



Women Veterans' Health

The Role of Organizational Factors in the Provision of Comprehensive Women's Health in the Veterans Health Administration



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A B S T R A C T

Background: Increasing numbers of women veterans present an organizational challenge to a health care system that historically has served men. Women veterans require comprehensive women's health services traditionally not provided by the Veterans Health Administration.

Objective: Examine the association of organizational factors and adoption of comprehensive women's health care.

Study Design: Cross-sectional analysis of the 2007 Veterans Health Administration National Survey of Women Veterans Health Programs and Practices.

Methods: Dependent measures included a) model of women's health care: separate women's health clinic (WHC), designated women's health provider in primary care (DWHP), both (WHC+DWHP), or neither and b) the availability of five women's health services: cervical cancer screening and evaluation and management of vaginitis, menstrual disorders, contraception, and menopause. Exposure variables were organizational factors drawn from the Greenhalgh model of diffusion of innovations including measures of structure, absorptive capacity, and system readiness for innovation.

Results: The organizational factors of a gynecology clinic, an academic affiliation with a medical school, a women's health representative on one or more high-impact committees, and a greater caseload of women veterans were more common at sites with WHCs and WHC+DWHPs, compared with sites relying on general primary care with or without a DWHP. Academic affiliation and high-impact committee involvement remained significant in multivariable analysis. Sites with WHCs or WHC+DWHPs were more likely to offer all five women's health services.

Conclusion: Facilities with greater absorptive capacity (academic affiliation and women's health representation on high-impact committees) are more likely to adopt WHCs. Facilities with separate WHCs are more likely to deliver a package of women's health services, promoting comprehensive care for women veterans.

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The number of women serving in the military has increased over the last several decades with women now comprising 14% of enlisted forces ([National Center for Veterans Analysis and Statistics, 2011](#)). Following from this expansion, there has been a parallel influx of women patients into the Veterans Health Administration (VHA). Women are a minority population in the VHA (6.5% of all VHA patients in 2012), but they are among the fastest growing populations of VHA users, nearly doubling in the last decade ([Women's Health Evaluation Initiative, 2014](#)). Women veterans are more likely to use VHA services compared

with men (Hayes & Krauthamer, 2009), report poorer health status compared with male veterans and nonveteran women (Skinner et al., 1999), and require reproductive and gynecologic care not traditionally provided by the VHA (National Center for Veterans Analysis and Statistics, 2011).

Accommodating this rapidly growing demographic of patients into a health care system that historically has served primarily men poses challenges. Following a report by the General Accounting Office in the 1980s that found women veterans failed to receive comprehensive care within the VHA, legislation was passed mandating greater accessibility to a broader range of services for women. The first comprehensive women's health centers were formed in the early 1990s, aiming to provide "one stop shopping" for women veterans by delivering primary care and basic reproductive health services in one location (U.S. General Accounting Office, 1982, 1992).

Since the 1990s, there has been a growth of both women's health clinic (WHC) and designated women's health provider in primary care (DWHP) models of health care delivery for women veterans (Yano, Goldzweig, Canelo, & Washington, 2006). A WHC is a distinct physical location in a VHA facility with dedicated examination rooms and women's health staff, and may include a range of providers from general internists, nurse practitioners, and obstetrician/gynecologists. A WHC is also different from women's cancer screening clinics, providing both primary care and gender-specific services, rather than a few gender-specific services (Yano et al., 2006). In contrast, a DWHP has a panel of women patients who are seen in the general primary care clinic alongside male veterans.

A developing body of literature has examined the role of organizational factors on the adoption of women's health within

the VHA. For example, VHA facilities that are larger, have a separate budget for women's health, and are academically affiliated have been associated with greater availability of women's health services, including cervical cancer screening and evaluation of common gynecologic complaints (Washington, Caffrey, Goldzweig, Simon, & Yano, 2003). Having women's health clinical experts and same gender providers on staff is associated with provision of hormonal contraception (Katon et al., 2013). In addition, greater women's health clinical leader autonomy in staffing decisions, urban settings, hospital-based clinical settings, and academic affiliation also have been associated with advanced on-site gynecologic services (Cope, Yano, Lee, & Washington, 2006; Katon et al., 2013; Seelig, Yano, Bean-Mayberry, Lanto, & Washington, 2008).

In this study, we adapted the Greenhalgh model of diffusion of innovations in service organizations, which considers how an organization's structural characteristics, absorptive capacity for change and readiness for change are associated with adoption of innovation, specifically comprehensive women's health care (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Figure 1). Structural factors include size, centralization in decision making, and specialization of the organization. Absorptive capacity is an organization's ability to identify, assimilate, and integrate new knowledge (Cohen & Levinthal, 1990), whereas system readiness for change includes the resources an organization has for adoption and its ability to assess the innovation. We hypothesized structural, absorptive capacity, and system readiness organizational factors would be positively associated with adoption of WHC, and that WHC adoption would be positively associated with the availability of a package of women's health services (Greenhalgh et al., 2004; Rubenstein et al., 2014).

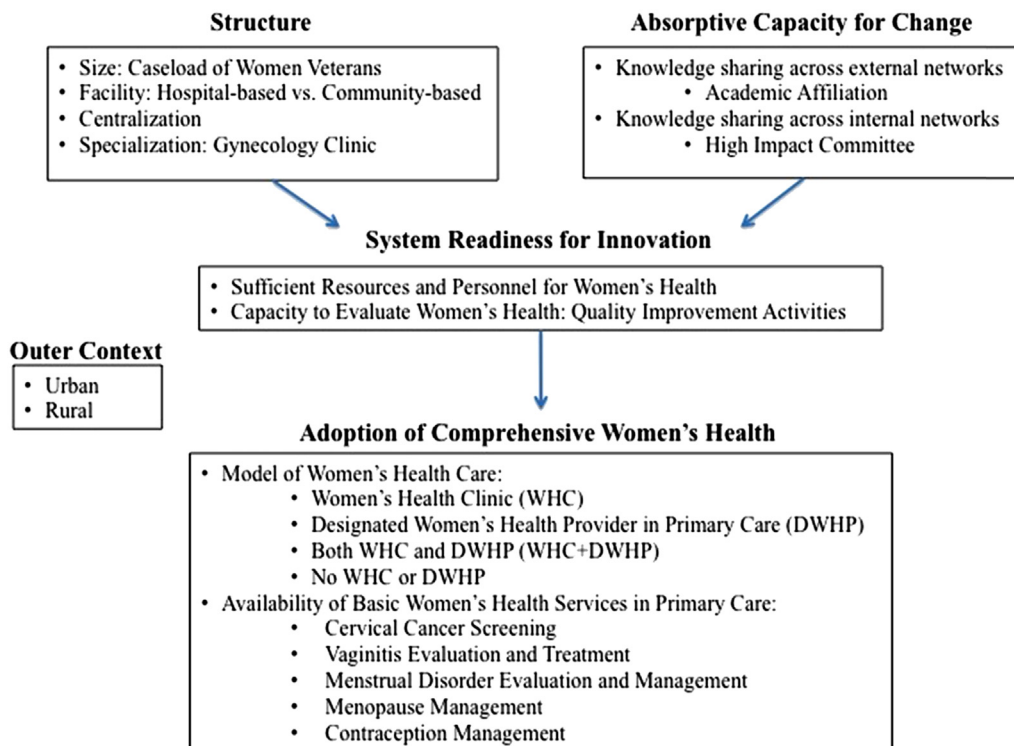


Figure 1. Conceptual framework.

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