer screening among women based on sex of	98,000 between ages 18 – 75 years over 17 year	R= reliable. Useful in providing data related to reasons	Useful for later discussion in proposing solutions for

	the VA healthcare system?	provider. Useful information when used in light of psychosocial factors affecting use of VA health care by women veterans.	period.	for utilization, somewhat related to this clinical inquiry. Melnyk level IV.	possible inequalities in methods of providing VA healthcare.
7 Yeager, 2007	Do womens face unique challenges as combat victims after returning from war?	Qualitative information sampling from LA, Calif, VA. Not national representation. Would require broader sampling for national application.	Credible and relevant information, but not wide sampling.	R= Reliable data, but more random sampling needed. Melnyk level V	Would apply to my clinical inquiry, but additional information needed.
8 Meehan, 2006	What do statistics show regarding the growth in number of women veterans and their use of the VA?	Overview of challenges facing health care provision by VA. Useful analysis.	Relevant, large sample	R= Reliable Wide sampling. Melnyk level III	Applies to clinical inquiry question. Useful data.
9 Murdoch, 2006	What needs should be recognized by providers when providing health care for women veterans?	Paucity of information known by providers related to this population exposed. Useful for CIQ.	Clinician's exposure to this population's needs	R= Reliable Solid research, historic overview. Melnyk II	Applies to clinical research goals of evaluating current VA clinical conditions.
10 Lee, 2007	Is there a relationship between patient anxiety and gender of provider?	Cross sectional pilot study assessing methods of anxiety reduction in clinical	Study of 31 women veterans with hx of sexual trauma	R= Reliable Self report instruments, anxiety levels assessed related to	Applicable to clinical research question and inquiry.

		settings. Useful for inquiry/evaluation of VA clinics.		physical exam Melnyk II	
11 Goldzweig, 2006	What is the state of women veteran's research within VA currently? What is the influence of MST and PTSD on the evaluation of women veterans and their experience of VA health care?	Measurement of 182 studies PTSD and health status of women veterans. Would use larger n in future evaluation.	77 studies pertaining to stress of military life	R = Reliable Rates of harassment and relationship to health status assessed Melnyk II	Applicable to research question and posed clinical inquiry question.
12 Yano et al, 2006	What clinical conditions are needed to meet the needs of current population of female veterans?	Surveys of 1500 female veterans assessing clinical preferences	Multiple studies – one ongoing assessing 3,000 females currently accessing VA clinical use.	R = reliable. Identifies gaps in service and need for increased research.	Very applicable in current findings and potential research data.

RUNNING HEAD: STATUS OF WOMEN VETERANS' HEALTH CARE AT THE
PORTLAND VA MEDICAL CENTER

NUR 703: Clinical Inquiry Methods

Women Veterans' Health Care

at the Portland VA Medical Center

Nancy Sloan

The recent influx of women using the Veterans Administration (VA) health care system has created challenges to providing adequate health care for women veterans. Literature has shown that women veterans are not receiving comparable health services to male veterans due to the VA being historically focused on providing health care for males. The literature further indicates that health care needs for women veterans are significantly different than for male veterans. For example, diagnosis of military sexual trauma (MST) and post-traumatic stress disorder (PTSD) occur more frequently among women veterans, suggesting that a different health care environment is needed if they are to feel comfortable while accessing health care services at the VA. Data needs to be gathered to assess what current gaps exist in health care delivery and what interventions are needed to improve health care services for women veterans. This clinical inquiry/program evaluation will address this issue in relationship to the Portland VA Medical Center (PVAMC).

Recent mandates designed to improve health care for women veterans within the VA on a national level have served to make this investigation timely and have made women veterans' access to PVAMC health care a high priority. The media also serves to continually heighten public awareness regarding existing disparities among this cohort throughout the VA health care system.

The low numbers of women veterans accessing the PVAMC for health care currently suggests that barriers exist that prevent use of VA health care. This inquiry is two-fold:

- 1) Identify services that are needed based on the most frequent diagnoses experienced by women veterans currently using the PVAMC and;

- 2) Discover what current barriers discourage women from using PVAMC health care services.

***Clinical Inquiry Design
Program Evaluation***

This clinical inquiry/program evaluation will serve to reveal current gaps in health care for women veterans at the PVAMC. It is also hoped that the barriers women veterans experience when attempting to use the PVAMC will be identified. From the data gathered, interventions can be made which address the disparities and barriers identified. To date only one third of the national VA Medical Centers have dedicated women's health clinics; therefore the information gained will be useful and applicable to other VA Medical Centers around the country (Veterans Administration, 2007).

Clinical Inquiry Questions (CIQ):

- 1) What are the clinical characteristics (demographics and most common diagnoses) of women veterans using the PVAMC?
- 2) What are the current barriers that women veterans experience in accessing health care at the PVAMC?

This clinical inquiry/program evaluation will use a cross-sectional, descriptive design. The data for CIQ #1 will be drawn from Veterans Support Service Center (VSSC) data base *ProClarity*. *ProClarity* is used by the VA to collect statistical information that is used locally, regionally, as well as nationally, to evaluate the types and use of services within the institution and guide the VA as it evaluates current programs and prepares for future needs of veterans. It will provide demographic and clinical characteristic data for this clinical inquiry on clinical characteristics and demographics of women veterans who have accessed the PVAMC during the year beginning July 2007 through June 2008. In

addition to the demographic data collected, this study will also analyze most commonly occurring diagnosis (using ICD-9 codes) experienced by women veterans.

To answer CIQ #2, this program evaluation will use three focus groups held over the 12 week inquiry period in a location off the PVAMC campus. Three groups are chosen as a feasible number of groups to hold on a once a month basis over the inquiry period. Each group will consist of five to six women veterans (this is the recommended number advised when personal/sensitive information may be elicited during the focus group) (Morgan, 1997). The first two groups will be made up of women who are currently using the PVAMC for their health care services and the third and last focus group will be made up of women veterans not currently using the health care services at the PVAMC. Results from the focus groups will be contrasted. Non-users will be additionally queried about why they do not use services offered at the PVAMC. Participants in these focus groups will be women currently eligible to receive health care through the PVAMC. The women veterans' participation will be on a strictly voluntary basis.

Fliers advertising the purpose of these groups along with location and time of the focus groups will be placed in locations to maximize attendance in these groups (such as local veteran centers, community colleges, and the PVAMC women's health exam rooms). After arriving for the focus group the women will be given an information sheet outlining the purpose of the inquiry in detail and assuring the participants that no information they volunteer will serve as personal identifiers when the data is shared. This information sheet will serve as consent for participation in the focus group (when discussing this inquiry design with the IRB analyst the investigator was informed that due

to the nature of this inquiry it would not be necessary for the women to sign this information sheet). These participants will then be asked five questions in the course of the focus group (see section Data Collection Procedures). These questions will serve to gather details on barriers women veterans perceive when using the PVAMC. This inquiry design does not require that a control group be involved.

Clinical Inquiry Question #1: What are the clinical characteristics of women veterans using the PVAMC? This inquiry question is designed as a cross-sectional descriptive design. Diagrammed it would appear as:

O

Clinical Inquiry Question #2: What are the current barriers that women veterans experience in accessing health care at the PVAMC? This inquiry question would be cross-sectional, qualitative, and descriptive design. Diagrammed it would appear as:

O

Setting

This project will be conducted at the main campus of the PVAMC and the Veterans Center on Sandy Boulevard in Portland, Oregon. The PVAMC is a large medical institution which houses the primary care outpatient services for veterans. Within the primary care division there is a women's health clinic which operates four days per week. This currently consist of two exam rooms which are located in a semi-private section of the main clinic. The investigator for this inquiry/evaluation is the only clinician/provider providing services in this setting at this time.

The Veterans Center on Sandy Boulevard in Portland, Oregon consists of office space on the lower level of a mid-size business complex. It is centrally located in Portland and will be easily accessed by women veterans. Currently multiple social and educational activities related to women veterans are organized through this center and it is well known and will be considered a neutral location by women veterans. It is staffed by four social workers who oversee the activities and arrange services for veterans seeking various kinds of social assistance.

Recent mandates designed to improve health care for women veterans within the VA on a national level have served to make this investigation timely and have made women veterans' access to the VA health care a high priority. The media serves to heighten public awareness regarding existing disparities among this cohort throughout the VA system. Although the setting for this clinical inquiry will be the PVAMC it is hoped that the findings will be generalizable to other VA medical centers nationally.

CIQ #1 Setting The data collected for CIQ #1 will be from the VSSC *ProClarity* electronic database. It is a national VA data base which is used by the local PVAMC to collect statistical data for billing, coding, and patient demographics. It is populated with data entered by PVAMC employees and is updated on a monthly basis. Demographic data in this data base includes gender, age, ethnicity, years of education and distance of travel required to access services at the PVAMC. As previously mentioned, also available through this data base are ICD-9 codes which identify the specific health services accessed by veterans when using the PVAMC. Technical assistance for accessing this data on a local and regional level will be provided from the computer and data technicians along with information analysts associated with the PVAMC.

CIQ # 2 Setting The three women veterans focus groups organized for CQI #2 will be held at the Portland Veterans Center located on Sandy Boulevard, in downtown Portland. Five prewritten questions will form a questionnaire to guide the group in a 60 to 90 minute discussions. Fliers announcing the focus group's time and location will be distributed by the investigator of this inquiry, the representative of the Portland Veterans Center and the women's health nurse at the PVAMC. These fliers will be placed in locations where veterans will likely see them, such as community colleges, local veteran centers and the PVAMC women's clinic exam rooms. Those aiding in the distribution of the fliers will have no other involvement in the program evaluation. The contact information for the investigator will be available on the fliers for the women veterans who may desire to participate and/or have further questions about focus groups.

The investigator for this clinical inquiry serves as the PVAMC Women Veterans' Program Manager and the Chair of the Women's Health Advisory Committee. In these roles the investigator is able to regularly involve principle parties at the PVAMC about feedback and eventual implementation of the final recommendations. The PVAMC has recently approved of 3,000 square feet of dedicated clinical area which is ear-marked for the development of a Comprehensive Women's Health Center. The investigator has been highly involved in the allocation of this area and will be intricately involved in the education and training of staff to implement best-practice design for this future clinic.

Sample

The women veteran patients who are eligible to use the PVAMC comprise the target population for this clinical inquiry. This population is made up of women over the age of 18 of various ethnicities who have served in the military for any given period of

time (to serve in the military it is understood these women are US citizens and speak English). To date, the total number of the women veteran population enrolled for health care services at the PVAMC is 3972. This population of women veterans is projected to double within the next five years according to current estimates from the Department of Defense. The fastest growing segment of this target population are women veterans under the age of 40, single, ethnically diverse, and currently pursuing higher education. The samples that will be used to answer each clinical inquiry question are described below.

CIQ # 1 Sample The data collected for CIQ # 1 will be from VSSC *ProClarity* electronic medical records (see above for description of data base) and will look at data for women veterans currently using the PVAMC. This data will be pulled for the year beginning July 2007 through June 2008. This time frame is chosen to capture the data that has had opportunity to be fully integrated into the *ProClarity* data base and will also capture the most recent influx of women veterans at the PVAMC. This data will be descriptive in nature with the purpose of identifying the demographic and clinical characteristics of women veterans eligible to use the PVAMC.

CIQ # 2 Sample The population sample for CIQ # 2 will be drawn from all women veterans eligible to access health care at the PVAMC. These women veterans will be invited to participate in three different focus groups on three occasions over the course of the 12 week clinical inquiry period. These groups will be held at the local Portland Veteran Center on Sandy Boulevard in downtown Portland. Their participation will be on a strictly voluntary basis. The first two focus groups will be made up of women veterans who are currently using the PVAMC for their health care. This group will be leveraged to contact women veterans they know who are not currently using the PVAMC for their

health care. Each focus group will consist of five to six veterans. Participants in these focus groups will have to be eligible for health care through the PVAMC. Recruitment strategies are described in the procedures section of this proposal.

Data Collection Procedures

CIQ #1 Procedures For CIQ # 1 this evaluation will use the VSSC *ProClarity* electronic database to gather data that will serve as a focused database to illustrate the current health care disparities which exist between men and women's health care within the PVAMC. The procedure for extracting the data and de-identification for use in this project is: sorting the data into demographic classifications of age, years of education, distance needed to travel to the PVAMC, marital status, and ethnicity.

CIQ #2 Procedures Focus groups will be made up of five to six women veterans within the PVAMC catchment area who are eligible for health services at the PVAMC. Five sample questions will serve as a pilot for four to six women seen at the PVAMC's women's health clinic. The veterans will be asked these after their regularly scheduled appointments at the PVAMC. Questions will be given prior to these women to assess if the questions elicit the targeted information for the inquiry. These pilot questions will also test for clarity and validity. The appropriate questions will then later be used to encourage group discussion in focus groups to uncover barriers related to their access to the PVAMC. The investigator will eliminate questions that do not elicit information relevant to the inquiry. If they do not, the investigator will accordingly revise the questions. No record will be kept of these conversations and no personal information about the participants will be recorded or distributed.

Dr. David Morgan, from Portland State University, and author of *Focus Groups As Qualitative Research*, will be providing technical assistance for the first draft of this guide and will provide coaching to the investigator on techniques which lead to successful focus groups. The investigator will also arrange a lunch and learn to further assist in the process of the focus groups for this inquiry.

The focus group discussions will be audio-taped and later transcribed for the purpose of evaluating the data. The tapes will be destroyed after being transcribed. If the patient answers affirmatively, the pilot questions will be posed in the exam room at the conclusion of the examination procedure.

Recruitment for focus groups

Fliers will be posted in areas within the women veterans' clinical area at the PVAMC, local veteran centers, local community colleges and employment centers frequented by women veterans (*see attached draft flier*). The flier will have phone and contact information to allow veterans to contact the investigator of this inquiry.

The local women veteran representative, Mandy Martin, will be contacted to facilitate recruiting women veterans who frequent the main Portland Veteran Center and will also post fliers in the local Veterans Center on Sandy Boulevard. The first two groups will focus on women who are using the PVAMC. The women in the first two groups will be asked to help the investigator to recruit women who are not using services. These women will be asked to distribute fliers to women veterans they know who are not using services at PVAMC.

Pilot questions proposed for focus groups

- *What services do you use at the PVAMC and what others do you know to exist at the PVAMC?*
- *What additional services do you feel are needed at the PVAMC?*
- *What barriers do you experience when attempting to access PVAMC services?*
- *What do you believe prevents other women veterans from using the PVAMC?*
- *What are your perceptions of the breadth or quality of health care for women veterans when using the PVAMC?*

If these questions capture the targeted data they will then be used in the first two focus groups held at the Veterans Center. An additional question to these will be posed to the third focus group of non-users of the PVAMC which will gather information on why this cohort does not currently use the PVAMC. A sample of this question would be: *What current barriers stand in the way of your using the PVAMC for your health services?*

Focus Groups Interviews

Focus group interviews will be conducted at the Portland Veterans Center on Sandy Boulevard, in Portland, Oregon. Focus group interviews are expected to last 60-90 minutes depending on the amount of information each participant shares. Each session will be audio tape-recorded with two tape recorders to ensure no loss of data will occur due to equipment failure. This information will be later transcribed by the investigator.

An information sheet explaining the ground rules of the session will be distributed to each participant prior to each session. This information sheet will also outline the purpose of the clinical inquiry and the methods used for gathering the information. The fact that the focus groups will be audio-taped and later transcribed will be disclosed to the participants at the beginning of the session. The information sheet will serve as consent to

their participation in the focus group. The participants will not be asked to sign this information sheet. The participants will be assured that any identifying information related to them will remain confidential and be properly secured by the investigator. The participants will also be informed that the information gathered will be used in a presentation which will be part of an oral doctoral defense to be delivered at the end of the OHSU Doctorate in Nursing Practice program in May, 2009. Participants will be invited to disclose any concern they have related to personal identification or methods of inquiry prior to starting the focus group sessions.

If there is a lack of attendance in the initial focus group there will be a revision to the recruitment strategy such as telephone outreach and direct invitation. Collaboration with the local Veterans Benefits Administration will also be considered if more participants are needed to participate in the focus groups (Veterans Benefits Administration is able to arrange mail-outs to veterans).

The information gathered will be initially locked in file boxes and stored in the investigator's locked office at the PVAMC. All electronic data gathered will be kept in confidential electronic files and will be password protected. All hard-copies of gathered data will be destroyed once it has been entered into the electronic database.

Measures

CIQ # 1 Variables For CIQ # 1 demographic and health data of women veterans for the year July 2007 through June 2008 will be pulled from the VSSC electronic data based *ProClarity*. This data based is populated with data from the regional Veterans Administration Hospitals located in Alaska, Idaho, Washington and Oregon. This data can be pulled which is specific to each Veteran Hospital's catchment area. The data the

investigator will pull for this investigation will include demographic information for women veterans related to age (in years), ethnicity (Caucasian, Hispanic, Non-White, African American, Pacific Islander and Other), education (in years of schooling 1-16 years), marital status (0 = currently married or partnered 1= not married or partnered), employment status (0= yes 1 = no), and distance of travel from domicile to the PVAMC (0 = 1-10 miles, 1 = 10 – 20 miles, 2 = 20 – 40 miles, 3 = 40 miles and above).

Health variables will also be pulled from the same database to identify the ten most frequent diagnosis experienced by women veterans. Possible diagnosis will include depression, military sexual assault, post traumatic stress disorder, gynecological complications, hypertension, orthopedic injury etc. Understanding the most frequent diagnosis which bring women veterans to the PVAMC will provide valuable information to the investigator and those designing future programs for women veterans.

Variables and associated measures:

Variables	Measure	Level of Measurement
Demographics:		
Ethnicity	White, Non-white, Black, Hispanic, Pacific Islander, Other	Nominal
Education	Year in schooling	Interval
Marital Status	Single, Married, Partnered, Divorced, Widowed	Nominal
Employment Status	Employed, Not- employed, Student	Nominal

Distance of PVAMC from domicile	Miles	Interval
Age	Years	Interval

Clinical characteristics related to most frequent diagnosis experienced by women veterans will be gathered and organized into a data base set and will be entered into SPSS (version 15.0). After organizing this informational data into designated categories it will be displayed graphically by histograms and pie charts to convey the information to those interested in the outcomes of this clinical inquiry/program evaluation.

CIQ # 2 Variables For CIQ # 2 this inquiry will use focus groups organized to answer semi-structured questions using a focus group guide developed by the investigator. The topics that will be covered include:

- *What services do you use at the PVAMC and what others do you know to exist at the PVAMC?*
- *What additional services do you feel are needed at the PVAMC?*
- *What barriers do you experience when attempting to access PVAMC services?*
- *What do you believe prevents other women veterans from using the PVAMC?*
- *What are your perceptions of the breadth or quality of health care for women veterans when using the PVAMC?*

Analytic Methods

CIQ # 1 Analysis To find the ten most frequent clinical characteristics and diagnoses of women using the PVAMC, this inquiry will use the VSSC *ProClarity* data base. Demographic and clinical data will be entered into SPSS (version 15.0) to organize

the data for identification of trends in clinical characteristics of women veterans. This study will use a t-test for continuous dependent variables. A chi square will be used for analyzing the nominal/categorical dependent variables

CIQ # 2 Analysis Transcripts from the focus groups will be read in detail to capture common themes within the discussion of the focus groups. These themes will then be coded in a way that will illustrate most common barriers to less common barriers experienced by women veterans. These codes generated from the transcripts will serve to provide informational data which can then be displayed graphically to illustrate trends and patterns experienced by women veterans when using or not using the PVAMC.

Protection of Human Subjects/Ethics

The data from the PVAMC electronic database will be gathered according to OHSU Internal Review Board and PVAMC guidelines. All patient identifiers will be removed prior to any presentation of any data sets.

The participants in the focus groups will be given an information sheet outlining the purpose of the clinical inquiry and the methods used for gathering the information. The fact that the focus groups will be audio-taped and later transcribed will be disclosed to the participants at the beginning of the session. The information sheet will serve as consent to their participation in the group. The participants will be assured that any identifying information related to them will remain confidential and be properly secured by the investigator. The participants will be informed that the information gathered will be used in a presentation which will be part of an oral doctoral defense to be delivered at the end of the OHSU Doctoral in Nursing Program in May, 2009. Veterans who choose

to participate in the focus groups will indicate their consent by signing the information sheet.

The information gathered will be initially stored in locked file boxes and kept in the investigator's locked office at the PVAMC. All electronic data gathered will be kept in confidential electronic files and will be password protected. All hard-copies of gathered data will be destroyed once it has been entered into the electronic database. All information will be de-identified and made anonymous to anyone later interested in the findings of this inquiry/program evaluation.

Plan for Dissemination to Key Stakeholders:

The results of this investigation will be delivered by power point presentation to OHSU faculty who make up the investigator's Doctoral Advisory Board and to other interested persons from the local PVAMC. PVAMC quality assessment and program evaluation standards and OHSU Internal Review Board protocol will be strictly adhered to in the dissemination of this data.

Timeline for Project

Inquiry Time Line

10/25/08	11/15/08	11/15/08 - 3/31/09	4/30/09	04/30 - 5/20/09	05/20/09
IRB Proposal Submission	IRB Approval	Data collection Focus groups	Data Analysis Complete	Clinical Inquiry Project preparation	Defense of Clinical Inquiry Project

Running Head: STATUS OF WOMEN VETERANS HEALTH CARE

Research Findings

Nancy Sloan

Oregon Health & Science University

The recent influx in women using the Veterans Administration (VA) for their health care has created multiple challenges within a health care system that historically has focused on the health of male veterans. It is estimated currently that 15 % of active duty military are women, and this percentage is projected to increase to 20% within the next year. It is further projected that in five years the number of women veterans using the VA Medical Centers will double (U.S. Veterans Administration, 2007).

The sample for the first part of the clinical inquiry was drawn from data pulled from electronic databases at the Portland Veterans Administration Medical Center (PVAMC) for women veterans who have used the PVAMC for their health care from July 1st 2007 through June 30, 2008. The total number of women veterans sampled was 5916.

It was difficult to obtain a clean data sample as the PVAMC does not have a data system specific to women veterans. There was inadequate time available to identify where the data might best be found among multiple systems, and few technical advisors available who knew how to access the system(s) to identify and then pull the wanted data. As mentioned above, other difficulties included the existence of multiple electronic data sets that gave different results and challenges related to understanding which data set was the most reliable and valid. The facilitators in obtaining the sample data were the systems analyst at PVAMC, who made an effort to organize the data, and the statistician at OHSU. All data were de-identified to protect human subjects represented within the data. The inquiry and data acquisition were approved by the appropriate Internal Review Boards for both organizations involved in the inquiry.

Findings Clinical Inquiry Question (CIQ) # 1

CIQ # 1: What are the demographic and clinical characteristics of women veterans currently using the PVAMC?

This clinical inquiry used a cross-sectional descriptive design. The data for the first part of the inquiry were gathered from the Veteran Support Service Center (VSSC) data base, *ProClarity*. VSSC data provided demographic data and clinical characteristics represented by diagnosis ICD-9 codes for women veterans who accessed the PVAMC throughout the year beginning July 1st, 2007 through June 30th, 2008. The demographic variables were gender, age, marital status, ethnicity, and distance of veteran domicile to the PVAMC, assessed by zip code. The results of the demographic variables are seen in Table 1.

Table 2 shows the total number of women enrollees and users by year for the years 2002 through 2009. This table demonstrates an increasing trend in women veterans using the PVAMC. The most common diagnoses among women veterans by age group are shown in Table 3.

This data show the number of women using PVAMC services is growing substantially. The number of women veterans using VA services is expected to double in the next five years as the number of women in active service is projected to grow from 15% in 2008, to approximately 20% by 2010. Mental health, gynecological, and orthopedic problems are identified as the areas with largest usage by women veterans in the under-66 age categories. The youngest age categories are expected to show the greatest population growth, with gynecological and mental health services being the most prevalent diagnoses for this age group, followed closely by orthopedic services. The majority of women using the PVAMC traveled over 50 miles from their home to access health care. This was calculated by compiling zip code data of the women veterans using the PVAMC and pulling the most frequently occurring zip codes among this population.

Much of the macro and micro financial considerations related to this inquiry had been made prior to the inquiry completion. This is because the researcher's position as the Women Veteran Program Manager provided her with an understanding prior to this inquiry of the budget allocated for remodeling of space for a Women's Health Center at the PVAMC. These financial considerations involve the allocation of money for staff proficient in women's health care, and equipment for providing health care to women veterans that takes into consideration the anticipated growth of this population at the PVAMC. Money has also been slated for the remodeling of 2850 square feet of office space to create a clinic dedicated to providing health care to women veterans. Future interventions that require financial support, such as additional equipment and personnel, will be guided by the findings of this inquiry.

Situation analysis CIQ # 1

This inquiry followed the timeline as described in the methods section of the Clinical Inquiry Project (CIP) paper. It was essential that the DNP student researcher advocate for the population of women veterans and that she collaborate with all key stake holders to ensure the success of this inquiry. The data gathered was successfully integrated into the inquiry and support anticipated results based upon daily interactions with women veteran patients at PVAMC. The key to success of the CIP was in carefully outlining the methods that would be followed prior to starting the inquiry. As a DNP student, the researcher sought to champion the project to the primary stakeholders, who provided enthusiastic support, and collaboration from multidisciplinary departments throughout the PVAMC.

Outcomes CIQ # 1

The first part of this inquiry highlighted the demographic and clinical characteristics of women veterans currently using the PVAMC. This proved to be important information for

understanding the characteristics of this population with regard to age and diagnosis and will better allow better preparation for future interventions in providing women veteran's quality healthcare. Understanding the impact created by the increasing numbers of women veterans and the change in the age distribution, specifically increasing numbers of young veteran women, also guides the development of appropriate services, treatment modalities and suitable pharmaceuticals. In addition, knowing that the younger cohort mainly uses the PVAMC for gynecological and mental health treatments will guide the hiring of staff proficient in these areas.

CIQ # 2

Table 4 depicts the characteristics of the women veterans who participated in the focus groups. Challenges in gathering this data for CIQ # 2 involved finding women veteran participants for the three focus groups and then ensuring they would attend. Recruitment efforts included extensive advertising, widely distributed flyers and Public Service Announcements on public radio station KBOO. All participants were given an information sheet that served as an informed consent prior to those participating in the focus group. The facilitators for the focus groups were the Vet Center personnel, who were very enthusiastic about the project, and allowed the researcher to use their main conference room on these three occasions. Another facilitator, the group therapist at the Vet Center, encouraged her patients to join the focus groups. The PVAMC women's health RN attended each focus group and made the veterans feel comfortable with the concept of the focus group, and ensured the tape recorders were working throughout the sessions.

Any personal identifiers gathered in the process of the focus groups were removed when transcribing the data, and the audio tapes and transcribed material from the focus groups were destroyed after they were coded for data analysis. The women's health RN also offered an

unbiased review of central themes gathered from the focus groups with the researcher prior to the final write up of the findings.

Findings CIQ # 2

CIQ # 2: What are the current barriers that women veterans experience in accessing health care at the PVAMC?

The qualitative data suggests that the primary concern for women veterans is the lack of a gender sensitive environment to receive their health care. This issue accounted for a significant number of the responses and represented all age groups. The second most significant issue was reflected in of many of the comments and dealt with the general lack of information about specific services available to women veterans. This was heard mostly from younger age participants. Poor access to services and perceived quality concerns were raised primarily from older age groups. From this it's clear that creating a gender sensitive environment, plus educational outreach regarding available services for women would have a positive impact on health care delivery for women veterans at PVAMC. See table 5 for summary of major themes with exemplifiers.

Macro and/or micro financial considerations CIQ # 2

The financial considerations of this particular project involve monies needed to hire staff proficient in women's health and build a women's health center to address the need expressed in the focus groups for a gender-sensitive environment to receive health care. Much of the needed funding has already been allocated for this purpose, as mentioned in this section for CIQ #1. Insights from the focus groups will guide the way financial decisions are made in relationship to women veteran's health care at the PVAMC. Ongoing focus groups and *ad hoc* inquiries will

contribute to the sustainability of this care and allow women veteran's health services to grow in an evidenced based manner in the future.

Situation analysis CIQ # 2

The clinical inquiry project went very well after the initial IRB approval was gained. Allowing time to advertise the focus groups was crucial. My role as a DNP student was to provide leadership advocating for the needs of this population. I took the lead to organize the focus groups and enthusiastically recruited participation in hope that positive change could be realized for women veterans. I built on the concept that the DNP is an agent for positive change for those experiencing health disparities. As a DNP student I acquired the skills and developed the confidence to contact appropriate organizations, educate them about the nature of the project, and influence them by educating them on the needs of this population.

Outcomes CIQ # 2

In addition to a need for a gender sensitive clinical environment, the information gathered from the three focus groups revealed that women veterans feel that there is a need for more information about women's health services at the PVAMC. As a result, the Women's Health Program Manager will need to increase outreach in the form of public speaking in local colleges, interviews with the media, and networking with PVAMC departments involved in re-introduction of veterans to the civilian life post-deployment.

The preference by women veterans for a gender sensitive environment in which to receive health care has increased sensitivity to the delivery of health care for women at the PVAMC. This clear outcome has confirmed the need to continue with the development and planning of a new Women Veterans Health Center at the PVAMC.

Executive Summary

Nancy Sloan, ANP, RN, CNS

Women Veterans Program Manager

Portland Veterans Administration Medical Center

Doctor of Nursing Practice Candidate, OHSU School of Nursing

This clinical inquiry project was selected because the number of women veterans who are using the PVAMC for health care has recently increased precipitously, and is projected to double in the next five years. The PVAMC, as true of all other VA medical centers, has historically focused on serving the health care needs of male veterans. Women veterans have unique physical and emotional challenges when attempting to use the PVAMC for health care.

This inquiry project was designed to gain better understanding of these challenges to guide future practice as it pertains to women veterans at the PVAMC. Data was pulled from electronic data bases to reveal the characteristics of women veterans who used the PVAMC in the year 7/2007 through 6/2008. Three focus groups were also held to gain an understanding of what women veterans perceive are barriers to using the PVAMC for health care.

The findings from the electronic data show that the women veterans who use the PVAMC, do so for a wide variety of physical and emotional needs, with the majority of younger veterans using the PVAMC for gynecological and mental health care. Data from focus groups suggests that the preferred model of health care for women veterans is gender sensitive, staffed by proficient female providers, and located in an environment that offers privacy and a feeling of safety. Women veterans generally felt there was a lack of information on the services for women provided by the PVAMC.

The DNP student is currently the Women Veterans Program Manager at the PVAMC, which facilitated gaining information about women veterans, and paved the way for her to take the lead in this project and bring it to a successful conclusion. The findings from this research will be vital in guiding future program development as the population of women veterans increases in the next few years.

*Discussion for Clinical Inquiry Questions # 1 and # 2**Context CIQ # 1 and # 2*

The settings for this inquiry were a) the PVAMC and; b) the Vet Center located on N.E. Sandy Boulevard. These settings were extremely useful to access electronic data on women veterans, and to directly interact with women veterans, and to provide the focus groups a neutral place to meet. The PVAMC provided areas for the distribution of flyers to increase the chances of women veteran's participation.

The findings were not unanticipated. The researcher had prior experience with this population. Numerous anecdotal comments from women veterans heard over the past 3 years and the literature suggest that women veterans have a preference for gender-sensitive environments to receive their health care (Yano et al., 2006). The focus groups confirmed this. It was also shown in this inquiry, and substantiated by previous research that much more information is needed to further understand the health care needs of this population (Vogt et al., 2006). As a result of the clinical inquiry, change is already occurring, and there is increased focus on women veterans by key stakeholders.

Interpretation CIQ # 1 and # 2

The findings from this inquiry support a need for ongoing evaluation of current health services and the service environments at the PVAMC to continuously assess performance against women veterans' health care concerns and needs. For example, the high number of women seen at the PVAMC for depression and PTSD implies that there should be periodic evaluation of the adequacy of mental health services to ensure these services are adequate.

Focus group findings clearly indicate that the environment in which women veterans receive their care has a direct impact on whether these women feel comfortable in using the

PVAMC health care services in the future. The research also revealed that a portion of women veterans are unaware of their eligibility, the processes for registration, or the services available to women. These findings support the need to change the current women's health care environment and increase efforts to reach veterans with information about PVAMC eligibility and services.

Limitations CIQ # 1 and # 2

There were two major limitations: a) adequate time and; b) an easily accessible database. Additional time would have allowed for a broader sampling of women veterans who are not currently using the PVAMC, as well as an opportunity to review the findings with the participants. This additional step likely would have allowed refinement of the findings and increased the richness of data. Additionally, *ProClarity* data sets to pull information specific to women veterans are still being developed and refined by the VA nationwide. As information specific to this population becomes more available and sophisticated, more comprehensive information will facilitate addressing the health care needs of women veterans.

Conclusions CIQ # 1 and # 2

This inquiry identifies the main barriers to care for women veterans at the PVAMC as: a) lack of a gender sensitive environment; b) inadequate information on eligibility and services; c) difficulty accessing the system and; d) a perception that the quality of health care is substandard. This information supports continuation of the project to develop a comprehensive Women's Health Center at the PVAMC. It also supports a need for more research to provide ongoing guidance in developing services for women veterans. Further, information dissemination and increased education are needed to ensure that women veterans are better informed to what is available to them at the PVAMC. This inquiry also suggests more research in best practice and standards of care is needed to maintain a high quality of health care for women.

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Table 1.

Socio-demographic characteristics of women using the PVAMC July 1, 2007 through June 30, 2008.

Total of Unique Visits (Initial single visit per individual veteran, not including subsequent visits)

1. Age	Number of Unique Visits	Percent
18-34	704	11 (%)
35-49	1256	21 (%)
50-65	2440	41 (%)
66-older	1516	25 (%)
2. Race / Ethnicity %	Number of Unique Visits	Percent
White	1356	22.9 (%)
African American	58	0.01 (%)
American Indian	27	0.005 (%)
Hispanic	34	0.006 (%)
Asian, Native Hawaiian or Pacific Islander	31	0.005 (%)
Other / Decline to Answer	4410	75 (%)
3. Marital Status	Number of Unique Visits	Percent
Married	1466	35.2 (%)
Single	816	19.6 (%)
Divorced	1395	33.5 (%)
Separated	159	3.8 (%)
Widowed	327	7.9 (%)
Unknown / Missing	1752	29.0 (%)

Note. n = 5916.

Note. Veterans living within 50 miles of PVAMC total 2316 or 39.1%.

Table 2.

Women Veterans – Enrollees and Users – at PVAMC 2002-2009

Year	2002	2003	2004	2005	2006	2007	2008	2009 (thru January)
Female Enrollees	3526	3775	4028	4265	4477	4574	4718	4709
Number of Users	2039	2269	2475	2560	2651	2780	2883	2477

Note. “Enrollees” are defined as women veterans who have enrolled in the year noted and may or may not have used the VA.

Table 3.

Diagnoses by Age Groups

Top Diagnosis by Age	18-34	35-49	50-65	66-older
Gynecological	52.17	31.87	28.48	34.37
Mental Health	42.90	48.26	42.99	23.40
Orthopedic	32.44	39.04	49.26	49.93
Neurological	13.88	16.57	12.70	19.08
Endocrine	06.13	14.87	28.48	37.25
Cardiac	01.11	04.68	32.67	84.97

Note. This table identifies diagnoses of women veterans seen between 7/1/07 – 6/30/08. Some women had multiple diagnoses, explaining total percentages for most diagnoses reaching over 100%.

Table 4.

Focus Group Sample

Total for All Focus Groups	Total	VA Users	Non-Users
Total for All Focus Groups	27	24	3
1 st Group	4	4	0
2 nd Group	12	11	1
3 rd Group	11	9	2
Age			
18-34	8	.20	.10
35-49	12	.45	.00
50-65	4	.15	.00
66-older	3	.10	.00
Race / Ethnicity			
White	24	.87	.03
African American	1	.03	.00
Hispanic	2	.07	.00

Table 5

Barriers identified by women veterans to using the PVAMC

Barriers identified and specific comments with central themes related to barriers to accessing health care at PVAMC

Theme	Descriptions/Exemplifiers
-------	---------------------------

Lack of Gender Sensitive Environment:

Gender sensitive environment is seen as an environment that has all female staff proficient in women’s health and without male veterans in the waiting room.

Specific comments by separate individuals:

“Health care providers have little knowledge of women’s health issues and lack sensitivity to women veterans’ unique needs.”

“Lack of access to female physicians and medical personnel for gender-related examinations.”

“I’m not comfortable in a room full of men in the waiting area. I feel they are gawking at me.”

“I don’t feel safe or that I have privacy at the VA - there are too many men, all hanging out.”

Information About Services & Processes:

Knowledge about processes and services offered is unavailable, difficult to use or incorrect.

Specific comments by separate individuals:

“I didn’t know about requirements for eligibility. It is confusing and a ton of paper work.”

“No one told me about needing to establishing eligibility. I was hoping for more help.”

“I know a lot of women who have misunderstandings about VA eligibility, services, and costs.”

Perception of Poor Quality:

VA staff seen as generally not familiar with women’s health issues and overall care perceived as poor in comparison with the private sector.

Specific comments by separate individuals:

“I have heard that the VA has a poorer quality of health care.”

“Residents are allowed to ‘practice’ on patients.”

“There seems to be a lack of expertise in the medical personnel. That is why they work at the VA.”

“The doctors seem impersonal. The medical personnel often don’t listen. They lack empathy and respect.”



Women Veterans Health Care at the PVAMC

**Presented by: Nancy Sloan, MSN, ANP, CNS
DNP Candidate**

Date: May 20, 2009

Significance

- The VA has experienced a large influx of women using the institution for their health care
 - Due to the increase of women serving in the U.S. military
 - Guard and reserve population
- This population is creating unique challenges
 - VA has historically been focused on health care for men



Background

- Literature indicates women veterans have specialized health care needs:
 - Customized health services
 - Gender sensitive environment
 - Increased access to allow for frequent use of health care services (Yano et al., 2006)
 - Women are socialized to use health care more frequently
 - Annual gynecological needs
 - Maternity needs



Goals of Study

- Understand demographics of women veterans currently using health care at the Portland Veterans Administration Medical Center (PVAMC)
- Determine barriers perceived by women veterans in using PVAMC
- Clarify the needs of women veterans for the purpose of improving access and the quality of their health care services

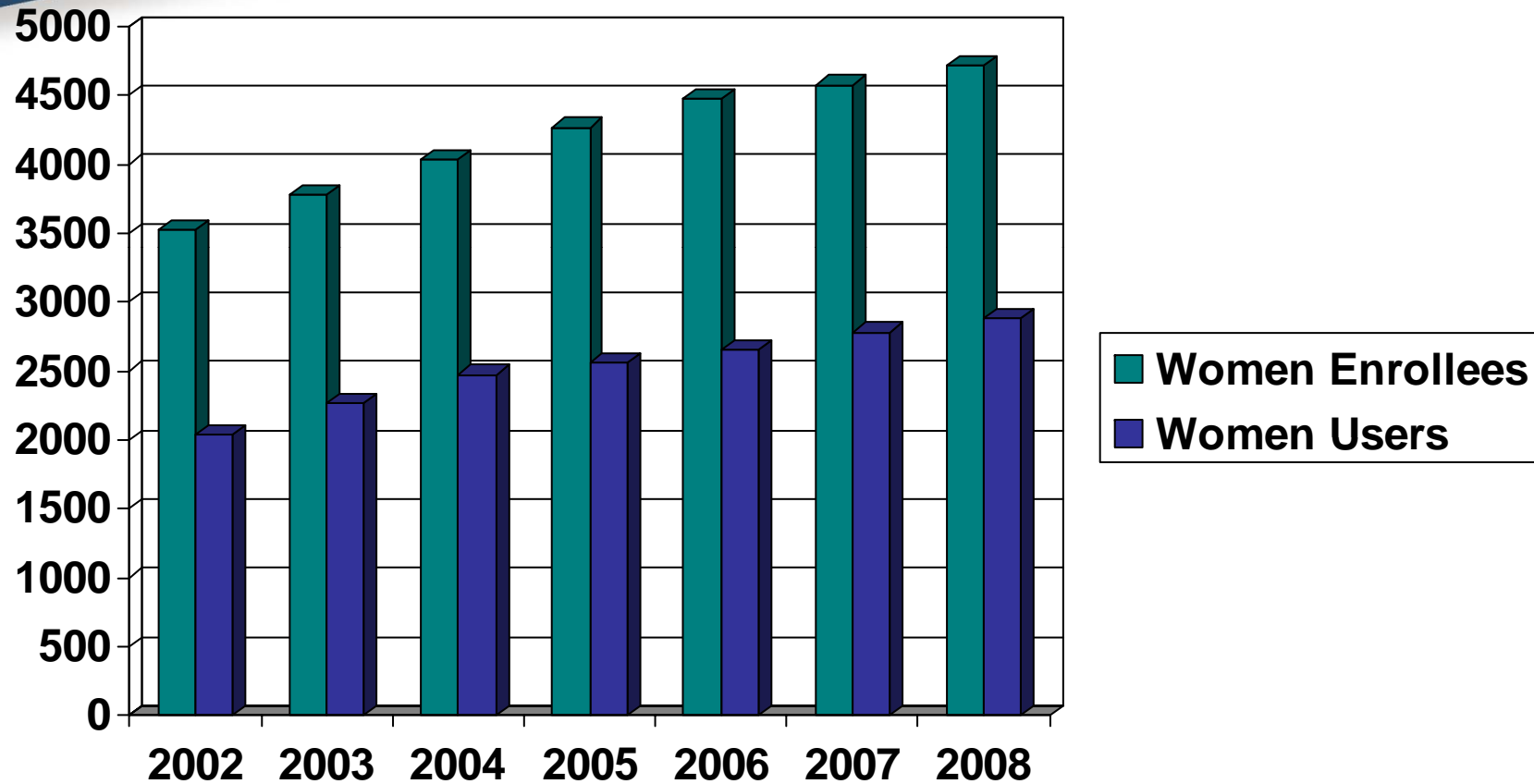
Clinical Inquiry Questions

1. What are the demographic and clinical characteristics of women veterans using the PVAMC?
2. What are the current barriers women veterans perceive when accessing the PVAMC?

Methods - Clinical Inquiry Question # 1

- What are the demographic and clinical characteristics of women veterans using PVAMC?
 - Data was pulled from the PVAMC electronic medical records (*ProClarity*)
 - Longitudinal data to establish trends in use of PVAMC
 - Cross-sectional data (July 1/07 – June 30/08)
 - Demographic variables: age, marital status, ethnicity
 - Clinical variables: mental health, gynecological services, orthopedic services, etc.

Women Veterans Trends – Enrollees and Users – At PVAMC 2002-2008

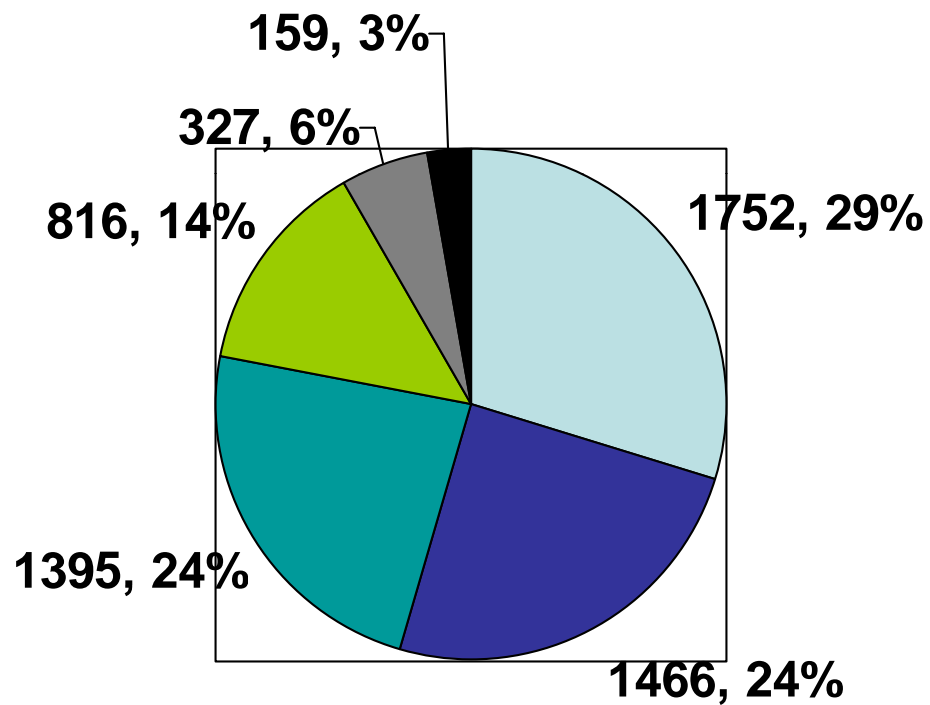


Women Veterans Trends – Enrollees and Users – At PVAMC 2002-2009

	2002	2003	2004	2005	2006	2007	2008	2009 (thru Jan)
Female Enrollees	3526	3775	4028	4265	4477	4574	4718	4709
Number of Users	2039	2269	2475	2560	2651	2780	2883	2477

Source: VSSC ProClarity DataCube, Current Enrollment Users and Enrollees by State and County; Pulled 4/2009

Marital Status of PVAMC Women Veterans (07-08)



Unknown

Married

Divorced

Single

Widowed

Separated

Unique Users by Age Group (07-08)

Total number of individual patients per category in the year

Unique Users by Race / Ethnicity (07-08)

Total number of individual patients per race / ethnicity in the year



Diagnoses by Age Groups (07-08)

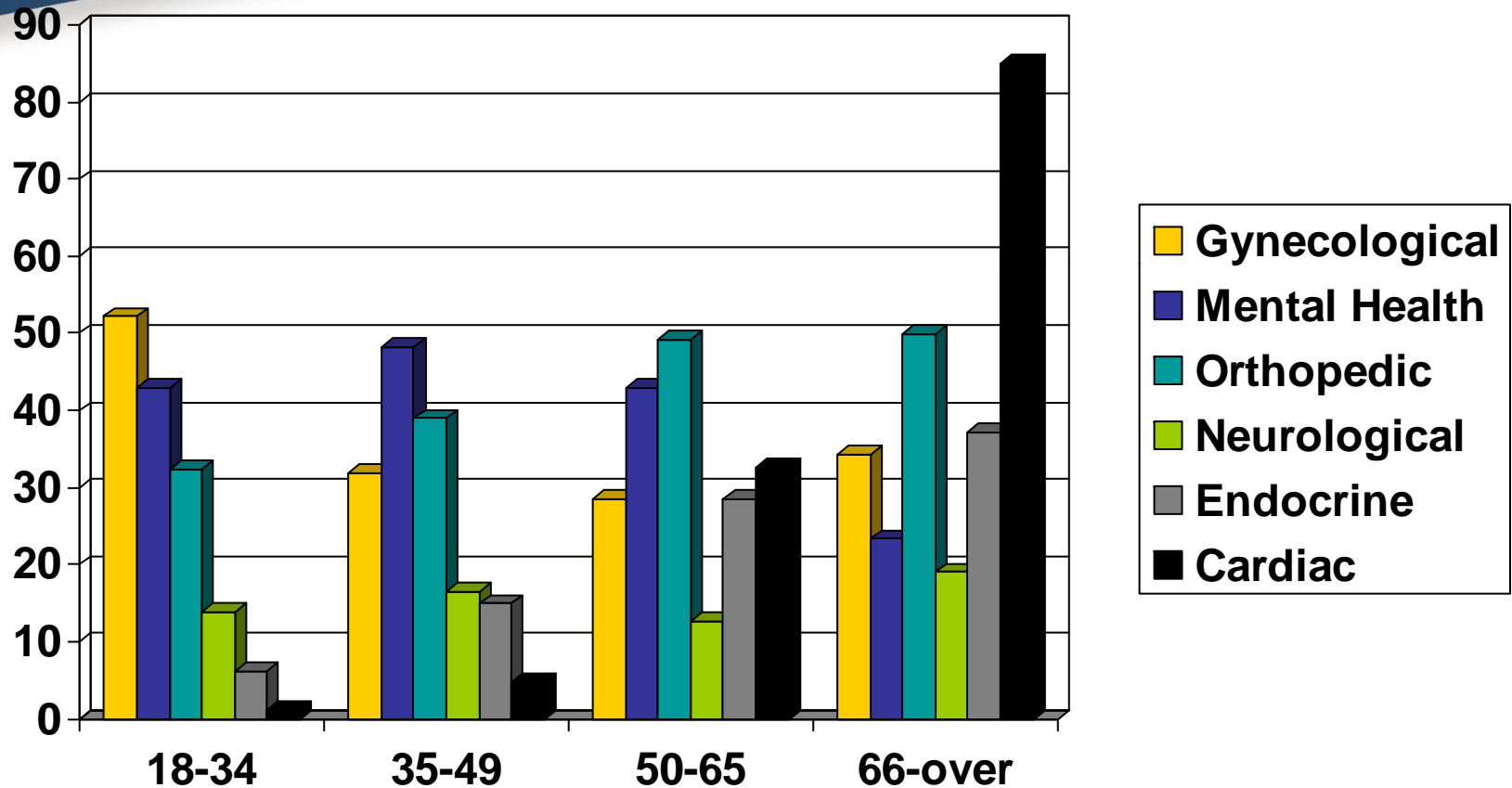
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Mental Health	42.9%	48.26%	42.99%	23.4%
Orthopedic	32.44%	39.04%	49.26%	49.93%
Neurological	13.88%	16.57%	12.7%	19.08%
Endocrine	6.13%	14.87%	28.48%	37.25%
Cardiac	1.11%	4.68%	32.67%	84.97%

Source: VSSC ProClarity PVAMC: July 1, 2007 – June 30, 2008

Red = highest %; Blue = 2nd highest % for each age group



Diagnoses by Age Groups (07-08)



Source: VSSC ProClarity PVAMC: July 1, 2007 – June 30, 2008

Methods – Clinical Inquiry Question #2

What are the current barriers women veterans perceive when accessing the PVAMC?

Focus groups held to assess women veterans perceived barriers to accessing health care.

Questions asked:

- What services are you aware of?
- What services are needed?
- Barriers when attempting access ?
- Perceived quality of PVAMC health services?



Qualitative Data Analysis

- Transcribed focus group interviews
- First reading to detect dominant themes
- Checked interpretations with RN who attended all focus groups
- Coded themes
- Tallied themes and selected prototypical comments

Main Themes of Focus Groups

- Lack of gender sensitive environment (defined as an environment with female staff proficient in women's health)
 - “The doctors have been treating mostly men for years. I think they find it awkward when they have a female patient.”
 - “It is really hard to get an appointment, and then a lot of physicians won't do female examinations.”
 - “I don't feel comfortable at the VA. When you check in there are men all around and you have to tell the check-in person why you are there – there is a total lack of privacy. The waiting rooms are full of men – I feel totally out of place.”

Themes cont.

- Lack of information about services and processes.
 - “I didn’t know women’s health was even an option at the VA.”
 - “I found out about services when I just happened to hear from a girlfriend that she was going to the doctor at the VA; I couldn’t believe it!”
 - “When I first came home (from overseas) I didn’t care at all about my health care – I just wanted to see my boyfriend and go out for a beer – eventually I started having health problems, and I didn’t know where to turn. The idea of starting the enrollment process to start using the VA seemed overwhelming.”

Themes cont.

- Perception of poor quality
 - “I heard that the VA uses doctors who can’t get a job elsewhere.”
 - “The doctors seem impersonal. I don’t think they care.”
 - “Residents are allowed to practice on us. I know it is a teaching hospital and all, but it really feels bad when a bunch of residents are in the room gawking at you.”

Focus Group Findings: Primary Themes

What are the current barriers women veterans perceive when accessing the PVAMC?

- Lack of gender sensitive environment
- Lack of information about and access to women's health care
- Perception of poor quality medical care

Limitations of study

- Incomplete electronic medical records
- Lack of access to women veterans who are non-users of PVAMC
- Participants not representative of total VA population of women veterans
- More extensive inquiry may generate more refined understanding of women veteran's attitudes and decisions in relationship to health care choices

Study Conclusions

- Poor data quality in VA database limits effectiveness of program evaluation
- Women veterans of all age groups have desire for a gender-sensitive environment with proficient female providers
- Women veterans want easier access to information about eligibility and available services

Conclusions cont.

- Gynecological and mental health services are in high demand by women veterans across their life spans.
- The findings from this project at the PVAMC are consistent with literature, e.g., Yano and Washington (2006)

Recommendations

- Improve electronic records, especially as they relate to women veterans
- Create Women's Health Center with appropriate environment for women veterans health services
- Work to improve outreach in the community to increase awareness of VA services for women veterans
- Launch educational programs for providers within the PVAMC interested in participating in women's health

DNP Program Summary

- Accomplishments / associated program competencies
 - Building / developing women's health care @ PVAMC
 - Collaborating with interdisciplinary medical teams and peers (locally and nationally)
 - Mentoring staff and residents in appropriate care for women veterans
- What are my plans as DNP?
 - Implement findings in future women's program and dedicated women's health clinic
 - Advocate for improved data collection for program evaluation and research in order to improve care for underserved populations

DNP Growth

- Enhanced leadership skills
 - VA executive committee participation
 - Regional and national women veterans representative
 - Media spokesperson for women veterans issues
- Program management
 - Point person seen as “expert” in field
 - Dedicated women’s health care clinic project
 - Involved with national research team on women veterans

Women Veterans Health Care at the PVAMC

Thank you!



Questions?





Women Veterans' Health Care at the PVAMC

**Presented by: Nancy Sloan, MSN, ANP, CNS
DNP Student**

Date: September 25, 2008

Background

- Literature shows that women veterans have special needs due to:
 - MST/PTSD in the military
 - Younger females need age appropriate and gender sensitive health care
 - i.e. maternity and gyn services
 - More frequent use of health care services

Significance

- The VHA has experienced a large influx of women using the VHA for their health care post-deployment
 - Due to the increase of women in the U.S. military
- New population is creating unique challenges
 - VHA has historically been focused on health care for men

Purpose of Study

- Complete a program evaluation of the current status of women veterans' health care at the PVAMC
- Make evidence-based recommendations to improve health care for women veterans
 - Needed services and protocols
- Long-term objective: implementation of recommendations

Clinical Questions

- What are the demographic and clinical characteristics of women veterans seen at the PVAMC?
- What are the current barriers to women veterans using the PVAMC?

Methods

- Demographic and clinical data will be pulled from the EMR of the PVAMC
- Focus groups of women veterans to determine barriers to care at PVAMC
- Data will serve to identify shortcomings in health care services within the PVAMC for women

Study Design

- This will be a cross-sectional data selection
- Demographic variables will be measured as nominal/categorical
- Clinical variables (i.e., depression, MST and PTSD) will be measured as nominal/categorical data.

Analytical Methods

- Independent T test will be used to analyze continuous variable interval data
- Chi square will be used to analyze the nominal/categorical data

Next Steps

- Gather data from EMR
- Enter and organize into SPSS
- Form focus groups
- Conduct interviews

Questions?

Thank you.

Running Head: POLICY ANALYSIS

Policy Analysis: Veterans' Health Care Eligibility Reform Act

Nancy Sloan

Oregon Health & Science University

School of Nursing

Context

Public Law 104-262 (PL 104-262), The Veterans' Health Care Eligibility Reform Act of 1996, was written to address the growing needs of veterans to receive adequate health care. The secondary aim was to standardize veterans' health care benefits. This presented an enormous challenge to the United States government at a time when the numbers and diversity within the U.S. veteran population was at an all time high. The horrors of the Vietnam War were still very much alive in people's memories and the negativity experienced by the veterans post-war was quite raw. The way the Congress handled the veteran population once state-side was open to public scrutiny and many heard rumblings about poor quality of health care and inadequate compensations. Ron Kovic, a two-tour marine who was severely injured in Vietnam, wrote a novel exposing the horrifying medical treatment he experienced in a Veterans' Administration (VA) hospital in the Bronx. This later was made into a movie entitled *Born on the 4th of July* (Longman, 2007). This exposure empowered an activist movement among veterans which resulted in a regular media campaign to draw attention to these dire conditions.

By the mid 1990's the general opinion held by the majority of the veteran population was that the government had let them down in regards to health care. This, coupled with the fact that the World War II veterans were dying of natural causes, dropped the numbers using the VA to reach an all time low. Some senior governmental advisors were questioning if the VA should continue to exist. Concurrent with this idea was the push by the Clinton White House for a nationalized health care plan. The solution for the VA health system would be to wrap it up within the Clinton plan and solve the crisis once and for all (Longman, 2007). It was at this point that a new leader was chosen to reform the VA and the transformation to its current state began.

The new director, Dr. Kenneth Kizer, proposed reorienting the VA away from a system that emphasized acute care in a hospital setting, to a system with an emphasis on preventive care and patient-centered medicine. He embarked on a public relations crusade to change the current attitudes toward the VA. He also endeavored to lay the foundation for the U.S. Congress to make new policy to guide the reformation of the VA health care system (Kizer, 1995).

Problem

In the mid 1990's the VA was loosely organized and suffered a very poor reputation. Few veterans felt they had adequate health care benefits. Up to this point some efforts had been made to consolidate resources and organize social support for veterans, but very little progress was made toward addressing the vast general needs of thousands of veterans. As mentioned, due to the VA suffering from poor perceptions by the veterans there had been a severe decline in enrollees. When market research looked into the situation during the mid-1990's three out of four veterans stated they would like to leave the VA system if given the opportunity (Yano, Simon, Lanto, & Rubenstein, 2007).

The VA policies which had been in place, such as the Servicemen's Readjustment Act and the GI Bill of Rights, focused on the rehabilitation needs of veterans following the physical trauma incurred during World War 2 (Perlin, Kolodner, & Rowell, 2004). This marked an improvement in VA services for veterans at that time, but these provisions later proved grossly inadequate in providing basic health care for the majority of veterans.

It is notable that at this time in history the standard model for health care focused on acute care and most health interventions were being delivered in hospital settings. There was little emphasis put on outpatient, preventative health care services. This had greatly influenced

the system of health care the VA was using (Assessing Impact of Public Law, 1996). As a result, preventive care, and what we now refer to as primary care was not emphasized. As a result veterans suffered with illnesses such as hypertension, diabetes and schizophrenia, often ending in critical states. Many of these chronic illnesses could have been effectively managed in outpatient settings. Likewise preventative medicine was not encouraged, which resulted in veterans suffering from influenza, high cholesterol and diseases related to tobacco use (Chen-Fen, Maciejewski, & Sales, 2005).

Another problem which plagued the VA system was the glaring inconsistencies in the distribution of services. Many veterans could not get into hospitals due to not having disabilities they could link to war time service. Other veterans were kept in hospitals for months and even years (Longman, 2007). These inconsistencies were often due to bureaucratic loopholes. For example, a veteran hospitalized for a broken hip would often have to remain in the hospital until fully mobile, due to the fact that a walker or cane was not part of his VA benefits. (Assessing the Impact of Public Law, 1996). These practices led to an enormously inflated budget which was serving less than 40% of the total veteran population (Longman, 2007).

Evidence

The reform act, PL 104-262, proposed basic health care for all veterans who were enrolled. This opportunity became widely publicized and was met by an overwhelming surge in interest on the part of veterans. This required a huge effort on the part of the VA to initiate and organize a workable enrollment process. Between 1997 and 2003 the foundation for this major system change was implemented. In that time period the VA saw an increase of over 60% in veteran enrollment (Perlin, Kolodner & Rowell, 2004). Access to the utilization of the VA

benefits became a key component for the success of this policy. Eight hundred new community based outpatient clinics were opened. The goal was to bring health care to the veterans in whatever part of the country they chose to live. (House Committee on Veterans' Affairs, 2004).

This change in VA emphasis toward a primary care model also brought a change in the characteristics of veterans using the system. Prior to 1996 many who accessed the VA health system described their health condition as “poor”. Following this change in focus in the VA, by the year 1999, there was a substantial increase in veterans stating their health was “fair” or “good” (Chen-Fen et al., 2005).

This change in health care focus greatly influenced a national trend toward primary care medicine. Today many researchers attribute the change within the VA as partially responsible for the national health care focus from acute to primary and preventive health care (Institute of Medicine, 2001).

When governmental departments looked closely into the health care that was being delivered, the disparities became evident. This inequity led to complicated legal cases which were difficult to manage at a governmental level (House Committee on Veterans' Affairs, 2004).

The restructuring of the VA system sought to appropriate funds more directly to all veterans with health care needs. Yet, Congress also recognized the obligation to provide continuous health care across veterans' life span. Interestingly, this need precipitated a revolution in the method of medical record management. The adoption and development of VistA, which eventually led to the Computerized Patient Record System (CPRS), is hailed to be largely responsible for the maintenance of the reform process (Perlin et al., 2004). This computerized system transferred the management of health care from paper processing to a nationalized

electronic health record. With this system veterans' records could be accessed by any VA across the country. CPRS, for example, is capable of maintaining health records of over 8.5 million VA patients in over 22 regions of the U.S. Recent health histories, laboratory findings and medications are now retrieved in minutes, even if records exist in up to three separate VA institutions (Department of Health and Human Services, 2004).

This so greatly enhanced the consistency and quality of health care delivery it has led other institutions to adopt similar systems. According to the Department of Health and Human Services (2004), because of CPRS, the comparison of quality in VA patient care data to Medicare patient care data sets VA care as a benchmark for quality clinical performance.

Policy Alternatives

The VA had various options when PL 104-262 was put on the Congressional agenda for discussion. For years the VA had resorted to a pension system which allowed money to be sent to veterans for health care. The amounts were based on the severity and cause of the injury. More money would be allocated for injuries caused during war. The money distributed allowed the veteran to seek the health care sources of their choice. The pension system was somewhat arbitrary in the amounts allocated and often resulted in the health needs of veterans not being fully addressed. There was ambiguity as to who received the money and discrepancies as to which veterans were entitled to what service. It proved to be a continual managerial challenge. Throughout the years of pensions being dispersed, amendments to pension policies were frequent and time consuming. Little benefit to veterans as a whole was realized and there was no provision for preventative health care (Brent, Levesque, Perlin, Rick, & Schectman, 2005).

The health care climate at the time of deliberating PL 104-262 was greatly influenced by national health care debates. Included in these debates were the national health care initiatives proposed by Hillary Clinton. Along with the national medical coverage debate, managed care was being introduced as a major force in health care cost reform (Skocpol, 1996).

Congress sought to select a model for the veterans that met the aspirations of several health care models and would also have the unique features needed by the VA health system (Corrigan, 2000). It is unclear how much Congress was influenced by Mrs. Clinton's very vocal and highly publicized campaign, but as the VA floundered, it was suggested that Clinton's plan was broad enough to incorporate the health care needs of the veteran population (Longman, 2007).

Another option the government had was that of managing the distribution of benefits from one central office in Washington D.C., such as the Medicare program initiated by President Harry Truman or the Tri Care program run by the Department of Defense (Brief, 2007). In spite of the VA's poor image at this time, no other federally run program was seen as significantly better. Due to this fact and under the leadership of Dr. Kizer the Congress elected to initiate a population-based distribution of health services. They opted to decentralize versus staying centrally controlled (Veterans' Administration, 2005). To this end, twenty-two service networks were established which divided the U.S. into four or five state geographical areas. These sections were better able to provide local management of primary care services. From these sections further breakdown of service areas resulted. Community based out-patient clinics (CBOCs) mushroomed across the country (Kizer, 1995).

With this new emphasis on the primary care model of health care, Congress elected to adopt the economic model that closely resembled the socialized form of medicine practiced in

Canada. The Clinton health care proposal fell flat and a movement to privatize and defer medical process and decisions to large health management organizations (HMOs) evolved. The decision by the 104th Congress to eventually adopt a socialized economic model for the VA was significant (Paduda, 2005).

Evaluation of Outcomes

Collins (2005) recommends analyzing the outcomes of the alternative interventions using the following criteria: 1) relevance, 2) progress, 3) efficiency, 4) effectiveness, and 5) impact.

In evaluating the relevance of the outcome had the 104th Congress elected not to pass PL 104-262 we would likely see an increase in low income veterans finding themselves without access to any health care (Peabody & Luck, 1998). If the government had elected to contract with private health care networks to manage the veteran's health care needs, problems similar to what is experienced by the current HMOs would be present. These institutions claim they accomplish gate-keeping and medical guidance yet medical prices continue to rise and more people are without adequate health care than at any other time in history (Murthy & Okunade, 2004). There could be some level of improved function for veterans who were able to pay for some of their own health care, but the needs of the majority of veterans would not have been addressed (Perlin, et al., 2004). If significant improvements in the veteran benefits were not made, it was predicted that it could lead to an overall loss of morale affecting peoples interest in enlisting in the military (Longman, 2007).

Similarly, if the government had opted to manage veterans' health care from one centralized governmental office, it is likely the effect would have been similar. The VA would suffer from not having a local presence to address the needs of the veterans. Based on

Rodriguez-Garcia's criteria, as cited in Collins (2005), the criteria for evaluation would suggest that there would be a very small chance of meeting the needs of the target population.

Continuing with the same criteria we would see an inefficient use of resources and few positive results in the actual realization of health care reform. Some have suggested that the inefficiencies that plague other governmental health care would have spread to the VA (Corder, 1998).

A need for a larger, broader distribution of health care was imperative. With the implementation of the preventative health care model in conjunction with the application of the primary health care model as outlined in PL 104-262, huge improvements were realized in the overall health status of the veterans (Perlin, 2004). With the restructuring of the VA health system, the VA emerged in to the largest integrated single payer system in the U.S. (Kazis, Miller, Clark, Skinner, Lee, & Rogers, 1998). When measuring quality of care, specific performance measures, outreach, and management of increased population bases along with the introduction of preventative health care methods, there is no doubt that the implementation of PL 104-262 effectively created a vast improvement in the previous conditions existing within the VA health system (Armstrong, et al., 2005).

A survey which served as a measurement tool to analyze these effects was the *Veterans' Health Study*. The health study involved 1,667 patients in the years shortly following the implementation of PL 104-262. This study was conducted as a two year longitudinal study using ambulatory outpatients in four VA facilities in the New England area of the U.S. This population was then compared to a non-VA population for the purpose of comparison in relationship to access, acuity of illness, and general health conditions with the level of care received. The VA patients showed substantially worse health than non-VA populations, and younger veterans were

shown to be experiencing worse health-related quality of life than the older veterans (Kazis et al, 1998). This study reflects the level of acuity being experienced by the VA population at the beginning of assessments prior to implementation of PL 104-262. Numerous studies following this one concluded that the overall impact on the health and socio-economic status of veterans improved dramatically when compared with similar patients in the private health care sector (U.S. General Accounting Office, 1999).

Weigh the Outcomes

The Veterans Eligibility Reform Act of 1996 assisted the VA in achieving greater efficiency in providing health care to veterans by increasing effective management and establishing an improved distribution of health care. The shift in focus from inpatient to outpatient created an initial savings to the budget of the VA of roughly 39 million dollars (Harrison & Ogniewski, 2005). As projected by the 104th Congress the implementation of these changes in the health care services for veterans would be cost neutral (104th Congress, 1996).

Not only did the VA's reorganization benefit access for those veterans needing ambulatory care, but veterans needing various other types of health care, such as home care and long-term care facilities were also aided. Over 300 long-term health care facilities were started over the few years following the passing of this legislation. Along with this, numerous home health care programs were initiated and continue to this day (Perlin, 2004). As a result of this, patient access was greatly increased and outcomes measured by Kappa statistics and repeated-measures analysis of variance (ANOVA) controlling for health status, age and the number of visits with overall continuity of care was substantially improved (Rubenstein, Yano, Fink, Lanto, Simon & Graham, 1996).

From the years 1996 to 2003 the individual number of veterans treated annually increased by 75%, from approximately 2.8 to 3.9 million. In spite of this shift in care and increase in outreach, Congress continued to meet their goal of maintaining the appropriated budget. The VA budget continued to be cost neutral from the years 1995 to 1999. When budget increases were eventually realized it reflected the purpose of the overall policy, which was to steadily increase the application of health benefits to increasing numbers of veterans. With this growth, new proposals by Congress allowed for an increased budget from four billion dollars to 25 billion dollars for fiscal year 2003. Correspondingly there was an increase of 32% cumulatively over the next six years. This was well within expected parameters (Perlin, et al., 2004).

When growth of this nature occurs there is a great challenge to the management of quality. Measures were developed by the VA to address this. By using an evidence based medical approach involving strict requirements for meeting quality, high standards of quality were maintained. Appropriate quality outcome measures became imperative, not only for clinicians, but also for the those in the administrative arena. This created a consolidated effort on the part of the entire VA organization to work toward quality care. This concept was newly termed by the VA to be *evidence-based quality management* (Perlin, et al., 2004). Performance measures became an inextricable part of patient care and medical records.

As this restructuring took place another reformation phase was occurring. This involved the evolution of the VA into the United States' largest affiliate of teaching hospitals. From the years 1993 through 1999 internal medicine students choosing residencies at the VA doubled. The number of academic medical centers in partnership with the VA grew to over 70% nationally.

These numbers included a large number of students seeking training in primary care in outpatient settings (Yano, Simon, Lanto, & Rubenstein, 2007). In part, due to this added work force, the percentage of veterans who could obtain all or most of their primary health care in the VA rose from 38% in 1993 to 95% in 1999. The VA mission to expand services to fit the needs of the veterans and medical student alike proved to be successful.

Today the VA provides clinical opportunities to more than 100,000 students and trainees in more than 40 disciplines. Over 107 of the nation's 125 medical schools have affiliation agreements with the 131 VA medical centers. By 1998 the VA was funding over 8,500 medical residency positions which resulted in more than 65% of all physicians practicing in the U.S. receiving all or part of their medical training through the VA health care system (Kizer, et al., 1998).

The eligibility reform act upheld its promise to allow the VA to offer the "right care at the right place at the right time" (Veterans' Administration, 2008). The restructuring of their services allowed large numbers of veterans to access the system and inarguably save federal resources. Using the valuable resource found in medical students and those choosing residency programs, further gave the VA cost effective care and correspondingly gave back to the medical community in ways few other institutions could claim. Due to this partnership many veterans have been drawn to this revitalized health care system which is now perceived to be more responsive to the veterans' basic health care needs than at any time in history (Veterans' Administration, 2008). The Washington Post (2005) stated that "in the past decade, largely unnoticed by the public, the (VA) system has undergone a dramatic transformation and now is considered by some to be a model" (cited in Gaul, 2005). Some evaluators have even suggested

that the VA makeover is a lesson in how to solve the trouble within the U.S. health care system. The chief executive of the Institute for Healthcare Improvement concurs, stating “If you take a five or six-year perspective, I think what the Veterans Health Administration has done is stunning” (cited in Gaul, 2005).

As previously mentioned, much of the improvement in quality is attributed to the electronic records system which was acquired by the VA to assist in the reform process. Now the computer software monitors performance and provides incentives for clinicians to adhere to best practice guidelines. For example, due to the computer tracking system now used, the rates of screening for breast and cervical cancer increased over 30% and 60 % respectively from 1990 to 2000 (Gaul, 2005).

Veterans and their community organizations also applaud the reform of the VA. Surveys show that with the exception of waiting time to obtain appointments with their clinicians, most of the veterans are satisfied with the medical care they receive. Results from surveys conducted by the American Customer Satisfaction Index (ACSI) found that within both the federal and private sectors, the veterans' satisfaction rating was five percentage points higher than the average satisfaction rating for those with private health care services (American Customer Satisfaction Index, 2006). This high rating has continued since the year 2000 (Perlin, et al., 2004).

In spite of these positive outcomes, problems continue to dim the success from the implementation of PL 104-262. For example, there are long waiting times for veterans to get appointments. Also, many feel that quality of medical care could still improve. Some reports

show that some veterans are dissatisfied with the specialized health care programs within the VA (House Veteran's Affairs Subcommittee on Health, 2001).

Particular challenges face the VA in relation to the new type of warfare that is being fought in Iraq and Afghanistan. With improved military defense gear many more veterans are living through active combat and sustaining injuries which present new challenges to the VA. It is projected that the veteran population using the VA will grow by an additional 1.6 million in the next two years (Robinson, 2007). Traumatic brain injury (TBI), post-traumatic stress disorder (PTSD) and military sexual trauma (MST) are often unseen and undiagnosed. Due to the apparent external health of these veterans many are graded by the VA to be healthier than they in fact are. Some are even redeployed only to suffer further mental break down and in some cases jeopardize the lives of their colleagues (Robinson, 2007). The VA is pouring funds into programs to meet these new health challenges for these veterans. It has now become an important campaign issue for the 2008 presidential election. It is projected that the over 600,000 veterans waiting for benefits to be distributed to them will the cost over 150 billion dollars (Longman, 2007).

Final Decision

PL 104-262 was implemented at a time when veterans were accusing the government of providing poor quality health care and abandoning their responsibilities to the veteran population. It was essential that an intervention be made if the government was going to maintain a sufficient military with high morale. This reform not only brought change to an existing system that was wrought with problems but improved on the overall quality of health

care for veterans by establishing a system whereby the veterans could find a safety net for a wide variety of their health care needs.

The success of the reform has been touted by multiple large health organizations as innovative and comprehensive. Although a work still in progress, the adapted model of outpatient primary care has provided veterans with consistent and sustained health care. This model has allowed preventative medicine to be a part of the health care process, which has helped to increase the general quality of life experienced by veterans. An example of this is the VA program *MOVE*, which encourages veterans to lose weight, stop smoking and eat well (Veterans Administration, 2007).

Implementation of this policy when proposed was hailed to be cost neutral. When first introduced, the shift from acute care to primary care proved to be exactly that. As increasing numbers of veterans used the system and the budget increased correspondingly. The system has never exceeded the appropriated Congressional budget (Longman, 2007).

A growing concern at the time of the implementation of PL 104-262 was that the majority of veterans were not able to access health care benefits to which they were entitled. This policy successfully decentralized the distribution of health care by restructuring the VA into geographical regions for dispensing health care. These regions were further subdivided into community health centers with the goal that all veterans be within thirty minutes of receiving health care. This has resulted in the VA operating a total of 172 medical centers, more than 800 ambulatory health clinics, 137 nursing homes, 206 readjustment counseling centers and 73 comprehensive home care programs (Veterans' Administration, 2007).

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Running Head: CARDIOVASCULAR DISEASE IN WOMEN VETERANS

Cardiovascular Disease in Women Veterans

A Case Report

Nancy Sloan

Oregon Health & Science University

Introduction

Women will account for over 11% of U.S. veterans by the year 2015 (U.S. Department of Veterans Affairs, 2007). Due to this population being relatively new to using the Veterans Administration (VA) there is still much knowledge that needs to be gained to provide them quality health care. One example of this is in the area of cardiac health. It has been suggested that women veterans with vascular disease have been less studied than male veterans (Hayes, 2007). This is alarming, due to coronary heart disease (CHD) now being the leading cause of death for women in the United States (Liewer, Mains, Lykens & Rena, 2008). Deficits in understanding CHD in women veterans could lead to increases in morbidity and mortality in this population (Johnson, et al, 2007).

CHD is often thought of as a “man’s disease,” possibly due to greater numbers of men than women suffer from heart disease under the age of 60 (Price et al., 2005). However, research shows that after age 60, women quickly take the lead in heart disease in this country. By the age of 75 they have outranked men with this malady by 10% (American Heart Association, 2005). Cardiovascular mortality trends follow suit. While male mortality related to heart disease has decreased since the year 1980, women’s mortality from heart disease has risen to over 500,000 cases in 2000 in comparison to male mortality of 430,000 (American Heart Association, 2005). In the United States, women continue to die from heart disease at a rate of one woman per minute, causing death to more women than the next 5 known causes of death combined (American Heart Association, 2005). CHD is the leading cause of death among African American women, followed by Latinas, Asian American, Pacific Islanders and American Indians (American

Heart Association, 2005). In these populations, heart disease is often also complicated by co-morbid conditions of diabetes, obesity and hyperlipidemia.

It has also been shown in the literature that social and contextual factors greatly influence the etiology of women and CHD. These include issues such as socioeconomic status, access to health care, working conditions and social isolation (Fleury, Keller & Murdaugh, 2000). These factors increase the challenge of distribution of pertinent health information and treatment to this population. The treatment of CHD among women veterans and how an advance practice nurse can influence outcomes related to CHD will be the focus of this paper.

Case Study

Henrietta (fictitious name) is a 55 year-old, divorced, African American female who presented to the women's clinic at the Portland Veterans Medical Center (PVAMC). Henrietta had served in the military as an army sergeant during the Vietnam conflict. She recently lost of her job as an automobile assembly line worker in Michigan, and subsequently also lost health insurance. She was unaware of VA health care services being available to her so was putting off addressing any health care needs until a future time. She moved to Oregon to join her sister, hoping to save money by sharing expenses. While looking for work on the VA website, she realized there were VA health care options for her. She began the enrollment process and eventually was able to use her VA health care benefits.

During the initial interview Henrietta stated that she generally considered herself to be in good health. She was at one time diagnosed as diabetic and had been on sulfonylurea and metformin twice daily for her diabetes. She also stated she had

previously been on atorvastatin for hyperlipidemia. She had stopped taking all of her medications due to losing her insurance. She admitted that she smoked cigarettes as a teenager and young adult, but quit 30 years ago. Her family history was positive for hypertension, type II diabetes, and myocardial infarction (mother with diabetes at 58 and father suffered an MI at 62). However, she had little knowledge of the increased risks that family history, diabetes, hypertension, and hyperlipidemia can create for a woman of her ethnicity and age.

Her initial examination revealed a woman with the height of 5' 10" and weight of 193 lbs, in no acute distress. Her review of systems was essentially negative, except for occasional fatigue. Henrietta's blood pressure was 142/87 mm/Hg, pulse was 70, respirations 12 and temperature was 97.6. Initial serum laboratory values revealed a random glucose of 210 mg/dl, triglycerides of 192mg/dl, total cholesterol of 259 mg/dl, LDL cholesterol of 192 mg/dl, and hemoglobin A1C of 7.1%. The advance practice nurse advised Henrietta of her slightly elevated blood pressure and cholesterol. Additional notice was taken of the family history of MI. The nurse further advised Henrietta to reduce cholesterol through improved diet and prescribed a lipid lowering statin medication, and HCTZ to help reduce blood pressure. It was also decided she should restart her diabetic medications. She was advised to start a daily exercise program and was referred to the VA *MOVE* program for help with this. It was also arranged that a staff nurse would call her weekly to determine if her blood pressure medication was effective in lowering her blood pressure.

Follow-up telephone calls by the clinic nurse revealed Henrietta to be doing well; yet one month later she presented to the emergency room (ER) at the PVAMC

complaining of shortness of breath and heart palpitations. On admission to the ER, she had elevated blood pressure of 165/94 mm/Hg, pulse of 85, respirations of 14 and temperature of 98.7. However, the ER examination was negative, showing a normal electrocardiogram and cardiac enzymes. She was discharged the next morning after an overnight stay for observation in the PVAMC hospital. On discharge, she was told to continue on her medications as directed and follow up in the PVAMC women's clinic within the week. On her follow-up visit it was noted that she now weighed 202 lbs. and her blood pressure of 135/83 mm/Hg. She admitted she had not been exercising and stated she had not been making serious attempts to lose weight. Her cholesterol levels taken during the ER visit showed no significant changes.

She was referred to a dietician for a nutrition consultation for dietary modification. She promised to start working with the *Move* program as previously advised. At this point it was also seen advisable that she be referred to cardiology for a full workup and treadmill stress test. After this Henrietta was asked to return to the clinic in 4 weeks. On this subsequent visit Henrietta was found to be stable and showed a slight weight loss of 3 pounds. Her blood pressure improved slightly to 130/83 and pulse was 75. Her cholesterol had improved to within normal range with total cholesterol level of 195 mg/dl and her hemoglobin A1C was 6.5.

Case Analysis

Unfortunately, 36% of women in the U.S. do not perceive themselves to be at risk for heart disease (American Heart Association, 2005). Furthermore, women have also been shown to be generally unaware of the fact that CHD is now the leading cause of death of women in the United States (Gibbons, 2000). Henrietta's case illustrates this

point. The significance of gender and age and health conditions as related to heart disease was generally unknown to her. This case highlights the challenge that exists to educate women regarding their individual risks.

It is also of critical importance to educate women on the signs and symptoms of acute coronary distress. Research shows that women experience these episodes quite differently than men (O'Keefe-McCarthy, 2008). Presentations of cardiac distress in women may be vague clinical symptoms of fatigue, discomfort in the shoulder blades, and shortness of breath (O'Keefe-McCarthy, 2008). For these reasons it has been strongly suggested in the literature that all clinicians treating women incorporate complete cardiac assessment in their exam including a discussion on the risks of cardiac disease, risk reduction and nutrition (Gibbons, 2000).

Henrietta's case further illustrates how vital it is to be aware of the social and contextual influences on coronary heart disease. Her low socioeconomic status (disadvantaged minority and out of work), social isolation (divorced and living alone for years), impaired access to healthcare, and working conditions (unemployed) greatly influenced her risk of suffering from heart disease (Fleury, Keller & Murdaugh, 2000).

Intervention and Strategies

The advance practice nurse seeks to identify at risk populations and sees that their health care needs are addressed. It is imperative the advance practice nurse educate individuals, communities about the risks and prevalence of CHD. It is imperative that evidence-based practice based on research be used as a guide for current practice and as a foundation in the education of others.

Updates on treatments and new recommendations for those suffering from CHD should be discussed among nursing peers and highlighted in clinical settings. For example, publications can be shared among colleagues both informally and within journal clubs to increase awareness. Teaching opportunities should be looked upon as opportunities to enrich the communities with the latest findings in this area. Participation in conventions that address topics on cardiac issues are also opportunities an advance practice nurse can seize to learn and also educate others about current research findings. Initiatives such as these will significantly impact this population by improving their knowledge about cardiac risks, understanding signs and symptoms of cardiac disease and encouraging healthy lifestyles.

Evaluation of Care and Potential Impact on Specialty Population

The DNP student will identify and address barriers that exist to CHD in this population. This will improve their delivery of care to women and increase the overall health quality experienced by these patients. Through education provided by the DNP women will feel empowered to take more control over their future health outcomes. It is expected that these interventions and treatments there will create a significant decrease in the morbidity and mortality for women suffering from heart disease.

The role of the DNP is to serve as a leader in health care systems and champion the causes of those suffering from health disparities. They will be recognized in their community as those who are strong advocates for healthy living both by their examples and the education they provide to the community. They will also be leaders in policy change as it relates to marginalized populations and stand as advocates on state and

national levels to ensure that health disparities are recognized and addressed appropriately.

Personal and Professional Skills Needed

When addressing the case of Henrietta, it was imperative that as an advanced practice nurse and DNP student, I be aware of the implications of her multiple risk factors, ranging from socioeconomic to familial. It was also vital that I understand the significance of her current laboratory values and observe her overall presentation at the clinic to make critical decisions related to her health care. Patient education was also essential to reinforce the serious nature of her condition and guide her towards healthier life choices and improved health outcomes.

The DNP program has enabled me to see how an advanced practice nurse can affect health outcomes in whole populations. It has helped me to see how one can redress negative health trends and improve the delivery of health care for marginalized groups. By virtue of the DNP program I was able to see Henrietta as part of a distressed population as well as an individual patient. My involvement in the program has enabled me to use evidenced based research to guide my daily clinical practice. Knowing that Henrietta had multiple high risk factors and knowing the applicable evidence-based research for addressing these risk factors allowed me to more effectively guide her treatment regimen.

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RUNNING HEAD: THE HIDDEN FACE OF POSTTRAUMATIC STRESS
DISORDER

NUR 790: Case Report

The Hidden Face of Posttraumatic Stress Disorder

Oregon Health & Science University

Nancy Sloan

Introduction

Trauma caused by combat occurs in many forms, and can affect soldiers both physically and mentally. Due to a precipitously growing number of women experiencing combat we are seeing symptoms of trauma increase in this population. One form of trauma that affects many veterans, and is seen in growing numbers of women veterans, is posttraumatic stress disorder (PTSD). PTSD is a disturbing and confusing condition for the victim. The Portland VA's Women's Health Center increasingly sees patients who are suffering from PTSD. It is critical that the advance practice nurse be able to diagnose and treat this challenging condition appropriately. PTSD and how it affects women veterans will be the focus of this paper. The goal is to improve the advance practice nurse's understanding of PTSD as experienced by women veterans, and serve as a guide for treatment.

Population and epidemiology

The Department of Veterans Affairs (VA) has historically been an institution that has served the health care needs of male veterans. Until now women veterans have comprised a very small percentage of the total patient population. This situation is rapidly changing due to women being the fastest growing segment in active duty military ranks. To date more than 177,000 women have served in Iraq, Afghanistan and the surrounding region. This number is compared to the 7,500 who served in Vietnam and the 41,000 deployed during the Gulf War (Disabled American Veterans, 2008). The Department of Defense has projected that over 400,000 additional troops will be deployed over the next five years, and of these 20% are projected to be women (Department of Veterans Affairs, 2007). Based on these trends, it is predicted that women will make up over 11 % of the

patient population who regularly use the VA health care system by year 2011

(Department of Veteran's Affairs, 2006).

Factors associated with PTSD

Two primary causes of posttraumatic stress disorder (PTSD) in women veterans are sexual trauma and combat trauma. Regarding the former, it has been suggested that some women join the military, as a way out of current negative and potentially violent situations (Office of Special Assistant for Military Deployments, 2007). For example, the prevalence of rape among American women in the general population is 13%. A study published in the *Journal of Traumatic Stress*, found that 36% of female Navy recruits admitted to having been raped prior to their military service (Stander, Merrill, Thomsen, Crouch & Milner, 2008). The research department in the VA's National Center for Post-traumatic Stress Disorder concurs, stating that evidence suggests that women who join the military have a high chance of having experienced trauma prior to their enlistment (Office of Special Assistant for Military Deployments, 2007). An additional study of women veterans in trauma treatment at the North Texas Healthcare System revealed that PTSD occurred seven times more frequently in women with a previous history of sexual assault (Suris, Lind, Kashner, Borman & Petty, 2004). These studies have resulted in research being done that focuses on military training to educate and protect these potential victims.

The other major source of PTSD is combat related trauma. Increasingly, deployed women are in harms way, making them more likely to experience this trauma. As a result, the types of injuries experienced by women soldiers have also changed significantly, creating new challenges in their treatment needs (United States Department of Veterans

Affairs, 2007). Women have traditionally been restricted to support roles in past conflicts, such as medical work, transportation, and guard duty. Because current methods of warfare are not limited to front lines, many of these women soldiers now find themselves in the midst of direct conflict. Often their injuries occur from randomized terrorist strikes and road-side explosions aimed at targeting major transportation routes. This can result in traumatic brain injury and severe mental stress leading to PTSD.

Case study

Josephine, (fictitious name) a 26 year old women veteran who uses the VA for her health care, states while in the military she experienced a traumatic event which forever changed her life. Recently, while seeking health care at the Portland Women's Health Clinic, she related her story.

Josephine served in the army in Iraq from 2004 to 2005. She recalls she and her team of eight soldiers were departing from Tajik, about twelve miles south of Baghdad, on a mission to pick up new fuel tankers and transport them back to Baghdad. She remembers she felt there was nothing especially hazardous about the mission, but acknowledged that insurgents were increasingly using roadside bombs to disrupt convoys. As a convoy team, they had been told it was important to stay on guard, as other convoys had recently been hit, but she and the team did not sense danger.

Josephine continued by stating she now has no memory of the convoy or the blast caused by the explosive that almost took her life. She remembers only slowly coming out of a coma two weeks later in Walter Reed Medical Center, in Washington, D.C. The only thing she knows about the convoy, explosion, and aftermath was what she had been told by her fellow soldiers. Their group had been sitting on the floor of the truck telling jokes

when the bomb suddenly went off. Initially it was thought there were no injuries. Shortly afterwards Josephine slumped over onto the lap of one of her colleagues. She was unconscious until the medics arrived. Josephine was found to be wounded along her right side. She sustained injuries to her lower back, hip, and head. Damage was said to be from “blast pressure” or powerful air waves that are produced when explosives are detonated. It was unclear initially the extent of injuries Josephine had sustained.

Josephine remembers her life becoming a series of hospitalizations, and strict regimens of physical therapy to build strength in her limbs affected by the bombing. She recalls being constantly exhausted, dizzy, and feeling an overwhelming sense of helplessness. When well enough to be moved, she was taken to a special VA Medical Center to receive further physical rehabilitation for her arms and legs. Six months later she was discharged to her parent’s home in Portland, Oregon.

When presenting to the Women’s Health Clinic at the Portland VA for her annual exam, it was clear she had much on her mind. After her exam she requested to speak privately with her provider. She divulged that intrusive thoughts and nightmares were making it difficult for her to sleep. She also stated she was easily startled at the sound of cars backfiring and other loud noises. She was discouraged by the fact that in spite of trying to move on with her life, attend school, and start socializing with people her age, she had difficulty feeling “connected” and tended to prefer time alone. She stated that when she awoke at night she felt compelled to check all the doors to make sure they were locked.

Her women’s health provider listened compassionately. She explained the causes and symptoms of PTSD, and reassured Josephine that these symptoms were not

uncommon after experiencing trauma. Recent laboratory results, ordered by her primary care provider, were normal. It was recommended she start on an antidepressant and a medication that has been shown to help reduce nightmares in those suffering from PTSD. Referrals were made to VA behavioral health resources that specialize in providing support for women suffering from PTSD.

Physiology of PTSD

Interestingly, among trauma victims, only a third develops PTSD at some point in their lifetime (U.S. Department of Veterans Affairs, 2006). Research studies have shown that there are certain characteristics in the brain that may predispose some to develop PTSD versus others. It is thought that variations in the neurocircuitry and neurochemicals within the brain, contribute to the development of PTSD. With the use of modern imaging techniques, such as MRIs and molecular imaging with PET technology, new insights into processes underlying PTSD are possible. More study is needed to sufficiently address the potential role of regulating neuroreceptors and transporter mechanisms in an effort to understand how to reduce the cluster of symptoms associated with PTSD (Neumeister, 2006).

Symptoms of PTSD

Often the symptoms of PTSD are vague and misunderstood. This may be due to the fact that many victims have little knowledge that they have been affected until they experience a “trigger” or event that can produce an onslaught of traumatic memories that had been hidden from the conscious mind. The symptoms are frequent nightmares, insomnia, hyper-arousal and a feeling of detachment from people (Wiencke, 2007). After traumatic events it is common for victims to feel terrified, confused and even angry. In

some individuals these feelings may go away with time; however, some victims are unable to forget the traumatic event leading to severe disruption of their lives. Symptoms such as hyper arousal, insomnia, anxiety and depression can escalate to the point it becomes difficult to carry on daily activities. Occasionally the traumatic events are suppressed and it may take years for the victim to come to terms with the memory (Basu, 2006).

It has been found, yet not fully understood, that women with PTSD have an increased number of medical conditions, such as arthritis, lower back pain, obesity and hypertension (Bender, 2004). Depression is also seen to complicate their overall physical wellbeing. With the volume of symptoms a victim may experience, risk of suicide is increased (Bender, 2004). Providing treatment for these women can be challenging at best. Anger, distrust, and fear can complicate their seeking health care and support (Kelly, Vogt, Scheiderer, Ouimette, Daley, & Wolfe, 2008).

Treatment of PTSD

Treatment of PTSD is difficult due to deeply entrenched belief systems and coping styles that patients develop in an effort to manage basic functions of life. Currently there are two main modalities for treatment of PTSD: medications and various forms of psychotherapy. There are various models of therapy that have been shown to be effective, but the therapy model that has gained recognition recently is *prolonged exposure psychotherapy*. *Prolonged exposure therapy* was developed about twenty years ago by Denda Foa, PhD for the single purpose of addressing PTSD in patients. Due to its high success rate, the VA and the Department of Defense have selected it as the recommended treatment for victims of PTSD (Basu, 2006). The goal of this therapy is to

help the victims of PTSD recall the traumatic events and associated haunting memories within a safe and secure environment. This allows the victims to relinquish patterns of protective behavior and safely confront the traumatic memories they are avoiding (Basu, 2006).

In Josephine's case, a twelve week course of *prolonged exposure psychotherapy* was conducted. This was reported to have greatly lessened her PTSD symptoms and improved her wellbeing. Further suggestions from the International Society for Traumatic Stress were given to Josephine, including staying closely connected to her natural support system of friends, family, coworkers and neighbors. She was also advised to take care of basic physical health such as getting sufficient sleep, eating well, exercising and keeping basic routines (International Society for Traumatic Stress Studies, 2007).

DNP role as advocate for victims of PTSD

As an advocate for victims of PTSD, the role of the DNP is to diagnose, treat victims, educate healthcare providers and be involved in research. Support for victims of PTSD is vital for insuring this population regains full potential in their lives. The initial role of the DNP in relationship to PTSD is one of identification, education, and support for the patient. The symptoms of PTSD can be confusing and overwhelming. In many cases there is no physical injury associated with PTSD. A patient may have delayed reaction to the trauma, feeling like they are getting through life well and then suddenly finding they are unable to cope. A DNP will be alert to these circumstances and will provide the needed support. It is also important that all health care providers involved with patient care in this population be well informed on the symptoms of PTSD. DNPs will see that there is ample ongoing education related to PTSD is available to support VA

and private sector providers who treat women veterans. DNPs can also be leaders in research to find improved treatment modalities which can facilitate healing in those who suffer from this challenging condition.

Role as personal advocate for those experiencing PTSD

The individual role of the DNP is to successfully treat those experiencing PTSD. This begins with being sensitive to the needs of the PTSD patient. It is vital to create an environment in which the patient feels safe and comfortable to discuss the true nature of their problems. As a clinician working in women's health at the PVAMC, I have seen and treated thousands of female patients and have had the opportunity to evaluate and assess them in relationship to previous experienced trauma.

In my role as an advanced practice nurse and a doctoral student in nursing practice, I promote the education and support for this group by directly teaching the latest findings related about PTSD and publicly training those who are offering health care to this group of women. As an advanced practice nurse and in my role as the women veterans program manager, I advocate for change within the current health care environment within the PVAMC. A conducive environment for care is paramount to facilitating positive health outcomes. In my effort to champion women's health care for veterans at the PVAMC, I feel I am using the skills I have acquired through my advance practice nursing training to promote quality health care services.

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Running Head: ENVIRONMENTAL CASE STUDY

Environmental Case Study

Nancy Sloan

Oregon Health & Science University

Introduction

The recent increase in deployment of women in the U.S. military has resulted in a large influx of women veterans starting to access the Veterans Administration Medical Centers (VAMCs) for their health care. Historically the bulk of the VAMC patient population has been men. This sudden increase in women patients has created multiple challenges to providing quality health care for this unique population within this traditionally male dominated health care system.

As the Women Veterans Program Manager (WVPM) at the Portland VAMC (PVAMC), I hold the responsibility for insuring that women veterans receive the same quality of health care that is available to male veterans. Recent research shows that disparities exist in the quality of health care services for women within the VAMCs on a national level (Washington, Yano & Simon, 2006). Not only does this have ethical implications, but as women veterans' presence in the U.S. military continues to rise the issue of health care for this population is increasingly politicized. The purpose of this paper is to highlight the health risks that can be associated with an environment which is ill-prepared to meet the psychosocial risks which can result in health care challenges to this population.

Epidemiology

Women veterans under the age of 50 comprise the majority of patients accessing gynecological health care at the PVAMC (Department of Veterans Affairs, 2008). This population is likely to be unmarried, use the VAMC as the main health care resource and be pursuing an education using military benefits (Iqbal & Garovoy, 2008). Common diseases in these women are menstrual disorders (28%), inflammatory diseases of the

cervix, vagina, and vulva (27%), and pelvic pain (32%) (Iqbal & Gorovoy, 2008). Of this group 58% are likely to suffer from post traumatic stress disorder (PTSD) and depression (Iqbal & Garovoy, 2008). Research surveys show that over 50% of these veterans may have also experienced sexual harassment from male colleagues during military service (Iqbal & Garovoy, 2008). Thus, it has been shown that for women to continue seeking health care at the VAMC, the environment must be perceived as safe and free from risks of repeated trauma (Lee, Westrup, Ruzek, Keller & Weitlauf, 2007).

Physical Environment

The current physical environment at the PVAMC surrounding the delivery of gynecological care is not conducive to providing gender-sensitive care. The gynecological clinics at the PVAMC operate two afternoons per week and regularly treat over thirty female veterans weekly. The clinic is in a busy hallway with adjoining exam rooms. Other medical specialties such as dermatology, urology, and oncology frequently share the same area. Women veterans wait for their appointments in a large common waiting room alongside male veterans. The hallway outside the exam rooms is busy and often noisy. Due to the demands of the clinic, patients may wait up to an hour once in the exam room. This can cause increased anxiety and fear. Anecdotal reports suggest that women veterans feel discomfort and unsafe when accessing gynecological care at the PVAMC due to this clinic environment; many have voiced their concerns to local representatives of the women veteran population (C. Holt, personal communication, September, 15, 2007); (D. Benjamin, personal communication, October, 23, 2007).

Case Study

Susan, (fictional name) is a 36 year old unmarried female who has returned from active duty in Afghanistan four months ago. She is generally healthy, with a recent history of an abnormal pap smear, categorized as a “low grade squamous epithelial lesion”. The patient was referred to the specialty clinic for urgent follow up due to reports she made of three previous abnormal pap smears while in the military.

When Susan arrived at the PVAMC for her appointment she had difficulty finding the gynecological clinic. Volunteers at the information service counter were confused as to whether she was trying to locate the women’s health clinic or another clinic which they were unfamiliar with. An aged male veteran volunteer asks what the appointment is for and Susan feels others could be listening. After much deliberation the gynecological clinic is finally located and Susan proceeds to the area. She finds that the clinic is shared by several other health disciplines and is forced to wait in a busy crowded waiting room. It is hard not to reflect on her time spent in active duty when alone in large groups of male soldiers, which made her feel vulnerable and afraid.

When finally called for her appointment, Susan is met by medical assistants that seem cold and business-like. They know little about her history and the procedure she is about to have, which increase the patient’s feelings of loneliness and fear. . When the attending gynecologists appear, they are flanked by two residents, one male and one female, who are interested seeing a colposcopy, the designated procedure for this type of abnormal pap smear and patient history. Susan resigns to the situation, and again recalls many times she felt helpless when serving in the military and ended up carrying out orders for which she had little understanding.

The procedure goes well from the healthcare provider's perspective, and the attending physician reassures Susan that the results of the tests will be in the mail soon. Susan leaves dizzy and bewildered and takes the bus home where she falls into a deep sleep from the physical and emotional exhaustion caused by the experience.

Case Analysis

This case illustrates why it is so important to identify the multiple factors which need to be considered as they relate to women veterans seeking health care at the PVAMC. These will be addressed in the following analysis of this case.

Social and Cultural Factors

Understanding that many of these women veterans have been sexually traumatized while serving in the military mandates that they have a health care environment which is sensitive to making them feel safe and secure. Fontana and Rosenheck (2006) found that if a health care environment is not perceived as safe by women veterans they will cease using it. As in Susan's case, this increases the risk for untreated gynecological conditions (Fontana & Rosenheck, 2006). Research has shown that this population will more readily access health care when it is delivered in a clinical environment that is dedicated to women and is perceived to be free from potential recurring trauma and is staffed by gender-sensitive clinicians (Brittle & Bird, 2007). Because this group is likely to not have other means of health care, this puts them at high risk for not getting the medical attention they need and deserve.

Economic Factors

The average annual income of women veterans using the PVAMC is \$22,000 to \$24,000 (Department of Veterans Affairs, 2008). Women veterans are likely to lack

private health insurance and are frequently single mothers, and are often (65%) using veterans benefits to continue their education (Hayes, 2008). The VAMC is considered by most of these veterans as their primary source of health care (Hayes, 2008). If women veterans are not comfortable using this source for health care it is likely they will not have access to any health care.

Ethical Considerations

The ethics involved in relationship to this population relates to the VAMC mandate to provide appropriate health care for all veterans. Women veterans present unique challenges to the PVAMC to fulfill this mission due to the current structure and lack of gender-specific health care. Nonetheless, the PVAMC remains obligated to meet the health care needs of this population. It would be unethical to let these challenges interfere with the quality of health care women veterans receive.

Political/Legal Implications

The U.S. government is very concerned with the political repercussions stemming from the increasing numbers of women in today's military. How these women are treated and their access to benefits post-deployment is an issue which is highly scrutinized by the media and the public. The number of women serving in the military is projected to increase substantially in the near future, resulting in a drastically increased demand for VAMC provided health care for women veterans (Department of Veterans Affairs, 2007). The annual conference for national VAMC Primary Care Divisions held in Washington DC, July 29, 2008 – August 1, 2008, laid out a five year strategic plan for the development of dedicated Women Veterans Health Centers within all VAMCs. These

centers will be designed to meet the psychosocial and physical needs of women veterans (Hayes, 2008).

Recommendations and Interventions

As the WVPM and a DNP candidate, I strongly recommend the application of the national VA directive to create a dedicated Women Veterans Health Center within all major VA medical centers. It is hoped that this will reduce the environmental risk currently experienced by women veterans in the PVAMC. Toward this end and in the role of WVPM, I have made presentations to the PVAMC's executive body outlining current gaps in the quality of care being given to this population. This data was ultimately submitted in the form of a formal space proposal requesting a dedicated Women Veterans Health Center to be built within the PVAMC. On July 30, 2008 the executive body approved this proposal and allocated 3,000 square feet of space to be used for Women Veterans Health Center.

Since that time I have been working with engineers and architects to design an area which meets the criteria for quality health care delivery for women veterans. In addition to this I am hiring and training medical staff to the gender-sensitive needs of this population. In order to increase the number of providers who feel proficient to participate in the health care of this population extra training in women's health is being offered by the national VA in the form of mini-residencies across the country. I have arranged for several staff from the PVAMC to receive this training and they are now in turn sharing the knowledge and skills they gained with others at the PVAMC.

As a DNP, I will continue in this leadership role to ensure that gender-sensitive and quality health care is available to this population of women veterans. Cases such as

Susan's, will be minimized by providing an environment which is sensitive to their needs and will insure that women veterans have high quality health care in an environment that is perceived as safe and comfortable to them.

Self – reflection

I have found from working with this population that personal commitment and compassion are needed to continue advocating for this group. Within a large healthcare system like the PVAMC, there are thousands of patients with multiple needs. As in many health care systems, the VA has limited resources and there are huge demands on the system. Yet, due to the enormous growth that is projected affecting in the numbers of women veterans, an ongoing analysis of the current status available health care is essential to insure their needs be met. Perseverance is required to keep advocating for this population so they attain the level of health care they deserve.

I plan to continue focusing on the needs of women veterans and educating the stakeholders at the PVAMC about the health trends in this population. As my clinical inquiry associated with the DNP degree progresses I will be presenting ongoing data to those associated with the development of the Women Veterans Health Center which will serve to direct the implementation of the health program for women veterans at the PVAMC.

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Running Head: ETHICS FOR SCHOLARLY PRACTICE CASE STUDY ANALYSIS

Ethics for Scholarly Practice

Case Study Paper

Nancy Sloan

Oregon Health & Science University

Mary (fictitious name) is a 56 year old female with a history of schizophrenia. She is in the Veteran Administration's (VA) gynecological clinic today for follow up on an abnormal pap smear which showed "high grade squamous lesions". She is in need of a colposcopy and biopsy to further analyze the extent of the cellular dysplasia. She appears disheveled and unkempt. She was brought to the clinic by a caretaker from the group home where she resides. She has been chronically ill with schizophrenia since her early twenties when she had her first psychotic episode while undergoing the rigors of boot camp. She has been under the care of a VA psychiatrist ever since. She is on several anti-psychotic medications which allow her to function at a basic level.

When preparing Mary for the procedure a medical resident reviewed the medical process of the colposcopy and obtained an informed consent. The resident then returned to report to the gynecological team. A physician and I then went into the patient's exam room and introduced ourselves. We quickly see the patient is confused and cognitively challenged.

We proceeded to ask her if she knew what the medical procedure she would be having done today was and the reasons for performing the procedure. In response she stated, "Yes, you are going to be checking to see if I am pregnant." She exhibited that she was clearly is confused about the procedure and its' purpose. The clinic was very busy and many patients were waiting. If the procedure isn't done there could be grave health consequences to the patient.

What should be done at this time?

Review of Topics:

Medical Indications

The diagnosis this patient had was “high grade squamous epithelial cells with probable glandular involvement”. This is a diagnosis which is taken very seriously in gynecological settings. Cells of this type can lead to cervical cancer if not caught early and can mean death for the women who are diagnosed with it. According to the American Cancer Society, 3,670 women die of cervical cancer in the United States every year. (Anonymous, 2007). A colposcopy, which is performed to visualize and identify suspicious cells on the cervix, is a life saving treatment for many women. With the correct identification of the type of cell dysplasia that caused the initial abnormal pap smear, medical professionals can closely monitor and prevent the development of cervical cancer.

Patient Preferences

Even though this patient has signed the informed consent we are not sure whether this patient can be considered ‘informed’. Does the patient comprehend the reasons for the treatment and the medical process she is about to undergo? Are the risks of the procedure fully understood by the patient? If she did sign the informed consent was she competent to make the decision? Are her medications interfering with the clarity of her thoughts? Is this confusion something that will clear and allow the patient to participate in her health care choices in a more coherent way later on? At this point we are unsure what the answers to these questions are, but we do know that we need to reassess the patient’s comprehension and decision making capacity before we proceed any further. We must analyze and determine what the overall goals of the patient are. What does the patient

want? Are there options that the patient would prefer if the full range of treatments were understood? If the patient is truly incompetent to make their own medical decisions, is there a legal surrogate who can be contacted and enlighten the clinicians regarding the patient's full capacity and preferences?

Quality of Life

If this patient were allowed to proceed without treatment it could lead to cervical cancer and result in painful procedures. Many women end up having a hysterectomy when cervical cancer is found. That can put a female into early menopause which can greatly alter mood, comfort and even sense of self. If cervical cancer metastasizes there will be an involvement of other vital organs and could eventually lead to death. It could be argued that this patient with a chronic illness does not have a high quality of life as perceived by others, but that would not be justification for non-treatment. Ethically as clinicians we must not fall into the practice of judging quality of life by our own perceptions and values. This has occurred in history and has led to barbaric medical experiments and ruthless clinical behavior (Anonymous 2007). In this case our interest is to prevent further need for painful treatments, hospitalizations, surgeries and possible chemotherapy. Allowing this patient to undergo unnecessary pain and discomfort is a strong incentive to act to continue and or improve her current quality of life. How do these issues affect our decision to proceed?

Contextual Features

At this point in our decision making process we need to balance the ethical and legal obligations involved in this patient's healthcare. We have started the process of caring for this patient's gynecological health by initially doing a pap smear. With the support of her group home care managers she has consented to the prior health exams with the possible understanding that these exams could lead to more extensive care. The patient is not resisting treatment at this time; rather, she is presenting herself to the clinic as a patient for the purpose of the medical professionals managing for her health care needs. But the question still remains; can we ethically proceed with the procedure while the patient exhibits a questionable level of mental competence?

Case Analysis

This is a case of questionable mental competence in a patient presented with the signing of an informed consent. This raises the ethical question of how much information is sufficient for any patient to be truly informed prior to their signing an official informed consent document?

There have been many previous ethical cases involving the issue of informed consent being obtained from mentally ill patients. When patients are confused or unable to comprehend the medical procedure for which they are being asked to sign consent; there are often legal channels within a hospital system which can allow the greater good to be done for the patient within legal parameters (Goldblatt, 2006). Obtaining consent from a legal guardian (Welie, 2006) or allowing time for the patient to clear mentally in order to comprehend the upcoming medical treatment would be two of the many choices

that allow the patient to be treated with respect and autonomy while preserving the clinicians interest in doing no harm (Howe, 2006).

The ethical decisions regarding this case would be significantly different if the patient's mental illness was causing her to vehemently oppose the medical procedure. Also, if the patient had not already been under the care of the VA hospital's gynecological clinic and had willingly presented for treatment there could be greater questions regarding her willingness to subject herself to a medical procedure trusting that her care in the past has not caused her harm. With these principles in mind it would seem logical that the patient be reeducated about the procedure at a level she could hopefully comprehend. This could let the clinicians proceed with the medical intervention to the benefit and protection of the patient, and satisfy the ethical principles of beneficence on the part of the clinicians.

This case also illustrates the need to apply the principle of autonomy to insure all patients are given full respect and opportunity to participate in their healthcare process. This would necessitate one avoid stereotyping patients which can lead to presumptive behavior within healthcare settings. As the health care providers for this patient, as well as any others with questionable mental competence, we would be risking serious error in judgment to fall into a paternalistic pattern of assuming our opinions and decisions should supersede the will of the mentally challenged patient (Hoffman, 2006).

The VA invites a large cross section of humankind into its healthcare service. Often due to the rigors of war and the traumatic experiences endured by individuals in battle many who avail themselves of the VA services have serious mental challenges. This

poses an ethical dilemma to clinicians who need to practice the ethical principle of autonomy, to respect that all individuals have the right to make their own healthcare choices. Yet, we need to insure that patients are able to comprehend the medical procedures they are agreeing to. This also would be in harmony with the ethical principle of beneficence, which dictates that the clinician practice in a manner which would promote the overall health and well-being of their patients.

When a clinic is busy and rushed in an effort to see many patients as possible the just course that would dictate all patients have the same opportunity to achieve the same quality of medical treatment is a challenge. With this goal also comes a desire to be efficient and deliver care in a competent and effective manner. The clinician's challenge is to avoid acting in a paternalistic way, assuming that the patient and provider have the same goals (Deber, 1994). How did my views of those suffering from brain injury or mental illness affect my rational and judgment regarding the patient's ability to competently engage in decisions involving their own medical treatment?

Kleinman describes transactions between healer and patient in an effort to address the variety of situations which would cause a clinician or "healer" to abandon his internal ethical sense and submit to another voice (Kleinman, 1981). He suggests these interfering factors include:

- Institutional setting
- The character of the interpersonal interaction
 1. number of participants present
 2. quality of interaction and time spent on patient/clinician discussion and education

- The idiom of communication
- The orientation of the institution, i.e., disease or illness centered (disease being the biomedical model and illness being the patient experience).
- Therapeutic expectation of all concerned
- Mechanisms of therapy
 1. How the procedure is done
 2. How the procedure is assessed
 3. How the procedure is evaluated (pg. 349)

In this case the institutional setting was unfavorable for the patient to make a clear, informed consent. Her long history of chronic mental illness coupled with the rushed and busy atmosphere of the clinic created a highly anxious patient with less ability to comprehend medical information. To apply moral competence and human values in this health care setting it was decided that the clinicians involved would take the needed time to review the colposcopy procedure with this patient and fully assess her capacity to sign an informed consent.

We addressed the situation in light of Kleinman's recommendations noted above.

- We limited the number of people in the room so the patient wouldn't feel overwhelmed.
- We allowed sufficient time for the education of this individual patient, keeping in mind her challenges and needs.
- We insured we were communicating at the right level and with the appropriate vernacular.
- We attempted to be patient centered in our approach.

- We reviewed the therapeutic expectations for all concerned; determining whether the clinicians and patient had the same goals and understand the evaluation of success for this procedure.

With a full discussion and assurance of patient understanding we could proceed with confidence that the patient was fully informed and aware of the full medical implications and purpose of the procedure.

This ethical dilemma is addressed by the University of Washington School of Medicine in an article written about Ethics in Medicine. The author reinforces the principle of patient's autonomy by stressing that the physician should make very clear that the patient is a participant in a decision making process, not merely signing a consent form for a procedure. The informed consent should be viewed as an invitation to the patient to participate in their healthcare (Edwards, 1998).

In Edward's research the needed criteria for a patient to give informed consent would be that they:

- Understand their medical situation.
- Understand the risks associated with the procedure at hand.
- Communicate a decision based on that understanding.

These suggestions again address the ethical principle of autonomy. Do we allow the patient to choose medical treatment based on an education of alternatives and risks; or do we arbitrarily and perhaps paternalistically decide who is or is not competent to give full informed consent and proceed with our own assessment of the situation?

This discussion cannot be complete without fully addressing the overall issue of informed consent.

- What would the average patient need to know in order to be an informed participant in the decision?
- What would the average patient need to know and understand in order to make a truly informed decision (Kuczewski, 1996).

Clearly a patient without medical training cannot be expected to fully grasp the entire scope of a medical procedure and its' inherent risks. An established level of understanding would seem necessary to determine to set a standard for the level of information needed to establish guidelines in this area.

In addressing these issues inherent to the process of informed consent we must heed the ethical principle of justice. If guidelines were enforce a level of competence needed for a patient to sign an informed consent we could be jeopardizing medical treatment to those who suffer from cognitive challenges and mental illness. We must be careful in over legislating in this area due to protecting the rights and health care needs of patients who are at risk of being stereo typed as being mentally incompetent.

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Running Head: HEALTH CARE ISSUES AFFECTING WOMEN VETERANS

N790 Clinical Residency

Health Care Issues Affecting Women Veterans

Nancy Sloan

Oregon Health & Science University

Population and Epidemiology

The recent increase in women being used in the military has created a sharp rise in those accessing health care at the Veterans Administration (VA) on return from military duty. These women veterans now comprise 8% of the veterans using VA health services nationally. Of these, 86% are under the age of 40 and ethnically diverse (U.S. Department of Veterans Affairs, 2007). In addition to these factors it has been estimated that over 60% of these women have suffered from some form of military sexual trauma (MST) while serving in the armed forces (U.S. Department of Veterans Affairs, 2007). The VA defines MST as sexual assault or repeated unsolicited threatening acts of sexual harassment between at least two people in which someone is involved against his or her will (U.S. Department of Veterans Affairs, 2007).

The VA health system has historically provided health care for males, so this new influx of women veterans with their unique needs has proved challenging for VA medical centers nationally. While the VA is now aware of possible disparities and has made recent directives to address them, current conditions have not yet been modified sufficiently to address all of their concerns. This threatens the quality of health care services now being provided for women veterans. Some of these disparities include a lack of providers/clinicians with up-to-date skills and knowledge in women's health, a gender-sensitive environment for providing care for women with MST and a lack of specialized gynecological services.

Female veterans currently number approximately 1.7 million nationwide and represent more than 7% of the total veteran population (U.S. Department of Veteran Affairs, 2004). As of September 2005 women represented 17% of active duty personnel

and 17% of reserve and guard personnel (Women's Research & Education Institute, 2007). These numbers are projected by the Department of Defense to increase to over 20% the next few years (U.S. Department of Veterans Affairs, 2007). It has been discovered that many women enter the military with significant trauma histories and when further exposed to traumatic events during the course of their military service their risk of experiencing higher levels of mental and physical illness is increased (Zinzow, 2004). The National Center for Post Traumatic Stress Disorder (PTSD), a VA research center located in Palo Alto, California, analyzed data gathered from 185,880 women veterans related to MST and the connection with their subsequent health and environmental needs. Positive screens for MST were associated with increases in all categories of mental health issues, including PTSD, depression, adjustment disorder and anxiety (Kimerling, 2007). Associated medical co-morbidities included pulmonary disease, liver disease, and chronic pain (Kimerling, 2007).

Women veterans were shown by the Palo Alto VA research center to be more likely than male veterans to experience sexual assault and as likely to be involved in combat as male veterans when deployed (Kimerling, 2007). This increases the likelihood that this population will continue to have multiple trauma issues when seeking health care post-deployment (Vogt, Pless & King, 2005). With the burgeoning number of women serving in the military the needs of this cohort need to be given serious attention or it could greatly affect their overall health and well-being.

Case Study Analysis

Due to the recent rise in women veterans being used in the Iraq and Afghan conflicts the new cohort of women veterans using the VA health system are largely from

this group. The following case study will discuss the life of one of these women which is highly representative of their background and the challenges they face.

Mary (fictitious name) is a 26 year old Caucasian female who has recently return from Iraq. She was raised in a farming community in Oregon and is the middle child of four siblings. Her mother is a local baker and her father was a farmer. He passed away in a work related accident when she was 8 years old. Impacts on her life which have greatly influenced her have been her father's death, her low-social economic level, the nature of her family's work and education level, and being one of four children in a small farming community in Oregon.

Mary joined the military at 19 years old, shortly after graduating from high school. She was soon deployed to Iraq in July, 2005 and was the only female in her unit. Mary was given the responsibilities of driving a truck transporting equipment and supplies, which meant she was often in hostile territories. She was stationed in Iraq 12 months and has recently returned to her home state of Oregon.

While in Iraq, Mary endured a number of severe hardships such as extreme temperature, carrying heavy gear, driving long distances in dangerous territory, moving heavy equipment and walking for long distances. There was constant fear of setting off landmines, negative interactions with male counterparts and impaired hygiene conditions. She missed her family and home town, and felt quite alone.

This patient presented to the VA outpatient clinic in Portland, Oregon complaining of lower back and foot pain experienced since deployment. She also has lower abdominal pain and menstrual irregularities since her return. Mary denies any

health issues prior to deployment, and her family history is negative for significant medical conditions.

Mary was initially examined for signs of traumatic brain injury (TBI) which is a routine screening done on all veterans since the beginning of the Iraq and Afghan wars. She is questioned about headaches and other neurological disorders, and given a thorough mental health exam involving screening for MST, PTSD, depression, alcohol use and anxiety. These and a cursory physical exam were assessed as negative by her clinician.

As Mary was turning to leave the exam room, she requested one more moment to address a concern. The patient then revealed a sleep disturbance (difficulty falling asleep and staying asleep) and admitted to headaches and irritability. Panic-like symptoms including pounding heart, shortness of breath and numbness. When encouraged by the clinician Mary continues the discussion speaking about feeling disconnected from her family and friends because she can't talk to them about her military experiences. She appears uncomfortable when broaching the subject of her boyfriend. The patient quietly tells the clinician she can't be intimate with him due to an incident which occurred while in active duty. Her eyes are cast down and she looks away as tears start to stream down her face. She whispers that she was sexually assaulted by a fellow soldier while in Iraq.

Mary continues to explain that not only was the sexual assault horrifying, but her exposure to combat casualties and scenes of violence have left her unable to have intimate relationships. Her panic, irritability, and sleep disruption have left her guarded, afraid and unable to trust others.

Comment [p1]: Avoid the redundancy of the word "she" ..

Case Review

For women veterans in this situation, literature has shown that the clinician must remain fully engaged and establish a trusting relationship (Iqbal & Garovoy, 2007). This includes maintaining eye contact, slowing the pace of the appointment, and taking a posture that exhibits time is not an issue. Validation of her concerns related to feelings of being disconnected from family and friends is critical. The clinician must show understanding in relationship to the troubles with her boyfriend. Being clear, honest, and respectful is paramount. It is important to communicate hope, validation and also acknowledge the difficulty of the disclosure. Reassurance about confidentiality and security need to be given to veterans in this situation. Likewise, it is critical the clinician not probe for details beyond what the veteran is willing to disclose (Iqbal & Garovoy, 2007).

In this case Mary was provided information and options for referral. With the appropriate interventions Mary was soon aligned with professionals within the VA health system which gave her the mental health support and the medical treatment she needed. It will be a long, uphill battle for Mary, yet she is determined to go to school to become a dental hygienist and eventually have a home and family near her home town in Oregon.

Intervention and recommendations

The challenges presented by this new wave of women veterans are two-fold:

- 1) How are the women veteran's medical and psychological needs best met?*
- 2) How do we address the life style needs of young women in relationship to their accessing medical care at the VA?*

In answer to meeting the medical and psychological needs of these veterans we need to consider the high numbers of women who have experienced trauma while in

active duty. Literature has shown that the best environment for these women to access health services is in a comprehensive women's health clinic which offers a private, secure environment staffed by proficient female clinicians (Yano, Goldzweig & Washington, 2006). This model addresses the gender-sensitive environmental needs of the women veterans and also provides a way for easy access and collaboration with sub-specialties. The environment of this comprehensive clinic would allow the women veterans to have a protected "psychological" space, free from possible exposure which would link them to MST/PTSD memories (Yano, Goldzweig & Washington, 2006).

As illustrated by the case study of Mary, the demographics of women veterans has greatly changed. These veterans most are now more likely to be under the age of 40, pursuing higher education and are frequently single mothers. This requires providing comprehensive and efficient health care that takes their busy lifestyle into account. The model suggested by the national VA women's strategic planning group is described as "one-stop shopping" (Hayes, 2007). This suggests the veteran women will have their needs specific to gender care provided in conjunction with their primary care needs. It has also been proposed that there be some provision for child care while the veterans are in the clinic (Hayes, 2007).

Strategies for Change

As the Program Manager for Women Veterans at the PVAMC and as a DNP student, I have advocated for this population with special needs. I have been highly involved in allocating space which would serve as a dedicated area for the development of a Comprehensive Women's Health Clinic at the PVAMC. Recently 3,000 square feet was approved for this purpose by the executive body of the PVAMC. As the Program

Manager for Women's Health I have been instrumental in hiring medical professionals who staff this clinic and contribute to providing gender-sensitive care for this population.

Expected Outcomes

When the designated space for the Women Veteran's Health Clinic becomes available, the Women Veterans Health Committee and the PVAMC Space Committee will start the construction of the approved floor plan. An interdisciplinary team made up of internal medicine, gynecology, urology, mental health and social workers specializing in women's health issues will occupy this clinic to provide comprehensive health care for women veterans at the PVAMC. The presence of this clinic is believed to greatly improve the availability, continuity and quality of health care services for the women veterans at the PVAMC.

Implications for Advance Practice Nursing and Health Policy

The implications of the successful implementation of upgrading standards of health care for this population is that it underscores the enormous role that advance practice nurses have in advocating for groups experiencing disparities in their access to health care. An advance practice nurse has the responsibility to be highly attuned to social inequities which negatively impact health care. Their role as a strong advocate for these groups is inherent in their profession. Further, the advance practice nurse will use political avenues to enact legislation which can lead to health policy changes to create lasting benefits to marginalized populations.

Self-reflection

The personal and professional leadership skills needed to analyze this case and situation among women veterans at the PVAMC and implement strategies were insight

into the overall goals of the PVAMC organization and understand the current priorities of the VA on a national level. I think leadership in this role also is enhanced by understanding that the stakeholders involved and assess what is key in driving current priorities. Coupled with this awareness, in my role as Program Manager for Women Veterans, I kept abreast with issues that the women veterans were experiencing, both physically and emotionally. In my role as an advance practice nurse, leadership is a large part of my role and is central to advocating in behalf of this population.

On a personal level, confidence and courage were needed as a new employee at the PVAMC organization to begin meeting with the Chief of Staff and the Medical Director regarding my concerns for women veterans. These meetings led my addressing larger PVAMC forums to highlight the existing disparities in health care for women at the PVAMC. I took the lead in organizing the Women Veterans Health Care Committee to offer multidisciplinary insight and guidance to direct initiatives in positive productive ways. Invitations to speak to the local media also created opportunities for me to advocate publicly for change.

There have been times in the past two years when women veterans' needs seemed to fade in the minds of the main executive body at the PVAMC. Finding stakeholders to champion the cause and re-ignite the enthusiasm for the change in health standards for this population was a vital part in achieving successful outcomes. The qualities mentioned above will continue to be developed and expanded upon as I advocate for the completion of the Women Veterans Comprehensive Health Clinic at the PVAMC.

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Running Head: HOMELESSNESS AND WOMEN VETERANS

Homelessness and Women Veterans

Clinical Case Report

Oregon Health & Science University

Nancy Sloan

Introduction

During times of war people naturally focus on the sacrifices and needs of military men and women in combat. However, it often goes unrecognized that post-deployment, a number of these soldiers become homeless. It is estimated that one out of every three homeless persons in the United States is a veteran, more than 65% being from the post-Vietnam era (U.S. Veterans Administration, 2006). It is reported that there are 195,827 homeless veterans in the United States, including an estimated 8,000 women veterans (National Coalition of Homeless Veterans, 2009). The number of homeless women veterans is predicted to increase, corresponding with the increase in numbers of women soldiers (Gamache, Rosenheck & Tessler, 2003).

Homelessness creates vulnerabilities that greatly increase the victims' chance of illness and death (Cheung & Hwang, 2004). These risks include physical and sexual victimization (Wenzel, Koegel & Gelberg, 2000). Factors such as mental illness and substance abuse in conjunction with poor survival strategies, contribute to these risks. Additionally, over 76% of the homeless veterans suffer from drug or alcohol addiction compounding their risks (Gamache, Rosenheck, & Tessler, 2003). Greater attention must be given to this population beginning with safe residences and treatment of their mental health disorders and substance abuse.

Research has sought to answer why homelessness is rising among the women veteran population specifically. It has been suggested there is a relationship between military sexual trauma (MST) and homelessness for women veterans (Himmelfarb, Yaeger & Mintz, 2006). Yet, overall it is recognized there is a deficiency in knowledge related to homeless women veterans and little understanding as to why their numbers are increasing (Gamache, Rosenheck, & Tessler 2003). The situation of homelessness as it relates to women veterans will be the focus of this paper.

Case Study

Looking back on Robin's (fictitious name) life of 39 years it seems easy to see where she lost her way. She was originally from Dayton, Ohio and at age 15 moved to Kentucky where her father sought coal mining work. She graduated from high school in spite of turmoil within the family as her parents struggled to keep their marriage together amidst dwindling finances. She enrolled in a local technical college where she studied electronics, but didn't finish due to her growing use of drugs. To avoid being penniless and in an effort to find structure in her life, she responded enthusiastically when an army recruiter told her about all the advantages and future benefits from serving in the military.

Within the military she was sexually harassed, abused or otherwise accosted numerous times by male colleagues in her regiment during military training in North Carolina. She stated that walking the streets around the barracks was scary due to the fear of further attacks. As time went on, depression set in and she turned to alcohol as an escape. As she prepared for deployment to the Persian Gulf in 1990, the army discovered she had scoliosis, an abnormal curvature of the spine, and gave her a medical discharge. Robin is unclear if this condition was being used to relieve her of duty, or if they had overlooked this on her enlistment. Out of work and unable to sit or stand for long periods of time due to her scoliosis, she collected a box of rejection letters from potential employers. Her alcohol use added to her malaise, and it took a long time to find work.

Having been on and off drugs over a period of ten years, Robin then lost her apartment where she had been living in for five years. She ended up staying in Central City housing, designed as temporary housing for the homeless, while waiting for housing in the Portland VA Medical Center's (PVAMC) transitional housing unit (THU) located in Vancouver, Washington.

Robin came to the Women's Health Center at the PVAMC late in the fall of 2008. She appeared unkempt and anxious. She carried medical records from her service in the military in a small dirty satchel which also contained various empty plastic water bottles and a half-eaten protein bar. She explained she was embarrassed by her appearance and asked we overlook her being unclean.

Robin's vital signs were stable at 123/82 mm/Hg, pulse of 72, respirations of 12 and temperature of 98.6. Her labs which had been drawn a week prior to her appointment as ordered by her primary care physician were all in normal range. Her weight was 127 and height 5'4". A basic gynecological exam was performed by the practitioner. This caused considerable anxiety for the patient due to her history of being sexually assaulted in the military. To reduce Robin's anxiety during the course of the exam, the practitioner asked her questions which led to her revealing her story.

Robin admitted to using alcohol as a way of reducing stress. She had avoided using the PVAMC for health care because she was ashamed of how her life had become. She distanced herself from her parents, now divorced, to avoid bringing them further shame. She expressed a sincere desire to return to a normal life, yet felt she had lost the way. The practitioner listened with empathy and allowed sufficient time to hear all of Robin's concerns. Options for recovery and stabilization were then discussed with Robin and are outlined later in this paper.

Case Analysis

Robin is one of over 7000 women veterans in the United States who find themselves homeless. Doubtless there are many more homeless women veterans who are not part of the official statistics, due to many sleeping on a relative's couch or moving from one family residence to another until forced to seek outside assistance (Kushel, Vittinghoff, & Haas, 2001).

Most shelters, including the VA THU, have few available beds and stays are time limited. It has been suggested anecdotally, that frequently veterans have to leave prior to being fully ready to start life on their own. Due to a growing awareness within the VA of these cases, more VA programs are focusing their attention on homeless women veterans. This awareness has resulted in increased program funding, allowing longer stays and an increase in recent VA incentives to build more shelters designed specifically for women (Mandy Martin, personal communication, veteran advocate, 2009). Social worker support has also been increased to give these veterans every opportunity of successfully reenter mainstream society (Swords into Plowshares, 2009).

Issues that impede homeless women veterans seeking treatment are shame, as in the case of Robin, and lack of awareness about available options. Women often find themselves in the minority when seeking shelter options, and feel uncomfortable discussing physical and mental health issues in the presence of men (Gamache, Rosenheck & Tessler, 2003). Fear of further violence is another barrier to women seeking refuge in co-ed shelters (Bassuk, Melnick & Browne, 1998).

Interventions and Strategies

The advance practice nurse (APN) and doctorate in nursing practice (DNP) student is in a unique position to assess and help overcome the barriers that limit access to health care and shelter for women. They recognize the homeless population has ongoing needs that deserve serious attention to prevent pitfalls that would return them to homelessness. Barriers that prevent access to care are multifaceted and often include finances, limited information, bureaucracy, stigma, and fragmented care (Bassuk, Melnick & Browne, 1998). APNs and DNPs can advocate as case managers for this population and assist patients to find lasting, holistic solutions to their problems. Due to the specific nature of their training, ANP and DNPs understand the need of

education and life-skills to help patients with holistic life-changes. This includes treatment for substance abuse and mental health issues along with providing protected environments where healing can occur (Gelberg, Gallagher, Andersen & Kogel, 1997). It is equally important that the APN and DNP develop a safe, caring and anchoring relationship with this population, as many have experienced betrayal in their primary relationships and need a safe therapeutic attachment to accomplish a full recovery (Bassuk, Melnick & Browne, 1998).

Evaluation of Care and Potential Impact on Specialty Populations

The training of a DNP adds to the ANP's basic foundation of knowledge, and increases awareness of structural models that predispose certain populations to the risk of homelessness, such as psychological distress, alcohol and drug problems, inadequate health care, and illness. Alert to the challenges that affect this group, they use foresight in their treatment to empower them to maintain healthy lifestyles. The DNP is also knowledgeable about social options to care for this population and can direct them to resources that have been shown to assist with achieving beneficial outcomes.

Expert assessment skills are used by the DNP to get a full understanding of the needs of each individual. In this way every patient is treated according to their unique needs enhancing the potential for optimal outcomes. In summary, the DNP understands the serious health risks facing this population, takes them seriously, and acts on them promptly.

Personal and Professional Skills Needed

As a DNP student I was aware of the complexities of Robin's case. Her risks ranged from a compromised socio-economic situation to military sexual trauma to substance abuse. Her social isolation made her vulnerable to further victimization and abuse. Her willingness and ability to access health care was jeopardized due to stigma, economic resources, and limited

transportation. Based on knowledge gained by research in the DNP program, I advocated that her case be handled in a gender-sensitive way to insure that Robin, as a women veteran would be placed in an appropriate setting.

The DNP curriculum has provided a greater understanding of the tremendous impact groups suffering health disparities can have on the overall health care system. For future cases like Robin I need to increase in my knowledge of resources that are available to this group, and triage and refer homeless veterans to safe havens in a more efficient manner.

The existing health care system labors under a huge burden attempting to care for the homeless veteran population. As a DNP student, I have learned to be a leader in addressing health disparities and now work on community, state, and national levels to solve social issues such as homelessness among women veterans. As a DNP student, I am becoming a leader within the VA system in addressing the disparities within this population. Under girded by the DNP experience, I have contributed to legislation on a state level to address these issues. Finally, because of insight gained through the DNP process, I see that it is imperative to act to discover better solutions to alleviate the suffering of homeless veterans and guide their successful re-entry into productive society.

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Running Head: DOCTORATE IN NURSING PRACTICE LEADERSHIP ROLE

Doctorate in Nursing Practice Leadership Role

Nancy Sloan

Oregon Science & Health University

A core principle within the United States is that all men and women are created equal. When it comes to providing health care, federal medical agencies including the Veterans Administration (VA) acknowledge that the reality falls short of this ideal (Spotswood, 2009). Quality and consistency of care, which greatly impacts overall health, life expectancy, and quality of life, is often divided unequally along racial, cultural, and socioeconomic lines. Historically, the VA has focused on meeting the health care needs of men - because men have made up the preponderance of the military workforce. As a result, women veterans seeking care at the VA have received less than an equal measure of care. With the increasing numbers of women in the military this health care inequity is becoming more apparent and is crucial it be addressed.

When first in my role as Women Veterans Program Manager at the Portland VA Medical Center (PVAMC), I was marginally aware of the responsibilities I needed to perform to advocate for women veteran's access to quality health care. As I spent time assessing the environment and culture that existed within the PVAMC, I became convinced that major changes needed to be made to fully address the status of women veterans within PVAMC, and the quality of health care being provided for local women veterans. I discovered that the delivery of health care was sub-optimal insofar as there being a relative dearth of women providers and services focused on the needs of women. Many women who had eligibility to use the VA were choosing to go elsewhere due to the conditions that were reported to exist at the PVAMC. The following case illustrates this fact.

Dawn (fictitious name) recently returned from Iraq where she served in the morgue, bagging bodies of deceased soldiers. She also worked in the kitchen serving meals and wondered if she would one day be bagging someone she was then serving. There were times when Dawn

had to bag the body of someone she recognized. She told herself she could handle things and that she was strong enough to be as good a soldier as anyone else.

On return from Iraq she wanted to catch-up on civilian life. She went to school to finish her bachelor's degree, and developed a personal relationship with a young man. Several years later she married the man and subsequently had a child. After graduation, Dawn started working as an accountant and was doing well, until her exam at PVAMC on this particular day. After her basically normal well-woman exam she broke down into tears. She admitted that she was not prepared to face the environment at the PVAMC. She stated that on arrival to the VA she spent over forty-five minutes circling the parking garage for a space to park. While circling she kept seeing young men, many in soldier fatigues; these men reminded her of the bodies she had had to bag in Iraq. The faces flashed before her repeatedly. When she finally entered the hospital atrium to request where the women's clinic was, they initially told her they didn't think there was a women's clinic. A few calls were made by the older gentlemen volunteers and she was eventually sent over to the Primary Care building across the street. While checking in, she was asked by a young male receptionist the reason she was at the clinic this day. She whispered in her lowest possible voice that she needed a female exam. She had no doubt her voice could be heard by others in line behind her. The receptionist looked quizzically at her, or so it seemed. In the waiting room she was surrounded by older men, many in wheelchairs, unkempt and staring at her in a way that made her uncomfortable. She desperately wanted to leave.

When Dawn was finally called, she sensed all eyes followed her out of the waiting room and down the hall to the two small exam rooms that serve as the current women's health clinic. Told to undress for her exam and put on the gown was equally traumatic in spite of a curtain between her and the door. Dawn could hear male voices of other patients along the main hallway

and the door of her exam room opened towards other rooms where male patients waited for their providers.

Dawn had been holding her emotions from the experience in Iraq in check until this day. Being at the PVAMC and around soldiers brought to the fore the suppressed trauma of her experiences. Furthermore, the environment of PVAMC with its predominantly male population led her to feel nervous and unsafe. During the exam the weight of her Iraq experience became overwhelming and she suffered a panic attack due to realizing the full impact of the traumatic experiences she had endured. The practitioner listened compassionately and attentively, calmed her, and ordered appropriate medications she could take once stable. Appropriate referrals to mental health were also made and arrangements were made for counseling to start within the next week. However, Dawn said she was hesitant to return to the PVAMC again due to the lack of gender-sensitive environment.

This case illustrates the situation that nearly 5,000 women veterans find themselves in when attempting to access health care at the PVAMC. Granted, not all have been traumatized in the same way as Dawn, and many are more comfortable in a still predominantly male environment. Yet, it is clear from national research that overall women veterans are more comfortable seeking health care in a gender-sensitive environment (Yano & Washington, 2006). This has been described as an environment where a proficient woman practitioner can provide care for women, there is female support staff, and the surrounding environment is perceived by the patient as safe and private (Yano & Washington, 2006).

As an Advanced Nurse Practitioner (ANP) and Doctorate in Nursing Practice (DNP) student, I see the need to take the lead in addressing this health care disparity experienced by women veterans at the PVAMC. Beyond helping Dawn in the immediate timeframe of her

treatment needs; I understood my role to make adjustments in the health care delivery model at the PVAMC for women veterans. I decided that a clinic dedicated solely to the needs of women veterans would address the concerns of Dawn and many of the 5,000 women veterans accessing health care at PVAMC.

To determine how best to achieve this goal, I made phone calls and did research on-line to determine how VA health care systems in other geographic locales managed the delivery of health care for their women veterans. I contacted my regional director of the Women Veterans Program and asked to meet with her to discuss the issue. We met several weeks later in Seattle, Washington, selected due to it being one of the relatively few VA facilities that has a separate comprehensive women's health center within the outpatient clinic.

At this meeting we determined that to succeed I would need organizational consensus within the PVAMC to overcome inertia and start an active project to create a dedicated women's health center. The regional director suggested a need for a clear methodology to move forward. Providentially, the DNP program curriculum was then focusing on organizational structure and change. As a DNP student, I used the information gleaned from these classes to select a leadership style and chose the transformational approach (Judge & Piccolo, 2004). This style highlights the importance of consensus building to achieve goals. I began to build a mental model of the relevant stakeholders and set about to determine the needs of this important group.

Among the most crucial stakeholders were the PVAMC Chief of Staff and the Chief of Nursing. I made separate appointments with them, discussed the current challenges for women veterans, and helped these key influencers to conceptualize changes that could improve health care for women at PVAMC. As the model suggested, I used enthusiasm to help motivate these stakeholders (Judge & Piccolo, 2004). Lively discussions ensued and I came away from the

meetings with a sense of support and an understanding of my role to take the lead in championing better care for women veterans and spearheading the building of a women's center at PVAMC. This was a key step to achieve consensus and advance my plans.

As a consequence of these discussions, I was soon asked to speak at the annual Executive Retreat, for the purpose of discussing the changes I perceived to be needed in women's health at the PVAMC. This was a critical second step in building organizational consensus to create a new women's health center. Based on recommendations within the DNP course materials, I sought to collaborate with experts in the field of hospital organization. As recommended by these resources, I incorporated current research into my presentation. Thanks to the DNP program, I set clear goals for improvement in women's health care at the PVAMC. After the delivery of my presentation I was able to answer questions related to the issues with confidence and clarity.

With some momentum established, I arranged meetings with my manager, the Director of Primary Care. We collaborated on how best to make women's health a strategic goal for presentation to the executive body for fiscal year 2008. This partnership and subsequent presentation made the issue of women's health more visible and furthered consensus for addressing the current gaps for women in the PVAMC system.

With encouragement from the executive body, I led the creation of a proposal for a space dedicated for women's health. I then presented this in detail to the executive body at PVAMC. The proposal delineated the vision and purpose for a women's health center, called for the allocation of a dedicated area within the hospital, and employed best business and finance practices learned within the DNP program to specify the necessary funding. In less than a year from germination this proposal was approved by the PVAMC executive body.

My leadership style focused on enthusiasm and the art of inclusion to build consensus. Backed by years of experience working with health care professionals and armed with the latest research and techniques gained from the DNP program, I was able to identify key stakeholders, understand their organizational needs, create an interdisciplinary advisory committee focused on the health care needs of women, involve committee members and stakeholders in conceptualizing the outcome and co-create the vision, and drive the program forward to meet the needs of this disadvantaged population.

From this project I learned that it is crucial to identify key stakeholders and their individual and organizational needs, the importance of building consensus, the need for enthusiasm to build support, and finally project confidence. When approached to lead future projects, I will draw on this experience and move forward with confidence and understanding of what processes can create accomplishment of goals.

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Running Head: HEALTH CARE ISSUES AFFECTING WOMEN VETERANS

Health Care Issues Affecting Women Veterans

Nancy Sloan

Oregon Health & Science University

Population and Epidemiology

The recent increase in women being used in the military has created a sharp rise in those accessing health care at the Veterans Administration (VA) on return from military duty. These women veterans now comprise 8% of the veterans using VA health services nationally. Of these, 86% are under the age of 40 and ethnically diverse (U.S. Department of Veterans Affairs, 2007). In addition to these factors it has been estimated that over 60% of these women have suffered from some form of military sexual trauma (MST) while serving in the armed forces (U.S. Department of Veterans Affairs, 2007). The VA defines MST as sexual assault or repeated unsolicited threatening acts of sexual harassment between at least two people in which someone is involved against his or her will (U.S. Department of Veterans Affairs, 2007).

The VA health system has historically provided health care for males, so this new influx of women veterans with their unique needs has proved challenging for VA medical centers nationally. While the VA is now aware of possible disparities and has made recent directives to address them, current conditions have not yet been modified sufficiently to address all of their concerns. This threatens the quality of health care services now being provided for women veterans. Some of these disparities include a lack of providers/clinicians with up-to-date skills and knowledge in women's health, a gender-sensitive environment for providing care for women with MST and a lack of specialized gynecological services.

Female veterans currently number approximately 1.7 million nationwide and represent more than 7% of the total veteran population (U.S. Department of Veteran Affairs, 2004). As of September 2005 women represented 17% of active duty personnel

and 17% of reserve and guard personnel (Women's Research & Education Institute, 2007). These numbers are projected by the Department of Defense to increase to over 20% the next few years (U.S. Department of Veterans Affairs, 2007). It has been discovered that many women enter the military with significant trauma histories and when further exposed to traumatic events during the course of their military service their risk of experiencing higher levels of mental and physical illness is increased (Zinzow, 2004). The National Center for Post Traumatic Stress Disorder (PTSD), a VA research center located in Palo Alto, California, analyzed data gathered from 185,880 women veterans related to MST and the connection with their subsequent health and environmental needs. Positive screens for MST were associated with increases in all categories of mental health issues, including PTSD, depression, adjustment disorder and anxiety (Kimerling, 2007). Associated medical co-morbidities included pulmonary disease, liver disease, and chronic pain (Kimerling, 2007).

Women veterans were shown by the Palo Alto VA research center to be more likely than male veterans to experience sexual assault and as likely to be involved in combat as male veterans when deployed (Kimerling, 2007). This increases the likelihood that this population will continue to have multiple trauma issues when seeking health care post-deployment (Vogt, Pless & King, 2005). With the burgeoning number of women serving in the military the needs of this cohort need to be given serious attention or it could greatly affect their overall health and well-being.

Case Study Analysis

Due to the recent rise in women veterans being used in the Iraq and Afghan conflicts the new cohort of women veterans using the VA health system are largely from

this group. The following case study will discuss the life of one of these women which is highly representative of their background and the challenges they face.

Mary (fictitious name) is a 26 year old Caucasian female who has recently return from Iraq. She was raised in a farming community in Oregon and is the middle child of four siblings. Her mother is a local baker and her father was a farmer. He passed away in a work related accident when she was 8 years old. Impacts on her life which have greatly influenced her have been her father's death, her low-social economic level, the nature of her family's work and education level, and being one of four children in a small farming community in Oregon.

Mary joined the military at 19 years old, shortly after graduating from high school. She was soon deployed to Iraq in July, 2005 and was the only female in her unit. Mary was given the responsibilities of driving trucks transporting equipment and supplies, which meant she was often in hostile territories. She was stationed in Iraq 12 months and has recently returned to her home state of Oregon.

While in Iraq, Mary endured a number of severe hardships such as extreme temperature, carrying heavy gear, driving long distances in dangerous territory, moving heavy equipment and walking for long distances. There was constant fear of setting off landmines, negative interactions with male counterparts and impaired hygiene conditions. She missed her family and home town, and felt quite alone.

This patient presented to the VA outpatient clinic in Portland, Oregon complaining of lower back and foot pain experienced since deployment. She also has lower abdominal pain and menstrual irregularities since her return. Mary denies any

health issues prior to deployment, and her family history is negative for significant medical conditions.

Mary was initially examined for signs of traumatic brain injury (TBI) which is a routine screening done on all veterans since the beginning of the Iraq and Afghan wars. She is questioned about headaches and other neurological disorders, and given a thorough mental health exam involving screening for MST, PTSD, depression, alcohol use and anxiety. These and a cursory physical exam were assessed as negative by her clinician.

As Mary was turning to leave the exam room, she requested one more moment to address a concern.. The patient then revealed a sleep disturbance (difficulty falling asleep and staying asleep) and admitted to headaches and irritability. Panic-like symptoms including pounding heart, shortness of breath and numbness. When encouraged by the clinician Mary continues the discussion speaking about feeling disconnected from her family and friends because she can't talk to them about her military experiences. She appears uncomfortable when broaching the subject of her boyfriend. The patient quietly tells the clinician she can't be intimate with him due to an incident which occurred while in active duty. Her eyes are cast down and she looks away as tears start to stream down her face. She whispers that she was sexually assaulted by a fellow soldier while in Iraq.

Mary continues to explain that not only was the sexual assault horrifying, but her exposure to combat casualties and scenes of violence have left her unable to have intimate relationships. Her panic, irritability, and sleep disruption have left her guarded, afraid and unable to trust others.

Case Review

For women veterans in this situation, literature has shown that the clinician must remain fully engaged and establish a trusting relationship (Iqbal & Garovoy, 2007). This includes maintaining eye contact, slowing the pace of the appointment, and taking a posture that exhibits time is not an issue. Validation of her concerns related to feelings of being disconnected from family and friends is critical. The clinician must show understanding in relationship to the troubles with her boyfriend. Being clear, honest, and respectful is paramount. It is important to communicate hope, validation and also acknowledge the difficulty of the disclosure. Reassurance about confidentiality and security need to be given to veterans in this situation. Likewise, it is critical the clinician not probe for details beyond what the veteran is willing to disclose (Iqbal & Garovoy, 2007).

In this case Mary was provided information and options for referral. With the appropriate interventions Mary was soon aligned with professionals within the VA health system which gave her the mental health support and the medical treatment she needed. It will be a long, uphill battle for Mary, yet she is determined to go to school to become a dental hygienist and eventually have a home and family near her home town in Oregon.

Intervention and recommendations

The challenges presented by this new wave of women veterans are two-fold:

- 1) How are the women veteran's medical and psychological needs best met?*
- 2) How do we address the life style needs of young women in relationship to their accessing medical care at the VA?*

In answer to meeting the medical and psychological needs of these veterans we need to consider the high numbers of women who have experienced trauma while in

active duty. Literature has shown that the best environment for these women to access health services is in a comprehensive women's health clinic which offers a private, secure environment staffed by proficient female clinicians (Yano, Goldzweig & Washington, 2006). This model addresses the gender-sensitive environmental needs of the women veterans and also provides a way for easy access and collaboration with sub-specialties. The environment of this comprehensive clinic would allow the women veterans to have a protected "psychological" space, free from possible exposure which would link them to MST/PTSD memories (Yano, Goldzweig & Washington, 2006).

As illustrated by the case study of Mary, the demographics of women veterans has greatly changed. These veterans most are now more likely to be under the age of 40, pursuing higher education and are frequently single mothers. This requires providing comprehensive and efficient health care that takes their busy lifestyle into account. The model suggested by the national VA women's strategic planning group is described as "one-stop shopping" (Hayes, 2007). This suggests the veteran women will have their needs specific to gender care provided in conjunction with their primary care needs. It has also been proposed that there be some provision for child care while the veterans are in the clinic (Hayes, 2007).

Strategies for Change

As the Program Manager for Women Veterans at the PVAMC and as a DNP student, I have advocated for this population with special needs. I have been highly involved in allocating space which would serve as a dedicated area for the development of a Comprehensive Women's Health Clinic at the PVAMC. Recently 3,000 square feet was approved for this purpose by the executive body of the PVAMC. As the Program

Manager for Women's Health I have been instrumental in hiring medical professionals who staff this clinic and contribute to providing gender-sensitive care for this population.

Expected Outcomes

When the designated space for the Women Veteran's Health Clinic becomes available, the Women Veterans Health Committee and the PVAMC Space Committee will start the construction of the approved floor plan. An interdisciplinary team made up of internal medicine, gynecology, urology, mental health and social workers specializing in women's health issues will occupy this clinic to provide comprehensive health care for women veterans at the PVAMC. The presence of this clinic is believed to greatly improve the availability, continuity and quality of health care services for the women veterans at the PVAMC.

Implications for Advance Practice Nursing and Health Policy

The implications of the successful implementation of upgrading standards of health care for this population is that it underscores the enormous role that advance practice nurses have in advocating for groups experiencing disparities in their access to health care. An advance practice nurse has the responsibility to be highly attuned to social inequities which negatively impact health care. Their role as a strong advocate for these groups is inherent in their profession. Further, the advance practice nurse will use political avenues to enact legislation which can lead to health policy changes to create lasting benefits to marginalized populations.

Self-reflection

The personal and professional leadership skills needed to analyze this case and situation among women veterans at the PVAMC and implement strategies were insight

into the overall goals of the PVAMC organization and understand the current priorities of the VA on a national level. I think leadership in this role also is enhanced by understanding that the stakeholders involved and assess what is key in driving current priorities. Coupled with this awareness, in my role as Program Manager for Women Veterans, I kept abreast with issues that the women veterans were experiencing, both physically and emotionally. In my role as an advance practice nurse, leadership is a large part of my role and is central to advocating in behalf of this population.

I will continue to work closely with the PVAMC mental health professionals to enhance my own counseling skills and knowledge related to MST and PTSD. Currently I sit on two mental health committees which are designed to address the unique mental health needs of women veterans. These committees are actively involved with the new Women Veterans Health Center which is being built, and will have permanent office space within the clinic so they are accessible for counseling and guidance for women veterans.

On a personal level, confidence and courage were needed as a new employee at the PVAMC organization to begin meeting with the Chief of Staff and the Medical Director regarding my concerns for women veterans. These meetings led my addressing larger PVAMC forums to highlight the existing disparities in health care for women at the PVAMC. I took the lead in organizing the Women Veterans Health Care Committee to offer multidisciplinary insight and guidance to direct initiatives in positive productive ways. Invitations to speak to the local media also created opportunities for me to advocate publicly for change.

There have been times in the past two years when women veterans' needs seemed to fade in the minds of the main executive body at the PVAMC. Finding stakeholders to champion the cause and re-ignite the enthusiasm for the change in health standards for this population was a vital part in achieving successful outcomes. The qualities mentioned above will continue to be developed and expanded upon as I advocate for the completion of the Women Veterans Comprehensive Health Clinic at the PVAMC.

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Running Head: ORGANIZATIONAL CHANGE - CASE STUDY

Organizational Change - Case Study

Nancy Sloan

Oregon Health & Science University

School of Nursing

Case Introduction

The change effort I addressed in my organization was related to the quality of care being delivered to a marginalized population within the Veteran's Health Administration (VA). Female veterans needing gynecological services were subjected to medical care in a substandard environment, both physically and emotionally, which led to their overall health care needs being compromised. Areas of concern involved clinic hallways being shared with other medical disciplines such as urology and dermatology. Male patients frequented the hallways while being seen by their providers and waiting for appointments. Female patients seeking to use restrooms in conjunction with their exams were forced to use these hallways to access these restrooms. At times female patients were would have to rush to these restrooms draped in the sheets that had been provided them for privacy during their gynecological exams.

It is estimated that over sixty percent of female veterans suffer from military sexual trauma and post-traumatic stress disorder (Hayes, 2007). This factor combined with the sub-standard environment of the gynecological clinic c clinic which could cause females to

neglect their health care leading to serious health consequences. For example untreated cervical dysplasia can lead to cervical cancer, which is responsible for 4,800 deaths in the United States yearly (American Cancer Society, 2007).

My effort toward change involved relocating the gynecological clinic to a more private clinical area for female veterans with bathrooms adjoining the exam rooms. My effort was unsuccessful due to my lack of understanding of the organizational culture and the priorities of the executive hospital hierarchy. The analysis of these barriers and the ability to create change within this system will be addressed in this paper.

Systems-level analysis

To fully analyze the organizational system in which to successfully effect change, one must understand the perspective the organization on both the individual level and on a contextual level, addressing both systems within the organization (King, 2006). One must also gain an understanding of the interdependent relationship between the two entities. Within the VA I found that the dominant philosophy which generates the most change is centered around the veteran perceived needs.

This is tantamount to the retail customer adage which states that the "the customer is never wrong." This is considered to lead to ultimate customer satisfaction. As a result of this it has been stated that often VA policy is to be driven by the evening news. If the veterans are unhappy with care they receive the media is able to quickly address these issues and changes often soon follow.

Another large factor influencing ability for change is the culture of the organization. Historically the VA has been predominantly "male-centric". Issues that deal with privacy and the special needs of a relatively small percent of the overall patient population would not be given much weight. Another influencing factor is the residual attitude that remains from a veteran's military training. This has been described as training in which the soldiers are taught that no one is "special" and individualism and personal needs should be minimized. This way of thinking is challenged with the introduction of females into the VA system after their military service. External forces, such as the media, parents of the veterans, and accepted standards in private health care systems, demand that a higher level of privacy and medically proficient gynecological care be given female veterans (Duggal, 2007).

Understanding these inputs and outputs which affect care as mentioned above enlightens one to the multifaceted and complicated root cause affecting potential change. In diagramming this one can use the fish-bone template or diagram. The overall problem of privacy and lack of specialized health care delivery in appropriate physical environment would be at the "fish's head". Continuing down the fish body we would see the people involved in the decision for making and change. Analyzing the procedures which contribute to the problems and the challenges inherent within the institution (history and culture of the VA) we can further drill down to the root of the problem. Within this fish-bone diagram we see the VA policies of the institution as pivotal in allowing change to emerge.

Within a well established health care system like the VA, which has a very strong inner culture coupled with very powerful external forces, such as the government agencies and wide media attention exerting significant pressure, it is imperative that the timing of change be given consideration. If an organization is not ready for change, regardless of the reason, change has little likelihood of occurring. Assessing the organization's readiness for

change can be done in multiple ways. Identifying the key positions within the organization which have an investment in the potential change is vital. Further analyzing why they have an interest and what benefit they would derive from the change is also paramount. In my change effort at the VA, I needed to assess the interest in changing the quality of female veteran's health care prior to trying to implement change. This interest had to be seen from the perspective of the Chief of Staff and the Chief Nursing Officer. Understanding the history of this type of change from their viewpoint helped me to identify the future barriers which I faced. Gaining insight into their value system, how they view the needs of female veterans along with understanding what they would regard as appropriate action was essential in moving forward.

My first attempt at creating change failed due to my failure to identify the true stakeholders in my change effort. I identified my immediate director of the primary care division, and the directors of the gynecological and surgical units as stakeholders within the organization, both having a direct interest in this issue. Within meetings I arranged with this group I had their tacit acknowledgment of the fact that there was a

problem, sympathetic nods of support, and brief discussions that addressed the difficulty of managing space issues within the VA health system. Results from these meetings were abysmal. In retrospect I see the analogy of an ant (me) trying to push an elephant up a glass mountain. Being new within the VA system I was ill prepared to tackle this change issues at this time. When asking myself the "five whys?" to drilling the problem to its' root cause, I saw I was requesting change from those who could not provide change and who had no power to cause change. I realized that the VA organizational structure had most of the power holders and decision makers at the very top of the local organization. The key decision makers I realized are the Chief of Staff, Chief Medical Officer and the Chief Nursing Officer. Second to these in power is the Chief Financial Officer. (Due to the VA being a governmental non-profit organization the Chief Financial Officer has less power than in a private hospital of the same size.) Another factor that I learned to be very important is that the central office in Washington, D.C., has a direct effect on policy and local VA center priorities. The local executives

communicate and deliver the mandates as dictated from the national central office. They are told what to prioritize and give weight to. This taught me that any issue is essentially a dead issue unless given weight by the national and central offices. This is illustrated by the visible flurry of hospital repair activity in Portland, Oregon, shortly after the Walter Reed Hospital in Maryland had been exposed as having serious repair needs (ABC News, 2007).

Discussion and Recommendations

The outcomes of my organizational change effort were poor, far below my expectations. In all fairness to the VA personnel I approached, I was given what they were able to give, which was a consultation room with seven computers adjoining a hallway near the gynecological clinic. This room has been a useful addition to the clinic in that the residents can write their notes and can discuss their cases with the attending physicians in privacy. This has increased quality for the patients in a way they may not be aware; by increasing the privacy surrounding the gynecological discussions and may lead to a higher satisfaction among residents and staff. However the main change effort I endeavored was far from realized.

My goal of moving the clinic to a better location was not met because I lacked knowledge of the internal power structure within the VA. The consolation in this failed effort is that the central office for the VA has stepped in to the situation on a national level and is now mandating that female veterans be given increased consideration and care. This includes incorporating their needs for privacy and space within the VA health environment.

In re-implementing my efforts toward change I have since spoken with the Chief of Staff and the Chief Nursing Officer for the VA. They have concurred that they are under pressure to improve the Women Veteran's Health Program as mandated by the Central Office in Washington, D.C.. The statistics for female soldiers in active duty is now estimated to be 20% of all in active duty (Women Veterans, 2007). Women statistically use the VA services more than their male counterparts. The executive branch knows that the Portland VA is ill-equipped to handle the increase in female veterans using the system.

Based on this data I have been invited to deliver a presentation on the needs in the Portland Women's Health Program to the executive branch of the Portland, VA. I am

currently developing presentation slides which will speak to the issues, needs and ultimate goals of the program.

The measurable outcome will be:

Short Term:

- Establish awareness about existing patient care delivery issues that are impacting female veterans
- Set up a committee to address the problem
- Make plans to research and model other VA health centers for solutions to the current problems.

Midterm:

- Dedicate human and financial resources to define scope of issues and formulate a shared vision and define solutions

Long Term:

- Open a dedicated Women Veteran's Health multidisciplinary clinic.

With this emphasis and defined objectives in connection with these mandates expressed by the central office VA, it is now hopeful that some movement toward better quality care for female veterans will result from these initiatives.

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Case Review: Ethical Issues in Informed Consent

Nancy Sloan, ANP, Women Veterans Program Manager

Portland, Oregon, Veterans Administration Medical Center

Abstract

The Veterans Administration (VA) is experiencing vast changes in its current patient population, resulting in a dramatic increase in the number of females accessing health care at the VA. Females between the ages of 18 and 40 now comprise almost 20% of those on active duty. This figure is projected to double within the next five years (1). Up to this point the majority of patients using VA medical services have been male, so this sudden increase of young female patients at the VA has created multiple challenges which potentially could affect the female veteran population's overall health.

One of these challenges is how best to meet the specific needs of female patients while maintaining high ethical standards in applying this care. New situations present themselves to VA providers as we experience this shift in population and seek to provide appropriate and gender-specific care. A case that exemplifies these challenges is highlighted in the following article.

Case Study

“Mary” is a 36 year old female with a history of schizophrenia. She presents to the VA gynecological clinic for follow up on an abnormal pap smear which showed “high grade squamous intraepithelial lesions” which suggests the need of colposcopy and biopsy to further analyze the extent of the cellular dysplasia. Mary appears disheveled and unkempt. She was brought to the clinic by a caretaker from the group home where she resides. Her history shows she has been chronically ill with schizophrenia since her early twenties when she had her first psychotic episode while undergoing the rigors of boot camp. She has been under the care of a VA psychiatrist ever since. She is on several anti-psychotic medications which allow her to function at a basic level.

When preparing Mary for the procedure a medical resident reviewed the medical process of the colposcopy and obtained an informed consent. The resident then returned to report to the gynecological team. VA clinicians then entered the patient’s exam room to continue the exam. It was soon recognized that the patient was very confused and cognitively challenged.

The clinicians proceeded to ask if she knew what the medical procedure she would be under-going and the reason she will be having it done. In response she states, “Yes, you are going to be checking to see if I am pregnant.” This clearly exhibits that she is confused about the procedure. The clinic is very busy and many patients are waiting. If the procedure isn’t done grave consequences could result. What should be done at this time?

Review of Topics: Medical Indications

The diagnosis for this patient is “high grade squamous intraepithelial cells with probable glandular involvement”. Cells of this type can lead to cervical cancer if left untreated. According to the American Cancer Society, 3,870 women will die of cervical cancer in the United States this year (2). A colposcopy, which allows the visualization and identification of suspicious cells on the cervix, can be a life saving means for guiding treatment for women with this diagnosis. With the correct identification of the type of cell dysplasia that caused the initial abnormal pap smear, medical professionals can closely monitor the dysplasia and prevent the development of cervical cancer.

Patient Preferences

Even though this patient had signed the informed consent it was still not clear whether this patient could be considered ‘informed’. Does the patient comprehend the reasons for the treatment and the medical process she is about to undergo? Are the risks of the procedure fully understood? If she did sign the informed consent was she competent to make the decision? Are her medications interfering with the clarity of her thoughts? Is this confusion something that will clear and allow the patient to participate in her health care choices in a more coherent way at a later date? We must analyze and determine what the priorities for this patient are. What does the patient want? Are there options that the patient would prefer if the full range of treatments were clearly understood? If the patient is truly incompetent to make medical decisions, is there a legal surrogate who can be contacted and enlighten the clinicians regarding the patient’s full capacity and preferences?

Quality of Life

If this patient were allowed to proceed without treatment it could lead to cervical cancer and could result in radical surgical procedures. Many women end up having a hysterectomy when cervical cancer is found. That can put a female into early menopause which can greatly alter mood, comfort, sense of self and quality of life. If cervical cancer metastasizes there will be an involvement of other vital organs and could eventually lead to death. It could be argued that this patient with a chronic illness does not have a high quality of life as perceived by others, but that would not be justification for non-treatment. In this case, our interest is to prevent further need for painful treatments, hospitalizations, surgeries and possible chemotherapy. Allowing this patient to undergo unnecessary pain and discomfort is a strong incentive to act in a way which will improve her overall quality of life. How do these issues affect our decision to proceed?

Contextual Features

At this point in our decision making process there is a need to balance the ethical and legal obligations involved in this patient's healthcare. A VA clinician had started the process of caring for this patient's gynecological health by initially performing a pap smear. With the support of her group home care managers she has consented to the prior health exams with the possible understanding that these exams could lead to more extensive care. At this time there is no indication that she has assigned anyone as a medical surrogate. The patient is not resisting treatment at this time; rather, she is presenting herself to the clinic as a patient for the purpose of medical professionals managing for her health care needs. But the question still remains; can we ethically proceed with the procedure while the patient exhibits a questionable level of mental competence?

Case Analysis

This is a case of questionable mental competence in a patient presented with the signing of an informed consent. This raises the ethical question of how much information is sufficient for any patient to be truly informed prior to their signing an official informed consent document?

There have been many previous ethical cases involving the issue of informed consent being obtained from mentally ill patients. When patients are confused or unable to comprehend the medical procedure for which they are being asked to sign a consent, there are often legal channels within a hospital system which can allow the greater good to be done for the patient within legal parameters. Obtaining consent from a legal guardian or allowing time for the patient to clear mentally in order to comprehend the upcoming medical treatment would be two choices that allow the patient to be treated with respect and autonomy while preserving the clinician's interest in doing no harm (3).

The ethical decisions regarding this case would be significantly different if the patient's mental illness was causing her to vehemently oppose the medical procedure. Also, if the patient had not already been under the care of the VA hospital's gynecological clinic and had willingly presented for treatment there could be greater questions regarding her willingness to subject herself to a medical procedure and trusting that her care in the past had not caused her harm. With these principles in mind it would seem logical that the patient be reinstructed about the procedure at a level she could comprehend. This could let the clinicians proceed with the medical intervention to the benefit and protection of the patient, and satisfy the ethical principles of beneficence on the part of the clinicians.

This case also illustrates the need to apply the principle of autonomy to insure all patients are given full respect and opportunity to participate in their healthcare process. This would necessitate one avoid stereotyping patients which can lead to presumptive behavior within healthcare settings. As the health care providers for this patient, as well as any others with questionable mental competence, we would be risking serious error in judgment to fall into a paternalistic pattern of assuming our opinions and decisions should supersede the will of the mentally challenged patient (4).

The VA invites a large cross section of humankind into its healthcare service. Often due to the rigors of war and the traumatic experiences endured by individuals in battle many who avail themselves of the VA services have serious mental challenges. These cases pose ethical dilemmas to clinicians who daily practice the ethical principles of autonomy. Yet, clinicians are still urged to insure that patients are able to comprehend the medical procedures they are consenting to undergo. This also would be in harmony with the ethical principle of beneficence, which dictates the clinician practice in a manner which would promote the overall health and well-being of their patients.

When a clinic is busy there is an effort to see as many patients as possible in the shortest amount of time. Allowing equal time and quality of care to all patients can be a challenge. There is also a challenge for the clinician to avoid acting in a paternalistic way, assuming that the patient and provider have the same goals. A clinician must ask themselves: Do my views of those suffering from brain injury or mental illness affect my rational and judgment regarding the patient's ability to competently engage in decisions involving their own medical treatment?

Kleinman describes transactions between healer and patient in an effort to address the variety of situations which would cause a clinician or “healer” to abandon his internal ethical sense and submit to another voice. He suggests these interfering factors include institutional setting, interpersonal interaction, and number of participants involved (5).

In this case the clinical setting was unfavorable for allowing the patient to make a clear, informed consent. Her long history of chronic mental illness coupled with the rushed and busy atmosphere in the clinic created even more stress to the patient making it even more difficult for her to comprehend medical information. To apply moral competence and human values in this health care setting it was decided that the clinicians involved would take the needed time to review the colposcopy procedure with this patient and fully assess her capacity to sign an informed consent. With this effort to review the therapeutic expectations for all concerned; it became apparent that the clinicians and patient had the same goals a successful procedure. The clinicians could proceed with full confidence that the patient was fully informed and aware of the full medical implications and purpose of the procedure.

Points for discussion

This case study addresses the ethical principle of autonomy. Do we allow patients to choose medical treatment based on a thorough education of alternatives and risks; or do we arbitrarily and perhaps paternalistically decide who is or is not competent to give full informed consent and proceed with our own assessment of the situation?

This discussion cannot be complete without fully addressing the overall issue of informed consent.

- What would the average patient need to know in order to be an informed participant in the decision?
- What would the average patient need to know and understand in order to make a truly informed decision?

A patient without medical training cannot be expected to fully grasp the entire scope of a medical procedure and its' inherent risks. An established level of understanding would seem necessary to determine a standard for the level of information needed to establish guidelines in this area.

In addressing these issues inherent to the process of informed consent, clinicians should consider the ethical principle of justice (6). If guidelines do not enforce a level of competence needed for a patient to sign an informed consent we could be jeopardizing medical treatment to those who suffer from cognitive challenges and mental illness. Medical institutions must be careful not to over legislate in this area and to insure the rights and health care needs of mentally ill patients. Likewise as we see new cases and situations within our VA medical centers it behooves us to handle each case in a patient centered and ethically appropriate way.

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Independent Case Report
Oregon Science & Health University
Nancy Sloan

Description of the Clinical Problem:

The Veteran's Health Administration (VA) has realized multiple changes since its inception. Many of these changes involve the type of warfare that the soldiers have experienced in the war arena. New types of warfare come with illnesses and injuries which are quite unique i.e., Agent Orange toxicity in Vietnam, chronic fatigue syndrome associated with Desert Storm etc. Perhaps nothing has challenged the VA health system more than the most recent phenomenon caused by the wars in Iraq and Afghanistan; the introduction of thousands of females into active duty within these current war zones. (This is not to suggest that females have not fought bravely in combat zones in past wars. This is a known fact, but the traditional role for the majority of enlisted females in the past was in translation services, office work and nursing (Murdoch, 2006). Due to current military strategies and needs, much of the Iraqi combat involves surveillance and monitoring. These duties are now seen to be equally performed by both men and women. Females now comprise over 20% of current military troops. The Department of Defense under President George W. Bush's administration is increasing the numbers deployed to over 400,000 troops in the next five years (VA, 2007). This will translate into over 80,000 females using VA services over the next decade. The VA, on a national level, is currently not prepared for this increase (Frayne, 2006).

Providing medical services for women within the VA has historically been one fraught with problems (Tseng, 2006). Medical providers working at the VA have not treated female patients on a regular basis. Exam rooms in the main primary care treatment areas are not designed for privacy and gynecological care. Medical support personnel are not familiar with needs and assessments specific for women (Tseng, 2006).

Sexual abuse of females during their military service greatly complicates this whole picture. Some form of military sexual trauma (MST) affects an estimated 60% of all female veterans (Dobie, 2006). Many females are unable to sit in waiting rooms full of male veterans due to memories of assault(s) being triggered by the male dominated environment. Some male veterans who are still unused to seeing females within their medical domain are less than sensitive to the needs of their female colleagues (Frayne, 2006).

The challenge now facing the VA is to adjust their medical services and environment to address these growing needs. Up to this point there has been only a tacit acknowledgement that these issues are looming on the horizon. Programs within the VA have started addressing the needs of female veterans and some VA hospitals have developed work forces to analyze what can be done to better meet the needs of this unique population (Bean-Mayberry, 2007).

General knowledge/literature:

Due to the increase and projected growth in numbers of female veterans there has been a new sense of urgency and attention given to this in the literature. Previous to this there was abundant interest in the quality of the national VA health care leading to the major congressionally mandated redesign following the implementation of health policy 262-152 in 1996 (Longman, 2007). Some of the focus of this policy change addressed the health issues related to the impending increase in the numbers of female veterans, but no one at this time foresaw the doubling of these numbers in the short period of time that is now being experienced (Goldzweig, 2006).

Organizational and local knowledge and status of the clinical problem:

The local Portland VA has recently become more acutely aware of the needs of the female veterans as evidenced in an interview held with the director of primary care in September of 2007. She stated that the issue of female health is now a key focus for primary care and addressing these veteran's unique needs was added to her annual strategic plan agenda for the year 2008 (personal communication, Jean Moore, 2007). However, the current clinical situation at the Portland, VA in relation to this problem is poor. There are currently no clinics which meet the vast spectrum of health needs of these veterans. There are two clinical exam rooms that alternate with primary care clinics to serve as a temporary Women's Health Clinic three times a week in the Portland, VA. The hallways adjacent to the clinics are dominated by male veteran patients and are often noisy and lack privacy. There are no restrooms adjacent to these exam rooms for the females to use for pre and post gynecological care and female hygiene needs. Prior to appointments the women must sit in waiting rooms which have predominately male patients where they may feel outnumbered and their sense of privacy may feel compromised by the nature of the setting.

The VA clinical area for gynecological special procedures is in worse condition. The intensity of this problem is increased by the nature of the procedures done in this clinic; they are particularly invasive and are especially challenging for populations who have experienced various types of military and sexual trauma. The physical environment lacks privacy and is exposed to a number of other clinics operating concurrently which are predominantly staffed with nurses and are most familiar with serving the health care needs of male patients.

The importance to advanced practice nursing:

The advanced practice nurse is a strong advocate for populations experiencing disparities within their health care delivery system. Using their knowledge of policy and applying known theoretical concepts to practice would lead the Doctor of Nursing Practice (DNP) to affect change in health systems to insure equal access and quality of care for the population in question. This is an area where the advanced practice nurse can provide strong leadership and direction to lead interdisciplinary teams toward organizing systems to make changes in the status of health care for female veterans. The advanced clinical expert can lead teams to understand the population with insight and implement critical decision making processes to change the status of past problems in system design and create new and lasting programs that are dynamic and effective and lead to positive health outcomes. This will lead to a source of information which can be tapped and used by other VA's on a national level.

Desired outcomes:

The desired outcome of this clinical inquiry project is to gain the knowledge necessary to make programmatic and clinical changes in the VA health care system to improve health care for female veterans. Research suggests that the overall conditions within national VA health systems are not meeting the current needs female veterans (Frayne, 2006).

The main beneficiaries of this evaluation would be the female veterans. Their health has already been shown to be compromised due to various traumatic experiences associated with their military service. Improving the environment in which they access health care would allow them to be advocates for their health. Other stake holders who would stand to benefit would be the VA leadership, who would be recognized as

addressing the clinical needs of this growing population and effect change toward improved health outcomes.

Purpose statement:

The purpose of this program evaluation is to assess the adequacy of current health care services for female veterans and make evidence-based recommendations to serve this evolving population.

Clinical Inquiry Question:

What are the current health care services available to female veteran's at the Portland, VA health system? Are these meeting the psychological, emotional and physical needs that exist in this population?

Conceptual Framework:

The attitudes of female veterans toward VA health care services are determined by multiple factors. They fall generally into the following three categories:

- 1) General quality of health care
- 2) Access of health care services
- 3) Psychosocial factors involved in health care
- 4) Environment in which health care is delivered

Most VA managers feel that access to health care and quality of services are the greatest determinates to patient satisfaction within the VA health care system. But this clinical inquiry will attempt to determine that other factors affect satisfaction and use of services such as self-efficacy and social support. I will analyze how these added criteria affect the levels of satisfaction experienced by female veterans and how this information can greatly affect the quality and level of health care achieved by female veterans.

Currently the quality of care as experienced by female veterans at the VA is challenged by lack of equipment, lack of clinical space dedicated to female veterans and a shortage of clinicians working in women's health care. This has resulted from the many years of concentrated focus on male veteran's health care. A consequence from this is a dearth of clinicians who feel proficient in providing women's health care including their gynecological care. Women veterans are generally viewed as having more complicated medical needs and have challenges that tax the already limited time allocated per patient visit at the VA.

Access has been a driving force within the VA in the past year. As soldiers return from Iraq and Afghanistan there is outcry from the media and as a result reverberated by the public that veterans are not able to be seen in a timely manner post military service. This is complicated by the fact that many veterans are injured in ways which are not readily visible to the clinician, such as traumatic brain injury and post traumatic stress syndrome. These conditions need early screening and intervention to prevent the intensification of health problems which lead to other sequelae from these injuries. When addressing the needs of female veterans these problems multiply. Birth control, military sexual trauma, and gynecological exams are needed on a timely basis.

Many female veterans have already endured challenges based on gender while in their tour of duty. The psychosocial factors that need to be addressed on their discharge are vast. Finding a social system for support along with developing a sense of well being and empowerment after deployment are challenges that need to be addressed. Meeting these needs greatly influences how the female veteran views their health care delivery by the VA. If we create a system by which access, quality, social support and self efficacy are

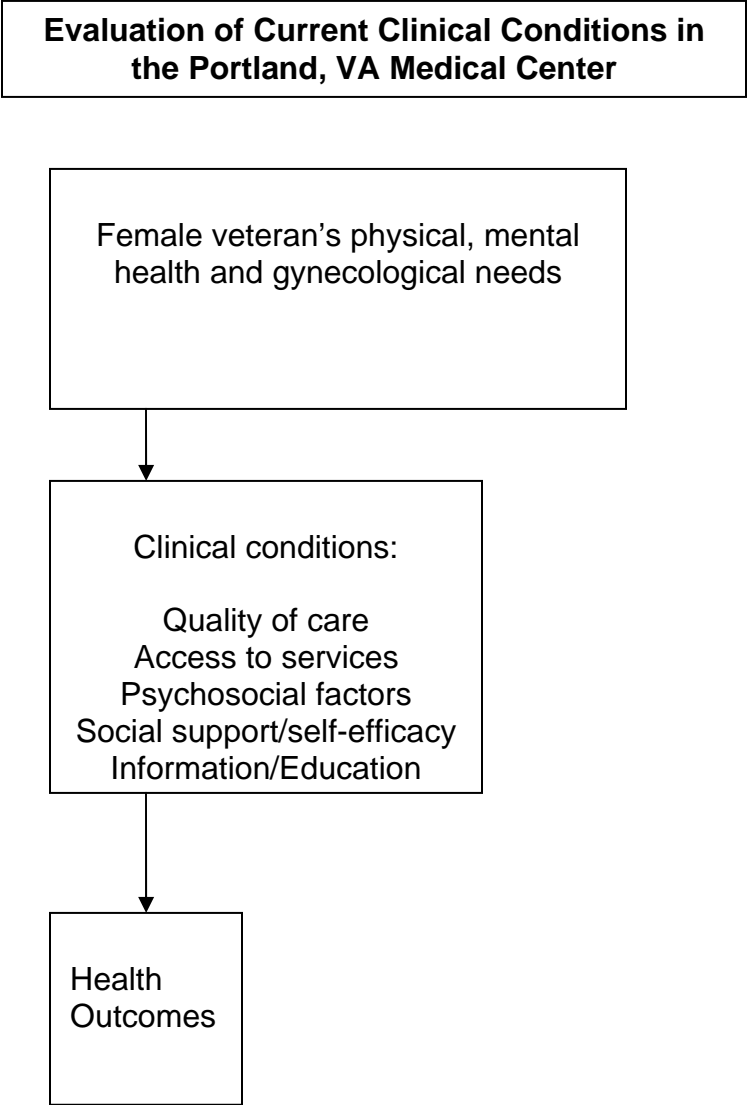
addressed we will increase the level of satisfaction in their use of the VA which will result in overall improved health for this population.

The Social Support theory is a middle range theory which postulates that emotional, physical, spiritual and educational support is needed to positively influence health outcomes. If a lack of support is perceived or experienced by an individual this can lead to inactivity which can result in poor responses to an individual's self health care needs. Support is not locked into one source or timeframe, but exists along a continuum and thus needs to be analyzed periodically to ensure that the outcomes maintain a positive impact. In application to the female veterans using the VA health system there is a need for ongoing emotional, physical, educational and spiritual intervention to fully support these individuals. Addressing the environment within the VA along with proficient medical staff many of these issues would be resolved.

The theory of Self-Efficacy is based on maximizing support, but from within an individual's own belief system. It encompasses a combination of inter-active attainment, vicarious experience, verbal persuasion and physiological feedback. It leads to positive reinforcement originating from believing that a task can be performed and resulting in the successful performance of this task. This accomplishment leads to a reassurance for the individual which then leads to an empowerment that allows the individual to continue on this positive trajectory of behavior. In relationship to health care this has wide application. Choosing to care for one's health and having this process reinforced by positive outcomes coupled with the empowering self-belief system in the individual can potentially lead to future positive changes that effect overall health and well-being. If an individual uses their human agency (the intention to perform an act) and experiences

positive responses from their behavioral changes, new experiences can be acquired over time which can create permanent beneficial outcomes. See Diagram 1.

Diagram 1.



The desired outcomes through the application of these theories would be that the quality of health care for female veterans as provided by the VA health system would better promote and maintain their overall health. The delivery of care would be enhanced by a better environment for health care delivery and an increase of education services which are sensitive to the unique needs of the female veterans. Self-efficacy would be enhanced in the veterans by way of knowledge and skill building along with coaching and support provided by their health care providers. The desired impact would be that female veterans nationally would increase their use of the VA health care services due to their increased satisfaction with the quality of health care and as a result realize an overall improvement in their health.

Review of Literature:

The female patient population faces the problem of receiving a substandard level of health care within the Veteran's Administration (VA). This is due to the system being historically dominated by male veterans based on the high ratio of men to women traditionally using the VA health services. In recent years the patient population has changed significantly. Females now comprise 20% of the active military. Statistically we see that female veterans use the VA services more frequently than their male counterparts (Duggal, 2007). If female veterans stop seeking health care due to the feeling that the care offered them is substandard or is perceived to be offered in an unsafe environment, their access to health care will be severely compromised. If these issues are not corrected we could see several negative outcomes:

- Females developing severe health problems due to lack of access to health care

- Increased use of emergency services for managing the female veteran's health needs causing increase in cost and an overtaxing of an already overused health care delivery system
- Negative publicity and press related to this neglect and resulting negative potential damage to VA image.

The main population at risk are female veterans who have recently returned from the Iraq and Afghan war zones. These are mainly young women who have seen an opportunity to serve their country via the military and who also have goals related to education, family, and securing a stable financial future on their return from the military. Many female have experienced a lack of social support within the constructs of the military and leave highly sensitized to inequalities that exist within the military system (Tseng, 2006).

A future intervention will be based on the findings from this clinical inquiry and will seek to adjust health care delivery systems to better meet the needs of female veterans. Ultimately this will involve the development of a VA Center for Women's Health within the Portland, VA which will adhere to the models of five currently operating nationally established VA Centers of Excellence in Women's Health (VA, 2007).

A comparison will be made to other VA health care systems for women's health in an effort to achieve a benchmark by which to move forward with application of this clinical inquiry. This is an acceptable and meaningful outcome in that it is now considered that a dedicated Women's Health Clinic is now standard of care among the large VA health care centers. Statistically females show that they consider non-

fragmented female care provided by proficient female providers to be a basic right due them by the VA health care system (Bean-Mayberry et al., 2004).

The following articles address the literature which identifies the current acknowledgement of the above problem experienced by female veterans.

In a research article by Tseng (2006), the unique needs of female veterans were analyzed. It is highlighted that there is a major reshaping of the military population from 2% females 30 years ago, to 20% of the military now being comprised of females. Compared with male veterans these females have very distinct and unique needs related to their health care. To illustrate this, in 1982 the General Accounting Office (GAO) found an insufficient amount of attention being devoted to gender-based health problems for females using the VA system. This situation had still not improved significantly when this was reassessed in 1993. At this time a congressional hearing exposed long-standing neglect for the health care needs of women and revealed ongoing problems (Longview, 2007).

Underscoring the acuity of this problem was given attention by Vogt et al.,(2006). Here it is highlighted that women veterans are generally less healthy than their non-veteran female counterparts. Emotional and physical barriers are seen as hindering their access of the VA health care system. In addition to this, their overall emotional health was viewed as compromised in comparison to their male counterparts. Many more females veterans have experienced traumatic events at higher rates than non-veteran women and their male veteran counterparts (Frayne, 2007). In spite of a greater need for services, these females experience increased challenges in accessing care at the VA. Historically these barriers have been categorized as individual/personal and

structural/institutional. Further research identifies the complications to health care access as being socio-economic, gender, patient age, and disease status (Vogt et al., 2006).

Goldzweig, (2006) highlights the factors that affect the role of military stress on the overall health of female veterans. As mentioned, high rates of military sexual trauma are experienced in this population. This is associated with physical symptoms, medical conditions, depression, alcohol abuse and eating disorders (Goldzweig et al., 2006). Post-deployment, women were more likely to have mental disorders and as a result maintain poorer health status. War trauma, sexual trauma and low social support on homecoming were all factors seen to contribute to the development of post-traumatic-stress disorder (PTSD) (Yano, 2006).

Research done reveals that the sequelae of sexual trauma, resulting with diagnosis of PTSD and military sexual trauma (MST), has greatly impacted the female veteran's anxiety level in relationship to accessing preventive health care measures. Studies reveal that provider gender and examination-related anxiety among female veterans are correlated. These findings emphasized the importance of screening for sexual trauma and the need for sensitivity to the female veteran's unique emotional needs during sensitive medical procedures (Lee, 2007).

Research conducted by the University of Washington's School of Medicine studied two thousand five hundred and seventy eight (2,578) female veterans in the Puget Sound, Washington's VA medical system and found that exposure to trauma in the military subjected female veterans to higher rates of medical/surgical hospitalizations and surgical inpatient procedures. In conjunction with this, more females with PTSD sought health care through the outpatient VA settings including the emergency departments,

primary care clinics, ancillary services and diagnostic testing facilities (Dobie, et al., 2006).

Frayne's research (2006) sampled 28,000 female veterans in an effort to learn of their experience with accessing health care within the VA health care system. She found that social support was a powerful contextual factor affecting a wide range of health outcomes for this population. Due to the nontraditional career choices of joining the military, made by these female veterans, it was found they experienced higher negative social ramifications connected with their military service. Results also revealed significant challenging demographic issues among this population in comparison to male veterans. The female veterans tended to be much younger, more highly educated than male veterans, and more likely to be nonwhite. Levels of social support were universally lower in women than in men. Women were more likely to be unmarried and lack transportation to their health care facility (Frayne, et al., 2006).

The theory of Social Support is seen as applicable in this research given that this population is not accessing adequate health care due to poor connection to a supportive group (Cassel, 1974). Research in this area has found that when social structures are in place, female veterans have increased compliance in accessing health care and applying healthy behaviors. This includes providing a supportive social environment within their health care facility which enhances their feeling of safety when seeking health care (Frayne, et al., 2006). Likewise the theory of Self-efficacy (Bandura, 1974) is highly applicable. Research has shown that an individual's concept and belief system related to their ability to achieve an outcome in a positive manner can directly enhance positive performance. If female veterans conceptualize positive experiences associated with their

use of the VA health care system beneficial outcomes could be increased and realized resulting in improved health care access and outcomes (Bean-Mayberry, 2006).

Research questions which remain pertain to how best to address the rapidly growing population of female veterans with their increasingly complicated health care needs. Still little is known in relationship to VA specialized women's health care centers, and what makes their provision of health care adequate, efficient and unique in addressing the health care needs of female veterans (Bean-Mayberry, 2007). According to Goldzweig (2006), there remains a lack of systematic evaluation of the literature related to female veterans which makes a summary of the knowledge in this field scanty. Goldzweig (2006) continues by stating that there is little research that evaluates treatment programs or approaches for women patients suffering from PTSD as related to sexual trauma, or in research related to prevention programs. Other gaps identified include limited information on chronic diseases experiences by female veterans. Utilization of health care of females based on perceptions from within the female veteran population as applied to current health care provided by the VA is also understudied.

When Congress mandates various studies to be conducted within the VA, a large amount of fervor related to certain research areas (such as the current increase in studies on mental health affected by military trauma) often results. This can leave other critical areas understudied, such as females access to basic primary care (Goldzweig, 2006). As a result general trends and broader studies within female veteran's lives have not been well studied (Vogt, et al., 2006). Questions remain regarding what environment and services which can be added to existing VA women's health care units to encourage females to better utilize the women's clinics. More research to answer the questions related to

gender specific care should be addressed. For example; what is the current perception of the female veteran in relationship to the gender of the provider involved in her health care? How does this affect her compliance with accessing and following through with health care behavior?

These questions have not been raised in relationship to these issues partially due to the fact that the increase in female veterans within the military is a relatively new phenomenon. The majority of the VA health care systems have been making efforts to manage this population with sublevel clinical environments. As the research shows this has greatly affected outcomes in the veteran population. With a renewed effort geared toward mediating these gaps in research findings information can be accessed to greatly improve the conditions in which a female veterans to seeks health care at the VA.

Yano (2006) identifies gaps in research related to current infrastructure and implementation of improved research to identify areas lacking in consistent gender sensitive care for female veterans. Further research taking these gaps into consideration should yield results to adjust clinical outcomes in a meaningful way.

There are rich sources of data available within the VA's current data system. It hasn't been accessed in a broad way to utilize information for the purpose of analysis for female veterans. Surveys which reach other patient populations and address access issues tied in with the military history of PTSD and other trauma related to or affecting the female veteran's access to health care are vital to continue understanding the needs of this population.

The current literature shows initial research efforts to capture information to direct the VA towards better practice in relationship to the growing female veteran

population. It would be helpful to have repeated surveys over the next five years to assess trends in the quality of health care offered females at the VA.

A research survey for the Portland, Oregon VA will serve initially to start the inquiry into the status of health care as perceived by the female veterans using the local VA. Based on the data received from these surveys practice will be guided to adjust for needs identified by research for this population.

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Clinical Evidence Table

Synopsis			Findings		Clinical Applicability
Citation	Clinical Question	Design	Credibility	Significance	Applicability
Author & Year	Hypothesis, Variables under study	Design Sample Population Would you change anything?	Rigor in data collection & analysis	Statistical & clinical significance Level of Evidence	To whom and under what situations could findings apply? Can these be applied to your inquiry?
1 Bean-Mayberry, et al., 2006	Women receive a lower quality of outpatient care due to care by gender being largely unexplored.	Randomized section of 86,000 patients across the US looking at quality of care in seven common health concerns. Would focus on environment specific to psychosocial needs of female veterans.	Qualitative study; data collection. Good sample, reliable data.	R= reliable; sample size adequate to reach statistical significance, would consider using data for my research. Level of Evidence=I (Melnyk).	Would apply to female patients in my research arena; can be applied to my clinical inquiry.
2 Saldago, et al., 2002.	Findings suggest that many negative health outcomes occur due to gender inequities within the VA health system	VA female patient care contrasted with non-veteran female patient care in private sector. Establishes benchmark for comparison.	Abundant study comparisons, rich resource material	R= reliable; Would use data for comparative research links in my research paper. Melnyk level II.	Applies to my clinical inquiry question in regard to standard quality of services which should be offered female patients.
3 Ashish, et al., 2005.	Examination of gender differences within the VA healthcare system using	Wide random sample of female VA patients and their purpose for accessing	Wide sampling with generalized sampling questions	R=reliable study. Melnyk level IV.	Large general population of females studied – general information

	clustered samples over 2 years in wide sampling of national VA hospitals	VA healthcare system.			useful in a descriptive and qualitative application
4 Washington, 2007.	Addresses challenges of conducting research of female veterans. Demonstrates need for studies that focus on perspectives and experiences of female veterans	This is more of a discussion of the challenge of research design and the various models used for study currently. Is not directly related to an evaluation of clinical adequacy in VA.	Well written and thoughtful article. Showed breadth of experience in this research area.	NR= not reliable; great article but not useful for data analysis. Melnyk level V.	Could be useful for design ideas which have been tried and succeeded or failed.
5 Duggal, et al., 2005.	Women returning from Iraq and Afghanistan and the comparison of healthcare utilization among men and women veterans.	Analysis of clinical utilization data from the VA's electronic medical record for returning veterans. Useful for understanding access to information within the VA for purpose of comparison with current data to be collected for CIQ.	Clinically significant data collection with significant outcomes.	R= Reliable; evidence based on systematic review of relevant controlled research. Melnyk level I.	Useful research and comparisons of groups addressed in clinical inquiry.
6 Lurie, et al, 1993.	Does sex of the physician factor into utilization of VA female in the VA	Examination of rates of cancer screening among women based on sex of provider.	98,000 between ages 18 – 75 years over 17 year period.	R= reliable. Useful in providing data related to reasons for	Useful for later discussion in proposing solutions for possible

	healthcare system?	Useful information when used in light of psychosocial factors affecting use of VA health care by female veterans.		utilization, somewhat related to this clinical inquiry. Melnyk level IV.	inequalities in methods of providing VA healthcare.
7 Yeager, 2007	Females face unique challenges as combat victims after returning from war	Qualitative information sampling from LA, Calif, VA. Not national representation. Would require broader sampling for national application.	Credible and relevant information, but not wide sampling.	R= Reliable data, but more random sampling needed. Melnyk level V	Would apply to my clinical inquiry, but additional information needed.
8 Meehan, 2006	Female veterans fastest growing segment in VA	Overview of challenges facing health care provision by VA. Useful analysis.	Relevant, large sample	R= Reliable Wide sampling. Melnyk level III	Applies to clinical inquiry question. Useful data.
9 Murdoch, 2006	Needs physicians should recognize in providing health care for female veterans	Paucity of information known by providers related to this population exposed. Useful for CIQ.	Clinician's exposure to this population's needs	R= Reliable Solid research, historic overview. Melnyk II	Applies to clinical research goals of evaluating current VA clinical conditions.
10 Lee, 2007	Relationship to anxiety and gender of provider	Cross sectional pilot study assessing methods of anxiety reduction in clinical settings. Useful for inquiry/evaluation of VA	Study of 31 female veterans with hx of sexual trauma	R= Reliable Self report instruments, anxiety levels assessed related to physical exam Melnyk II	Applicable to clinical research question and inquiry.

		clinics.			
11 Goldzweig, 2006	State of female veteran's research within VA currently. Influence of MST and PTSD on evaluation of female veterans experience of VA clinics.	Measurement of 182 studies PTSD and health status of female veterans. Would use larger n in future evaluation.	77 studies pertaining to stress of military life	R = Reliable Rates of harassment and relationship to health status assessed Melnyk II	Applicable to research question and posed clinical inquiry question.

Case Review: Ethical Issues in Informed Consent

Nancy Sloan, ANP, Women Veterans Program Manager

Portland, Oregon, Veterans Administration Medical Center

Abstract

The Veterans Administration (VA) is experiencing vast changes in its current patient population, resulting in a dramatic increase in the number of females accessing health care at the VA. Females between the ages of 18 and 40 now comprise almost 20% of those on active duty. This figure is projected to double within the next five years (1). Up to this point the majority of patients using VA medical services have been male, so this sudden increase of young female patients at the VA has created multiple challenges which potentially could affect the female veteran population's overall health.

One of these challenges is how best to meet the specific needs of female patients while maintaining high ethical standards in applying this care. New situations present themselves to VA providers as we experience this shift in population and seek to provide appropriate and gender-specific care. A case that exemplifies these challenges is highlighted in the following article.

Case Study

“Mary” is a 36 year old female with a history of schizophrenia. She presents to the VA gynecological clinic for follow up on an abnormal pap smear which showed “high grade squamous intraepithelial lesions” which suggests the need of colposcopy and biopsy to further analyze the extent of the cellular dysplasia. Mary appears disheveled and unkempt. She was brought to the clinic by a caretaker from the group home where she resides. Her history shows she has been chronically ill with schizophrenia since her early twenties when she had her first psychotic episode while undergoing the rigors of boot camp. She has been under the care of a VA psychiatrist ever since. She is on several anti-psychotic medications which allow her to function at a basic level.

When preparing Mary for the procedure a medical resident reviewed the medical process of the colposcopy and obtained an informed consent. The resident then returned to report to the gynecological team. VA clinicians then entered the patient’s exam room to continue the exam. It was soon recognized that the patient was very confused and cognitively challenged.

The clinicians proceeded to ask if she knew what the medical procedure she would be under-going and the reason she will be having it done. In response she states, “Yes, you are going to be checking to see if I am pregnant.” This clearly exhibits that she is confused about the procedure. The clinic is very busy and many patients are waiting. If the procedure isn’t done grave consequences could result. What should be done at this time?

Review of Topics: Medical Indications

The diagnosis for this patient is “high grade squamous intraepithelial cells with probable glandular involvement”. Cells of this type can lead to cervical cancer if left untreated. According to the American Cancer Society, 3,870 women will die of cervical cancer in the United States this year (2). A colposcopy, which allows the visualization and identification of suspicious cells on the cervix, can be a life saving means for guiding treatment for women with this diagnosis. With the correct identification of the type of cell dysplasia that caused the initial abnormal pap smear, medical professionals can closely monitor the dysplasia and prevent the development of cervical cancer.

Patient Preferences

Even though this patient had signed the informed consent it was still not clear whether this patient could be considered ‘informed’. Does the patient comprehend the reasons for the treatment and the medical process she is about to undergo? Are the risks of the procedure fully understood? If she did sign the informed consent was she competent to make the decision? Are her medications interfering with the clarity of her thoughts? Is this confusion something that will clear and allow the patient to participate in her health care choices in a more coherent way at a later date? We must analyze and determine what the priorities for this patient are. What does the patient want? Are there options that the patient would prefer if the full range of treatments were clearly understood? If the patient is truly incompetent to make medical decisions, is there a legal surrogate who can be contacted and enlighten the clinicians regarding the patient’s full capacity and preferences?

Quality of Life

If this patient were allowed to proceed without treatment it could lead to cervical cancer and could result in radical surgical procedures. Many women end up having a hysterectomy when cervical cancer is found. That can put a female into early menopause which can greatly alter mood, comfort, sense of self and quality of life. If cervical cancer metastasizes there will be an involvement of other vital organs and could eventually lead to death. It could be argued that this patient with a chronic illness does not have a high quality of life as perceived by others, but that would not be justification for non-treatment. In this case, our interest is to prevent further need for painful treatments, hospitalizations, surgeries and possible chemotherapy. Allowing this patient to undergo unnecessary pain and discomfort is a strong incentive to act in a way which will improve her overall quality of life. How do these issues affect our decision to proceed?

Contextual Features

At this point in our decision making process there is a need to balance the ethical and legal obligations involved in this patient's healthcare. A VA clinician had started the process of caring for this patient's gynecological health by initially performing a pap smear. With the support of her group home care managers she has consented to the prior health exams with the possible understanding that these exams could lead to more extensive care. At this time there is no indication that she has assigned anyone as a medical surrogate. The patient is not resisting treatment at this time; rather, she is presenting herself to the clinic as a patient for the purpose of medical professionals managing for her health care needs. But the question still remains; can we ethically proceed with the procedure while the patient exhibits a questionable level of mental competence?

Case Analysis

This is a case of questionable mental competence in a patient presented with the signing of an informed consent. This raises the ethical question of how much information is sufficient for any patient to be truly informed prior to their signing an official informed consent document?

There have been many previous ethical cases involving the issue of informed consent being obtained from mentally ill patients. When patients are confused or unable to comprehend the medical procedure for which they are being asked to sign a consent, there are often legal channels within a hospital system which can allow the greater good to be done for the patient within legal parameters. Obtaining consent from a legal guardian or allowing time for the patient to clear mentally in order to comprehend the upcoming medical treatment would be two choices that allow the patient to be treated with respect and autonomy while preserving the clinician's interest in doing no harm (3).

The ethical decisions regarding this case would be significantly different if the patient's mental illness was causing her to vehemently oppose the medical procedure. Also, if the patient had not already been under the care of the VA hospital's gynecological clinic and had willingly presented for treatment there could be greater questions regarding her willingness to subject herself to a medical procedure and trusting that her care in the past had not caused her harm. With these principles in mind it would seem logical that the patient be reinstructed about the procedure at a level she could comprehend. This could let the clinicians proceed with the medical intervention to the benefit and protection of the patient, and satisfy the ethical principles of beneficence on the part of the clinicians.

This case also illustrates the need to apply the principle of autonomy to insure all patients are given full respect and opportunity to participate in their healthcare process. This would necessitate one avoid stereotyping patients which can lead to presumptive behavior within healthcare settings. As the health care providers for this patient, as well as any others with questionable mental competence, we would be risking serious error in judgment to fall into a paternalistic pattern of assuming our opinions and decisions should supersede the will of the mentally challenged patient (4).

The VA invites a large cross section of humankind into its healthcare service. Often due to the rigors of war and the traumatic experiences endured by individuals in battle many who avail themselves of the VA services have serious mental challenges. These cases pose ethical dilemmas to clinicians who daily practice the ethical principles of autonomy. Yet, clinicians are still urged to insure that patients are able to comprehend the medical procedures they are consenting to undergo. This also would be in harmony with the ethical principle of beneficence, which dictates the clinician practice in a manner which would promote the overall health and well-being of their patients.

When a clinic is busy there is an effort to see as many patients as possible in the shortest amount of time. Allowing equal time and quality of care to all patients can be a challenge. There is also a challenge for the clinician to avoid acting in a paternalistic way, assuming that the patient and provider have the same goals. A clinician must ask themselves: Do my views of those suffering from brain injury or mental illness affect my rational and judgment regarding the patient's ability to competently engage in decisions involving their own medical treatment?

Kleinman describes transactions between healer and patient in an effort to address the variety of situations which would cause a clinician or “healer” to abandon his internal ethical sense and submit to another voice. He suggests these interfering factors include institutional setting, interpersonal interaction, and number of participants involved (5).

In this case the clinical setting was unfavorable for allowing the patient to make a clear, informed consent. Her long history of chronic mental illness coupled with the rushed and busy atmosphere in the clinic created even more stress to the patient making it even more difficult for her to comprehend medical information. To apply moral competence and human values in this health care setting it was decided that the clinicians involved would take the needed time to review the colposcopy procedure with this patient and fully assess her capacity to sign an informed consent. With this effort to review the therapeutic expectations for all concerned; it became apparent that the clinicians and patient had the same goals a successful procedure. The clinicians could proceed with full confidence that the patient was fully informed and aware of the full medical implications and purpose of the procedure.

Points for discussion

This case study addresses the ethical principle of autonomy. Do we allow patients to choose medical treatment based on a thorough education of alternatives and risks; or do we arbitrarily and perhaps paternalistically decide who is or is not competent to give full informed consent and proceed with our own assessment of the situation?

This discussion cannot be complete without fully addressing the overall issue of informed consent.

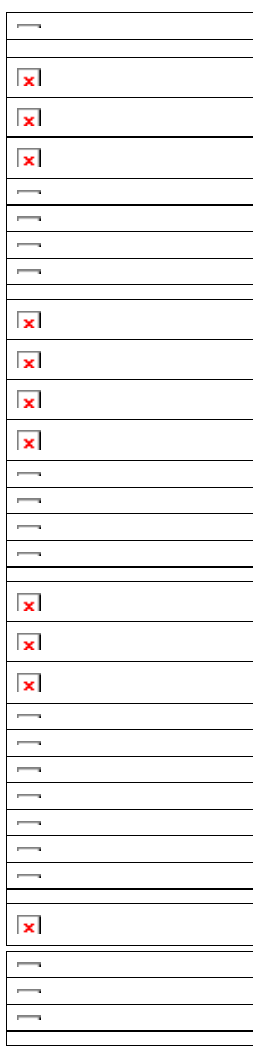
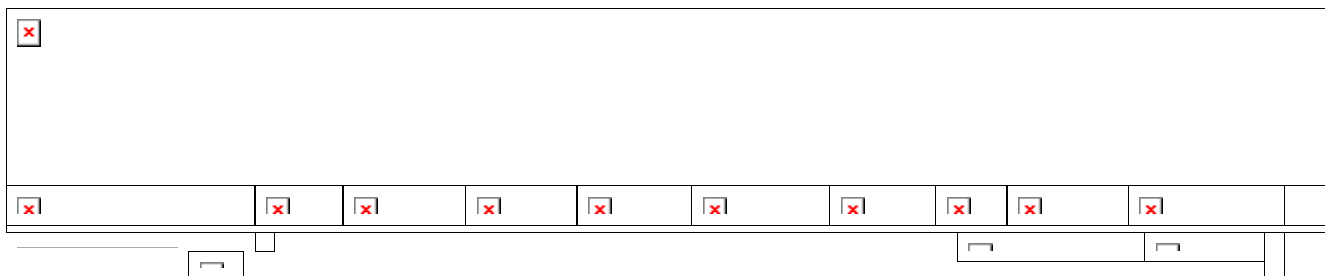
- What would the average patient need to know in order to be an informed participant in the decision?
- What would the average patient need to know and understand in order to make a truly informed decision?

A patient without medical training cannot be expected to fully grasp the entire scope of a medical procedure and its' inherent risks. An established level of understanding would seem necessary to determine a standard for the level of information needed to establish guidelines in this area.

In addressing these issues inherent to the process of informed consent, clinicians should consider the ethical principle of justice (6). If guidelines do not enforce a level of competence needed for a patient to sign an informed consent we could be jeopardizing medical treatment to those who suffer from cognitive challenges and mental illness. Medical institutions must be careful not to over legislate in this area and to insure the rights and health care needs of mentally ill patients. Likewise as we see new cases and situations within our VA medical centers it behooves us to handle each case in a patient centered and ethically appropriate way.

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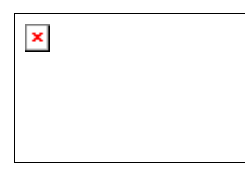
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Although abstracts are not published within the journal, the inclusion of an abstract with a submission assists in the review process and is required for certain manuscript types. Key words are similarly required. It is not necessary that these components be included in the manuscript file, however, as you will be prompted to enter them separately as part of the Editorial Manager manuscript submission process.

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In general, manuscripts submitted for consideration as feature articles should be 4,000 words or less, including references. They should begin with a strong introduction that catches the reader's attention, identifies the need for the article, and explains how the article adds to the literature on the topic. The preferred format for the introduction is three to four paragraphs that follow a "lead, need, sell" structure:

- **Lead:** First paragraph is designed to catch the reader's attention. It may include relevant statistics that illustrate the importance of the information that will be presented in the article, an illustrative case (either hypothetical or actual), or some other eye-catching technique appropriate to the article's style and content.
- **Need:** Second (and possibly third) paragraphs should clarify the specific focus of the article, identifying some problem or area of importance that will be addressed in the article.
- **Sell:** Third or fourth paragraphs should explain how this article will address the problem or area of importance identified and how it will add to current health care literature on this topic.

Present background concepts early in the manuscript, followed by more complex ideas. Use subheads to differentiate major points of emphasis. For research articles, follow a standard organizational structure (introduction, background information, methods, results, discussion, conclusion).



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Books:

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Book chapters:

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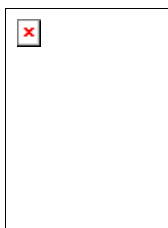


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SCHOOL OF NURSING
Ashland Klamath Falls La Grande Portland

DNP Clinical Inquiry Project Report & DNP Portfolio Approval

Student Name: NANCY SLOAN

Degree: Doctor of Nursing Practice

Title of Study:

Women Veteran's Health at the
PVAMC.

APPROVED:

Committee Chair: MAGGIE SHAW, CNM, PhD Signature: Maggie Shaw CNM, PhD
(name and credentials)

Committee Member: Deborah C. Messerer, PhD, MPH, RN, CNS Signature: [Signature]
(name and credentials)

Committee Member: _____ Signature: _____
(name and credentials)

Michael R. Bleich, PhD, RN, MPH, FAAN
Dean, School of Nursing

Signature: Michael R. Bleich

Date: JUN 4 2009

Submit completed original form to the Graduate Program office.

**Oregon Health & Science University School of Nursing
Doctor of Nursing Practice Program**

DNP Clinical Inquiry Chair and Committee Members Agreement

(The DNP Clinical Inquiry Committee consists of one chair, one faculty member, and one optional reader)

Student: Nancy Sloan
Print Full Name

Criteria for Clinical Inquiry Committee Chair

1. An earned doctorate
2. Member of OHSU School of Nursing DNP faculty
3. An advanced practice nurse
4. Demonstrated scholarship

I have consented to serve as Clinical Inquiry Committee Chair for the student named above:

[Signature] 5/10/09
Signature of Clinical Inquiry Committee Chair Date

error wrong line

Criteria for DNP Clinical Inquiry Committee Member

1. An earned doctorate
2. Content, methodological, or practice expertise related to the topic of the Clinical Inquiry.

(The Clinical Inquiry Committee member is selected by the student with the approval of the Clinical Inquiry Chair)

Clinical Inquiry Committee Member:

Name Signature Date

Criteria for DNP Clinical Inquiry Reader

Students have the option of inviting a clinical agency representative to serve as a Clinical Inquiry Reader.

Clinical Inquiry Reader:

Kari L. Tyne [Signature] 5/10/09
Name M.D. Signature Date

Approved:

Director, Doctor of Nursing Practice Program Date

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Portland VA Medical Center

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Responsible Individual: Nancy Sloan
 Department: Women's Health/Primary Care
 Project Title: Current Status of Women Veterans' Health Services

Please submit this completed checklist and a brief (1 page) description of the proposed project to the Research Assurance and Compliance Coordinator in the Research Office (Bldg. 101, Room 502).

CONDITIONS FOR DETERMINATION OF QA/QI STATUS		Yes	No
1. Is the project intended to measure variation by VA staff ¹ from standard of practice?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Is the project intended to improve adherence to standard of practice by VA staff?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the goal of the project to increase adherence to the formulary or national disease management guidelines?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Please indicate below all of the following that are measured with this project:			
a. <input type="checkbox"/> Variation from standard of practice	e. <input type="checkbox"/> Rate of adoption		
b. <input type="checkbox"/> Improved adherence with standard of practice	f. <input type="checkbox"/> Ease of implementation		
c. <input checked="" type="checkbox"/> Satisfaction with standard of practice	g. <input type="checkbox"/> Cost reduction		
d. <input type="checkbox"/> Feasibility	h. <input type="checkbox"/> Other:		
5. Is there a potential that this project could lead to publication(s) or presentation(s) reporting something other than those items checked in #4 above?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Does the project involve prospective assignment of patients to receive different or additional procedures or therapies?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Does the project involve a "control group" in whom an intervention is intentionally withheld to allow an assessment of its efficacy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Will individuals be exposed to additional physical, psychological, social or economic risks or burdens (beyond satisfaction surveys)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Will the project collect and record identifiers + health information (PHI ²) for purposes other than treatment, payment or operations?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Who or what VA organizational body (if any) authorized or sanctioned the project?			
11. Please include any comments or clarifications here regarding the project and/or questions:			

Nancy Sloan 10/1/08
 Signature of Responsible Individual: Date

Reviewer Comments: (Please document additional comments on the back)

Reviewer Signature and Name: Sola Whitehead Date: 10/9/08
E. Diane Anderson, RACC 10/9/08

¹ VA staff includes any individuals with a VA appointment. This includes staff paid by the VA as well as individuals who have a Without Compensation (WOC) appointment.

² PHI (Protected Health Information) = Health information + identifiers. The 18 HIPAA identifiers include:

1) Names; 2) All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of the zip code if according to the current publicly available data from the Bureau of the census: a) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and b) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

3) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and 4) ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.

5) Telephone numbers; 6) Fax numbers; 7) Electronic mail addresses; 8) Social security numbers; 9) Medical record numbers; 10) Health plan beneficiary numbers; 11) Account numbers; 12) Certificate/license numbers; 13) Vehicle identifiers and serial numbers, including license plate numbers; 14) Device identifiers and serial numbers; 15) Web Universal Resource Locators (URLs); 16) Internet Protocol (IP) address numbers; 17) Biometric identifiers, including finger and voice prints; 18) Full face photographic images and any comparable images; 19) Any other unique identifying number, characteristic, or code.

Project Description: Status of Women Veteran's Health at the PVAMC

The recent increase in the use of women in the military has resulted in an influx of women using the VA for health services. This has presented new challenges to the VA as they have historically been focused on providing health care for male veterans. The PVAMC is experiencing similar challenges. My 12 week project will assess what the current status of health care services are for women veterans at the PVAMC by analyzing data reflecting current use of PVAMC health services. I will also organize three focus groups through the local Veterans Center to discuss what women veterans see as barriers to their use of the PVAMC for health care.

Nancy Sloan, RN, ANP, CNS
Women Veterans Program Manager
Portland VA Medical Center