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Creating a Roadmap for Delivering Gender-sensitive Comprehensive Care for Women Veterans

Results of a National Expert Panel

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Background: Women Veterans are a significant minority of users of the VA healthcare system, limiting provider and staff experience meeting their needs in environments historically designed for men. The VA is nonetheless committed to ensuring that women Veterans have access to comprehensive care in environments sensitive to their needs.

Objectives: We sought to determine what aspects of care need to be tailored to the needs of women Veterans in order for the VA to deliver gender-sensitive comprehensive care.

Research Design: Modified Delphi expert panel process.

Subjects: Eleven clinicians and social scientists with expertise in women’s health, primary care, and mental health.

Measures: Importance of tailoring over 100 discrete aspects of care derived from the Institute of Medicine’s definition of comprehensive care and literature-based domains of sex-sensitive care on a 5-point scale.

Results: Panelists rated over half of the aspects of care as very-to-extremely important (median score 4+) to tailor to the needs of women Veterans. The panel arrived at 14 priority recommendations that broadly encompassed the importance of (1) the design/delivery of services sensitive to trauma histories, (2) adapting to women’s preferences and information needs, and (3) sex awareness and cultural transformation in every facet of VA operations.

Conclusions: We used expert panel methods to arrive at consensus on top priority recommendations for improving delivery of sex-sensitive comprehensive care in VA settings. Accomplishment of their breadth will require national, regional, and local strategic action and multilevel stakeholder engagement, and will support VA’s national efforts at improving customer service for all Veterans.

Key Words: comprehensive care, women’s health, sex sensitivity, Veterans

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Conceptual Framework for Evaluating Gender-sensitive Comprehensive Care

We integrated definitional elements of comprehensive care put forward by the Institute of Medicine (IoM) with aspects of gender-sensitive care culled from the published literature and expert opinion to arrive at domains of gender-sensitive comprehensive care for use in our expert panel (Fig. 1).

Methods

Gender-sensitive Care

The fragmentation of care that results from the often separate management of reproductive and nonreproductive health care needs for women has significantly complicated achievement of comprehensive care. The resulting “patchwork quilt with gaps” has contributed to significant gender disparities in care\(^{25}\) and bolstered recognition of the importance of advancing care that is gender sensitive.\(^{26-28}\) We examined the literature for domains of gender-sensitive care and interviewed selected subject matter experts outside the VA to identify discrete domains that spanned (1) gender-specific care (eg, female reproductive health services), (2) gender awareness (eg, clinical understanding and system of care features that acknowledge sex differences in the prevalence, presentation, and/or treatment of health conditions), and (3) sex sensitivity (eg, attributes of care that reflect relational and other preferences).

We then applied these domains to the VA healthcare system to arrive at our conceptual framework for evaluating aspects of gender-sensitive comprehensive care (Fig. 2). We integrated VA policies on primary care, women’s health, and mental health care delivery, including relevant guidance on VA’s patient-centered medical home model (Patient Aligned Care Teams or PACT). Aspects of care for other settings, such as emergency rooms and long-term care facilities, were not included. We specifically omitted aspects of emergency care because of recent completion of another expert panel focused exclusively on the resources and processes of care for women Veterans in VA emergency rooms.\(^{29}\) On the basis of the age distribution of women Veterans and their use of VA long-term care services, we also did not include aspects of extended care, with the exception of transfers from VA hospitals to nursing homes (as an aspect of care coordination). We also asked local VA managers and frontline women’s health clinicians to identify omissions and candidates for trimming.

Table 1 contains the final aspects of care organized along domains from our conceptual framework: first contact (19 aspects), primary care (49 aspects), specialty care (20 aspects), acute inpatient care (8 aspects), coordination of referrals (9 aspects), health care workforce (3 aspects), and quality improvement capacity (4 aspects). First contact, primary care, and specialty care were further divided into subgroups; for
Example, first contact care included aspects for outreach policies and practices, registration procedures for enrolling in and accessing care, and first appointment experience.

**Expert Panel Methods**

We applied expert panel methods using a modified nominal group technique to come to consensus on the aspects.
### TABLE 1. Median Score Rank Ordered Final Expert Panel Ratings of Importance of Tailoring Aspects of Care to the Needs of Women Veterans*

| First contact (19 aspects) | Panel Scores | Mean (SD) | Panel Scores | Mean (SD) |
|---------------------------|--------------|-----------|--------------|-----------|
| **Outreach policies and practices** |             |           |             |           |
| VA Web site (http://www.va.gov) | 5            | 4.67 (0.50) | 4            | 3.11 (1.17) |
| Information letters (ie, descriptions of VA health care options and services) | 5            | 4.33 (1.00) | 3            | 3.11 (1.54) |
| Outreach and education efforts in the community (eg, Vet Centers, social service agencies, state Veteran commissions) | 5            | 4.33 (0.87) | 3            | 3.44 (0.88) |
| Marketing campaigns to increase Veteran enrollment | 4            | 4.44 (0.53) | 3            | 3.33 (0.87) |
| First telephone contact | 4            | 4.22 (0.97) | 3            | 3.11 (1.76) |
| Debriefing phase (ie, information session immediately before military discharge) | 4            | 4.00 (1.00) | 3            | 3.11 (1.17) |
| **Registration procedures for enrolling in and accessing care** |             |           |             |           |
| Entrance to the VA (including front desk) | 4            | 3.89 (0.93) | 3            | 2.89 (1.36) |
| Registration office | 4            | 3.78 (0.83) | 3            | 2.89 (1.36) |
| General information when entering the VA health care system | 4            | 3.78 (0.83) | 2            | 2.89 (1.36) |
| My Health/Vet content (patient web portal) | 3.5           | 3.00 (1.31) | 2            | 2.89 (1.36) |
| Transportation to the VA | 3            | 2.78 (1.09) | 2            | 2.89 (1.36) |
| **First appointment experience** |             |           |             |           |
| Privacy issues | 5            | 4.56 (0.73) | 4            | 3.56 (1.01) |
| Physical safety on campus, in buildings | 5            | 4.44 (0.73) | 4            | 3.56 (1.01) |
| Making the first appointment | 5            | 4.33 (1.12) | 4            | 3.56 (1.01) |
| Availability of female provider | 5            | 4.33 (1.00) | 3            | 3.44 (1.01) |
| Availability of female nurse | 4            | 4.33 (0.50) | 3            | 3.44 (1.01) |
| First contact | 4            | 3.89 (1.05) | 3            | 3.44 (1.01) |
| Availability of other female personnel | 4            | 3.78 (0.97) | 2            | 2.22 (0.83) |
| Waiting room | 3            | 3.22 (0.83) | 2            | 2.22 (0.83) |
| **Ambulatory care settings: primary care (49 aspects)** |             |           |             |           |
| **Assessment, screening, and preventive care** |             |           |             |           |
| Obtaining mammogram | 5            | 3.78 (1.72) | 4            | 3.56 (1.01) |
| Obtaining Pap smear | 5            | 3.78 (1.72) | 4            | 3.56 (1.01) |
| Military sexual trauma (MST) screening | 4            | 4.33 (0.71) | 3            | 3.56 (1.01) |
| Approach to screening for sexually transmitted infections | 4            | 4.11 (0.78) | 3            | 3.56 (1.01) |
| Obesity management/weight loss programs | 4            | 4.11 (0.33) | 3            | 3.56 (1.01) |
| General mental health assessment | 4            | 4.00 (1.12) | 3            | 3.56 (1.01) |
| Medical history assessment (social history) | 4            | 3.78 (1.09) | 3            | 3.56 (1.01) |
| Smoking cessation programs | 4            | 3.67 (0.50) | 3            | 3.56 (1.01) |
| Medical history assessment (family history) | 3            | 3.56 (1.01) | 3            | 3.56 (1.01) |
| Cardiovascular risk screening | 3            | 3.44 (0.53) | 2            | 2.22 (0.83) |
| Immunizations | 2            | 2.33 (1.22) | 2            | 2.22 (0.83) |
| **Structure, staffing, and care arrangements** |             |           |             |           |
| Appropriately equipped examination tables routinely available | 5            | 4.89 (0.33) | 4            | 3.56 (1.01) |
| Reliance on designated women’s health providers in primary care/PACT clinics | 5            | 4.22 (1.09) | 4            | 3.56 (1.01) |
| VA-paid fee basis (per visit fee) or contract arrangements with providers in the community | 5            | 4.22 (1.39) | 4            | 3.56 (1.01) |
| Enhancing teamlet to women Veteran communication | 4            | 4.00 (1.07) | 4            | 3.56 (1.01) |
| Integration of selected high-use specialists by women Veterans directly in women’s clinics or Women’s Health PACT teams | 4            | 3.78 (0.83) | 3            | 3.56 (1.01) |
| Integration or referral to non-MD professionals | 4            | 3.56 (1.01) | 3            | 3.56 (1.01) |
| Enhancing within teamlet communication | 4            | 3.33 (1.41) | 3            | 3.56 (1.01) |
| Care management processes for women Veterans | 4            | 3.11 (1.45) | 3            | 3.56 (1.01) |
| **(Continued)** |             |           |             |           |

* Separate exclusive use examination rooms for women Veterans
* Availability of same-sex providers (if preferred)
* Approaches to improving preventive care
* Care management for high-risk patients
* Electronic consults in electronic medical record (e-consults)
* Approaches to improving care transitions (eg, between hospital and home, between hospital and nursing home)
* Availability of non-face-to-face care (eg, secured messaging)
* Approaches to improving chronic care management
* Separate waiting rooms for women Veterans
* Approaches to improving women Veterans’ transitions between teamlets and the larger team in PACT
* Availability of non-face-to-face care (eg, secured messaging)
* Current PACT teamlet composition
* Ability to offer same-day appointments
* Group visits
* Referral procedures for obtaining access to specialty care from primary care
* Telenursing
* Telenetting
* Content of care/services
* Patient education
* Diagnosis and treatment of pelvic and abdominal pain
* Chronic disease management
* Medication management
* Self-management support
* Diagnosis and treatment of chronic pain
* Diagnosis and treatment of gastrointestinal problems
* Health coaching (including motivational interviewing)
* Diagnosis and treatment of skin problems
* Shared decision making
* Diagnosis and treatment of minor illnesses (eg, upper airway infection)
* Approaches to involving patients in their own care
* Diagnosis and treatment of chronic fatigue syndrome

### Ambulatory care settings: specialty care (26 aspects)

#### Medical/surgical services

| Gynecology care (including obstetric care) | 5 | 4.56 (1.33) | 4 | 3.56 (1.01) |
| Postdeployment health care (ie, care for returning Veterans) | 4 | 3.56 (0.88) | 3 | 3.33 (1.22) |
| Cardiovascular care | 4 | 3.33 (1.22) | 3 | 3.50 (0.93) |
| Urology care | 3.5 | 3.50 (0.93) | 3 | 3.00 (0.87) |
| Surgery care | 3 | 3.00 (0.87) | 3 | 3.00 (0.50) |
| Orthopedic care | 3 | 3.00 (0.50) | 3 | 3.00 (0.50) |

#### Reproductive health care

| Contraception (including intrauterine devices) | 5 | 4.67 (0.50) | 4 | 3.56 (1.01) |
| Infertility problems | 5 | 4.67 (0.71) | 3 | 4.44 (1.33) |
| Maternity services | 5 | 4.44 (1.33) | 3 | 3.56 (1.01) |
| Availability of same-sex providers (if preferred) | 5 | 4.44 (0.88) | 3 | 3.56 (1.01) |
TABLE 1. Median Score Rank Ordered Final Expert Panel Ratings of Importance of Tailoring Aspects of Care to the Needs of Women Veterans* (continued)

| Aspect of Care | Panel Scores | Median (SD) | Mean (SD) |
|---|---|---|---|
| Menopausal complaints | 5 | 4.33 (1.32) | 4.33 (1.32) |
| Treatment of sexually transmitted infections | 5 | 4.22 (1.09) | 4.22 (1.09) |
| Mental health care | 5 | 4.78 (0.44) | 4.78 (0.44) |
| Screening for nonmilitary sexual violence (eg, domestic, intimate partner violence, nonmilitary-related rape) | 5 | 4.78 (0.67) | 4.78 (0.67) |
| Management of care for exposure to sexual violence | 5 | 4.78 (0.67) | 4.78 (0.67) |
| Care for posttraumatic stress disorder (PTSD) | 5 | 4.56 (0.73) | 4.56 (0.73) |
| Management of eating disorders | 5 | 4.44 (0.73) | 4.44 (0.73) |
| Availability of same-sex providers (if preferred) | 5 | 4.33 (0.87) | 4.33 (0.87) |
| Screening for military sexual trauma (MST) | 5 | 4.22 (0.97) | 4.22 (0.97) |
| Care for sexual dysfunction | 4 | 4.33 (0.71) | 4.33 (0.71) |
| Management of care for serious mental illnesses (eg, bipolar) | 4 | 3.78 (0.85) | 3.78 (0.85) |
| Management of substance use disorders (alcohol and/or drug) | 4 | 3.78 (0.67) | 3.78 (0.67) |
| Management of suicidality (ie, diagnosis and treatment) | 4 | 3.56 (0.88) | 3.56 (0.88) |
| Suicide prevention | 4 | 3.44 (0.73) | 3.44 (0.73) |
| Management of care for major depressive disorders | 3 | 3.44 (0.88) | 3.44 (0.88) |
| Management of care for anxiety disorders | 3 | 3.44 (0.88) | 3.44 (0.88) |
| Care for personality disorders | 3 | 3.33 (0.71) | 3.33 (0.71) |

**Other settings**: acute inpatient (8 aspects)

| Aspect of Care | Panel Scores | Median (SD) | Mean (SD) |
|---|---|---|---|
| Privacy issues (eg, private rooms, beds, bathroom) | 5 | 4.78 (0.67) | 4.78 (0.67) |
| Inpatient staffing mix (ie, availability of same-sex providers and/or staff) | 4 | 3.89 (0.93) | 3.89 (0.93) |
| Pain management | 3 | 3.44 (0.88) | 3.44 (0.88) |
| Nurse communication | 3 | 3.33 (1.12) | 3.33 (1.12) |
| Doctor communication | 3 | 3.22 (1.09) | 3.22 (1.09) |
| Admission processes | 3 | 3.00 (0.76) | 3.00 (0.76) |
| Transfer processes | 3 | 2.67 (1.22) | 2.67 (1.22) |
| Discharge processes | 2 | 2.67 (1.22) | 2.67 (1.22) |

**Coordination of referrals (9 aspects)**

| Aspect of Care | Panel Scores | Median (SD) | Mean (SD) |
|---|---|---|---|
| Care coordination between VA and non-VA providers | 5 | 3.89 (1.54) | 3.89 (1.54) |
| Use of peer navigators (ie, patients who help other patients with same diagnoses to navigate the system of care) | 3 | 3.67 (0.87) | 3.67 (0.87) |
| Transfer from VA emergency departments/rooms to other specialties including primary care | 3 | 3.22 (1.39) | 3.22 (1.39) |
| Information management and decision support tools integrated in VA electronic medical record (for prevention, diagnoses, and follow-up) | 3 | 2.78 (1.48) | 2.78 (1.48) |
| Specialty Care Access Network (SCAN) (ie, specialist-delivered electronic case conferences) | 3 | 2.78 (1.39) | 2.78 (1.39) |
| Transfer from VA hospital to nursing home (also called community living centers) | 3 | 2.56 (1.13) | 2.56 (1.13) |
| Approach to integrating family members into decision making | 2 | 2.67 (1.22) | 2.67 (1.22) |
| Care coordination of services within VA (referral processes, support in appointment management) | 2 | 2.44 (1.13) | 2.44 (1.13) |

**Coordination of referrals (9 aspects) (continued)**

| Aspect of Care | Panel Scores | Median (SD) | Mean (SD) |
|---|---|---|---|
| Care coordination between VA and non-VA providers | 2 | 2.33 (1.00) | 2.33 (1.00) |

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**Panelist Selection**

We selected panelists on the basis of their knowledge of the patient population and the VA, with a focus on expertise in women’s health, primary care, and mental health care. National VA leaders in women’s health and mental health were recruited and also asked for nominations of experts in the field, seeking a multidisciplinary mix of panelists representing a regional and urban/rural distribution. We also identified a pool of experts in women’s health outside the VA.

We sent email invitations to prospective panelists until we successfully recruited 11 panelists (9 clinicians/2 non-clinicians, 10 VA/1 non-VA expert, 9 urban/2 rural). Almost all of the VA clinicians also had university appointments, with non-Veteran patient panels at their respective schools of medicine. Final panelists represented 7 states in all 4 VA regions and included expertise in general internal medicine, obstetrics-gynecology, family medicine, clinical psychology, epidemiology, and sociology. Travel costs for attendance at an in-person meeting in Washington, DC were covered for...
each panelist.

Panel Process

In round 1, panelists received emails containing key articles on gender-sensitive care and a prepanel rating form that asked panelists to rate how important it was for the VA to develop a tailored approach for each listed aspect of care for women Veterans. We used a 5-point Likert scale from “1” (not at all important) to “5” (extremely important). (A copy of the rating form is available on request.) In round 2, the panel met face-to-face with 2 panel moderators (E.M.Y./M.d.K.) in a day-long meeting (June 2012) to review aggregated panel ratings as a guide to discussion of areas of agreement and disagreement. After reviewing aggregated ratings and open-ended comments for each aspect of care, we presented the panel with their top-rated priorities overall and went through an iterative discussion allowing members to add elements only if an equal numbers were deleted. Discussion continued until a final list reflected group consensus (Table 2). In round 3, panelists ratered the same aspects of care to verify consensus with the final priority ratings.

Statistical Analysis

We calculated univariate statistics for the panel ratings of each aspect of care. We used a median score of ≥ 4.0 (very-to-extremely important) on the 5-point scale as the criterion for required tailoring to meet women Veterans’ needs and thus a key aspect for achieving gender-sensitive comprehensive care.

RESULTS

Expert Panel Ratings by Domain

Table 1 contains the rank ordered final expert panel ratings within each domain of gender-sensitive comprehensive care. Overall, 68 of the 118 aspects (58%) had median scores that met our criterion for tailoring.

First Contact

Overall, 16 of the 19 aspects (84%) of women Veterans’ first contact with the VA healthcare system achieved a median score of ≥ 4 (ie, met criterion). All outreach policies and practices require tailoring to the needs of women Veterans, including VA Web site, information letters sent out to women describing VA healthcare options, outreach/education in the community, marketing campaigns, first telephone contacts, and the debriefing process following military discharge. Panelists also recommended tailoring registration procedures, attention to the main entrances to VA facilities and registration office, and all general information provided when entering the VA healthcare system. First appointment experiences were seen as a critical opportunity for making optimal impressions on women Veterans new to the VA. Top priorities included attention to privacy and physical safety on campus and in buildings, tailoring the processes for making the first appointment, as well as ensuring the availability of female providers and nurses.

Primary Care

Overall, 22 of the 49 aspects (45%) met criterion requiring tailoring. We organized primary care aspects into 3 subdomains: (1) assessment, screening, and preventive care (11 aspects); (2) structure, staffing, and care arrangements (25 aspects); and (3) content of care/services (13 aspects). Eight of the 11 aspects (73%) on assessment, screening, and preventive care scored 4+. Most focused on sex-specific screenings (eg, breast and cervical cancer screening) and sexual trauma/exposures (eg, MST, sexually transmitted infections). Others focused on health habits (eg, weight loss, smoking cessation) and approaches to assessment (eg, mental health and social history).

Nine of the 25 aspects (36%) of primary care structure, staffing, and care arrangements were rated as requiring
Tailoring. Structural aspects included availability of separate exclusive use examination rooms for women Veterans and routinely available and appropriately equipped examination tables. Staffing needs included reliance on designated women’s health providers in primary care/PACT clinics, integration of selected high-use specialists directly in women’s clinics or PACT teams, with integration or referral to non-MD professionals as needed. Attention to tailoring arrangements for women Veterans referred to community providers was also a priority. Ratings for tailoring care arrangements focused on enhancing PACT teamlet-to-women Veteran and within-teamlet communication, with enhanced care management.

Six of the 13 aspects (46%) of primary care content of care/services require tailoring. Chief among them was patient education, followed by special attention to diagnosis and treatment of pelvic and abdominal pain, chronic pain and gastrointestinal problems, chronic disease and medication management, and self-management support.

Specialty Care
Twenty of the 26 aspects (77%) of specialty care were rated as requiring tailoring. We organized specialty care into (1) medical/surgical services (6 aspects); (2) reproductive health care (6 aspects); and (3) mental health care (14 aspects). Half of the medical/surgical services aspects were recommended to be tailored, including gynecology, post-deployment, and cardiovascular care, while all aspects of reproductive health require tailoring based on final panel scores. Eleven of the 14 aspects of mental health care (78%) met our criterion for tailoring. Many of these aspects focused on sexual trauma/violence (screening, management of care for exposures) or sexual dysfunction, and also included care for posttraumatic stress disorder, eating disorders, serious mental illness, and substance use disorders. VA approaches to suicide prevention and management of suicidality were also rated as requiring tailoring to women Veterans’ needs.

Acute Inpatient Care
Two of the 8 aspects (25%) of inpatient care met our criterion and focused on privacy issues and inpatient staffing mix (ie, availability of same-sex providers and/or staff if preferred).

Coordination of Referrals
Only care coordination between VA and non-VA providers was rated as requiring tailoring (1 of the 8 aspects or 12%).

Health Care Workforce
All 3 aspects (100%) were rated as requiring tailoring: new employee orientation, ongoing medical staff education, and general education of clerks.

QI Capacity
All 4 aspects (100%) of QI capacity were also rated as requiring tailoring, and included attention to tailoring organizational culture, guideline implementation, clinical reminders/templates in the electronic medical record, and performance measurement (eg, evaluating determinants of sex differences).

Top Priorities for Achieving Gender-sensitive Comprehensive Care
After structured review of each domain, we presented the expert panel with their top-rated aspects of care across all domains and facilitated a final round of consensus development. Panelists worked collaboratively to recombine and distill several discrete aspects into broader recommendation statements, arriving at 14 consolidated priority recommendations for achieving gender-sensitive comprehensive care for women Veterans in the VA healthcare system (Table 2).

DISCUSSION
We used an expert panel process to evaluate the aspects of care that should be tailored to the needs of women Veterans to deliver gender-sensitive comprehensive care. Of over 100 discrete aspects of care, panelists rated over half of them as very-to-extremely important to tailor. Essential aspects spanned the need to tailor women’s first contacts with the VA healthcare system and their subsequent care in different VA settings, as well as the choice of community providers and the arrangements made to coordinate care between VA and community providers. The panel ratings suggest that meeting women Veterans’ needs will require tailoring the orientation, education, and training of the VA workforce to meet clinical care needs (eg, gender incorporated into guideline implementation) and to transform the organization’s culture to be more gender sensitive. Identifying strategies for offering access to same-sex providers and staff in all VA care settings if preferred by female patients will also be important. The panel ultimately came to consensus on 14 priority recommendations that broadly encompass the importance of (1) the design/delivery of services sensitive to women’s gender-specific care needs in the context of potential trauma histories, (2) adapting to women’s preferences and information needs, and (3) gender awareness and cultural transformation in every facet of VA operations.

Tailoring first contact experiences to the needs of women Veterans has important ramifications for the VA system, as recent evidence suggests high rates of attrition among new women Veteran VA users. Consistently ensuring the privacy, safety, and security of all entire VA campuses is essential, with explicit attention to building entrances and public spaces. One panelist mentioned a VA hospital where rows of waiting room chairs lined the main entrance, making women feel like they were “walking a gauntlet.” VA has also instituted a national call center for Veteran outreach, including tailored protocols for enrolling eligible women in VA care. However, the extent of tailoring of telephone protocols at local VAMC call centers is unknown.

Adapting primary care to the needs of women Veterans may be challenging on several levels. Although VA gender-specific preventive screening rates (eg, breast and cervical cancer screening) are higher than outside the VA, tailoring smoking cessation

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and weight management programs based on women Veterans’ preferences has proved difficult.35 Consolidating care to a subset of designated providers has improved women’s experiences with VA primary care,36 yet limits opportunities for others to gain needed expertise. As women who have lower ratings of a VA’s gender-specific features of care are much more likely to leave VA, the VA can ill afford to move beyond the designated provider model until the volume of female patients hits some critical threshold.37 Establishing arrangements with community providers for care outside the VA must also be tailored, though recent legislation fostering such access does not take gender differences into account.38

We found that the panel ratings of importance of tailoring specialty care varied, perhaps as a result of gaps in knowledge of women Veterans’ chronic care needs.39 All aspects of reproductive health were rated highly, consistent with strategies for transforming VA reproductive health care delivery.40 Most aspects of mental health care also warrant tailoring, for example, to address gender differences postdeployment.41 while gender differences in detection and management of cardiovascular disease have resulted in lingering quality gaps in VA.42 More research is needed to examine aspects of sex-sensitive medical/surgical specialty and acute care.

Improving the gender sensitivity of the VA workforce, given generations caring for men, could prove challenging. Certainly, universal access to same-sex employees is unlikely, as federal hiring practices preclude use of sex as a criterion. The VA has instead focused on proficiency, which is arguably more important as women are not automatically embued with gender sensitivity by virtue of their sex. Establishing women’s health proficiency standards (ie, training, minimum patient volumes) has resulted in placement of designated providers in the vast majority of VA facilities.43 An evidence-based curriculum that improves VA provider/staff gender awareness has also been developed, and is ready for broad deployment.44 VAMCs also have Women Veterans Program Managers, who conduct “environmental rounds” and locally implement aspects of VA’s national culture change initiative (eg, “not every GI is a Joe”). Ongoing monitoring of women Veterans’ experiences with VA care should be used to determine the effectiveness of these efforts and inform future improvements.

Integrating gender in quality improvement efforts is also key. The VA already reports quality metrics by gender11,33 and has used them to reduce disparities.52 Greater attention to tailoring clinical guidelines, as suggested by the panel, is needed in areas with lingering disparities (eg, cardiovascular risk reduction, sex differences in lipid-lowering therapies).42,46 The VA’s electronic medical record should facilitate implementation once gender-tailored tools are developed and tested.

This work comes with important limitations. First, we focused on the VA healthcare system. While we incorporated experts with non-VA experience, experts in other settings or contexts may have generated different aspects of care to rate and arrived at different ratings. We also focused on women Veterans, whereas gender sensitivity is just as important for men. Results are also sensitive to panel composition,47 and would benefit from replication.

CONCLUSIONS

Improving our understanding of the complex interplay of sex and gender on the delivery and experience of health and health care is essential to reducing longstanding disparities and improving population health.20 This paper aims to add to that understanding through use of expert panel methods focused on women Veterans in the VA healthcare system, while broadly contributing to the conceptualization of gender-sensitive comprehensive care.

More specifically, these expert panel recommendations may serve as a quality improvement roadmap for improving delivery of gender-sensitive comprehensive care in VA settings. Acting on these recommendations will require multi-level engagement of a broad range of stakeholders at national, regional, and local levels, with special attention to effectively engaging the Veterans we serve in designing first contact and subsequent care so that the VA is no longer another “patchwork quilt.”48,49

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